# THE CASE FOR A HEALTH CARE BENEFIT CORPORATION

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## FOREWORD

**"Teleology is the study of the ends or purposes that things serve, and Aristotle's emphasis on teleology has repercussions throughout his philosophy. Aristotle believed that the best way to understand why things are the way they are is to understand what purpose they were designed to serve."**

*Aristotle (384-322 B.C.)*,[1]

**"The origin, the subject and the purpose of all social institutions is and should be the human person . . . ."**

*John Paul II, Encyclical Letter Veritatis Splendor P97 (1993) (quoting Second Vatican Ecumenical Council, Pastoral Constitution Gaudium et Spes P25 (1965))*.[2]

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[1] Ronald J. Colombo, *Religious Conceptions of Corporate Purpose*, 74 WASH. & LEE L. REV. 813, 814 n.2 (2017) (quoting *Aristotle (384-322 B.C.) Themes, Arguments, and Ideas*, SPARKNOTES, http://www.sparknotes.com/philosophy/aristotle/themes/ [https://perma.cc/5XPW-V8D9]).

[2] John F. Coverdale, *Why The Bottom Line is Not The Bottom Line: John Paul II's Concept of Business*, 45 J. CATH. LEGAL STUD. 473, 518 (2006).

## I. INTRODUCTION

In 2015, we published an article proposing creation of what we termed a "Health Care Benefit Corporation" (HCBC)—a specific variant form of the hybrid "benefit corporation."[3] In explaining the conceptual underpinnings of the HCBC, we described how Katherine R. Lofft had suggested the benefit corporation's potential application to health care in a 2013 article:

> Uncertainties notwithstanding, Lofft *et al*. believe that this hybrid organization offers "some promise in helping bridge the gap that exists between the historic [binary] approach to business structuring in the United States and

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[3] *See* Terry L. Corbett, *Healthcare Corporate Structure and the ACA: A Need For Mission Primacy Through a New Organizational Paradigm?*, 12 IND. HEALTH L. REV. 103, 172 (2015). As we there noted:

> The Benefit Corporation began as a "project of the non-profit organization B Lab." A white paper discussing the need and rationale for model legislation (and containing the model legislation itself) was drafted by principal authors William H. Clark, Jr., of Drinker, Biddle, & Reath LLP and Larry Vranka of Canonchet Group LLC. Kanig provides an excellent, concise summary of this hybrid legal structure:
>
> "Benefit corporations are dual purpose, blended entities, adhering to the mold of Dodd's social enterprise theory and the social entrepreneurship movement, *with a legal structure that embraces both the pursuit of profit and the material enhancement of the public good*. This general legal structure provides a benefit corporation with two distinct advantages over non-profits and traditional corporate entities. First, unlike non-profits, the board of directors may issue dividend payments to shareholders. *Escaping the non-distribution constraint is essential to accessing sufficient financing to compete with traditional corporate entities, while also attracting management talent who desire wealth. Second, the benefit corporation also possesses an affirmative statutory mandate to pursue the general public benefit, in addition to any specific public benefits included within the articles of incorporation.* This enables benefit corporations to transcend the efforts of corporate social responsibility because they are manifestly enabled to construct positive externalities. *The express statutory purpose of the benefit corporation is to distance itself from the shareholder wealth maximization norm that has dominated traditional corporations, to increase transparency in corporate decision-making, and to increase accountability for promised social outcomes*."

*Id.* at 172–73 (quoting Ian Kanig, *Note – Sustainable Capitalism Through the Benefit Corporation: Enforcing the Procedural Duty of Consideration to Protect Non-Shareholder Interests*, 64 HASTINGS L.J. 863, 891–92 (2013) (emphasis added)).

> the reality of the health care market and health care delivery as it exists today."[4] The "forces of change" in health care generally, and the new imperatives of the ACA [Affordable Care Act] specifically, clearly will:
>
> "require providers to make substantial upfront investments in new programs, systems, technologies and/or equipment that will deliver efficiencies, improve quality and maximize value over the longer term. They may also require various parties, including insurers, providers, vendors and others, to come together and find new and innovative ways to collaborate and/or integrate – to share knowledge, data and best practices to achieve these objectives. It would seem clear that efforts directed towards improving healthcare quality and maximizing value would have a significant public benefit typical of the public and nonprofit sectors. Such efforts and initiatives, however, may require or at least benefit from the involvement, institutional knowledge and capital raising potential of the private sector."[5]

From this vantage point, we went on to note that today's hospitals and hospital systems—many if not the majority of which are large, commercial nonprofit organizations—might well be better served by a new organizational paradigm: one that would go beyond the limitations of the historical binary choice of nonprofit and for-profit organizational forms and better support the '"integrated and coordinated care model' envisioned by the ACA."[6] Since that care model will necessarily "require additional industry consolidation, increased access to capital, closer collaboration between and among system participants, and greater accountability for quality and high-value outcomes," it seemed to us that some *uniquely-tailored form of benefit corporation* "expressly designed for health care delivery and predicated upon the concept of mission primacy and the Fiduciary Medicine Model" was a solution with considerable potential.[7]

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[4] *Id.* at 175 (citing Katherine R. Lofft et al., *Is a Hybrid Just What the Doctor Ordered? Evaluating the Potential Use of Alternative Company Structures by Healthcare Enterprises*, 25 ABA HEALTH L. 9 (April 2013)).

[5] *Id.* at 175–76 (citing Lofft, *supra* note 4, at 9) (emphasis in original).

[6] *Id.* at 179–80.

[7] *Id.* at 180.

Briefly put, we saw the HCBC as a new, unique corporate form that could better meet the requirements that Lofft foresaw.

In this follow-up article, we now undertake to "flesh out" the HCBC concept by further examining the nature of American corporations and what Lofft described as "the historic [binary] approach to business structuring in the United States and the reality of the health care market and health care delivery as it exists today."[8]

Section II begins our analysis with a more detailed review of the "Berle-Dodd debate"[9] and its continuing influence on corporate business structuring today. The Section includes additional discussion of the American corporation's still-unresolved "existential nature" and its reduction to a limited, binary choice between for-profit and nonprofit forms.

Section III examines the social and moral dimensions of the modern corporation, and identifies and evaluates various dissatisfactions with the limitations of the for-profit/nonprofit dichotomy. These dissatisfactions have increasingly led to a call for "a broad new composite reality" and suggestions for innovations ranging from "social responsibility," to "social entrepreneurship/social enterprise," to "constituency statutes," and finally to the "benefit corporation."

Section IV then focuses on the basic concept of a "benefit corporation" and provides a more comprehensive review of the concept's founders,

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[8] *Id.* at 175.

[9] *See* Kanig, *supra* note 3, at 885.

> During the Great Depression, a famous exchange between Adolf Augustus Berle and Edwin Merrick Dodd on the pages of the *Harvard Law Review* phrased the question thusly: Are corporations solely responsible to private ownership interests, or do they also possess obligations to benefit the general public welfare? Lines were drawn in the intellectual sand between Berle's *"shareholder primacy" theory* and Dodd's *"stakeholder theory" of corporate governance* – the former embracing corporations as private property, the latter as an integral component of any comprehensive system of social welfare. The future of corporate law and the culture of American business were at stake.
>
> [S]hareholder primacy theory triumphed in the courts, and the "shareholder wealth maximization norm," which made the promotion of shareholder returns the exclusive mandate of corporate decision making, was unshakably ingrained into the corporate ethos. The effects of this normative choice were enormous. . . .

*Id.* at 870 (emphasis added).

development, and current status. The benefit corporation "Model Act" is critiqued and select recent state-adopted variations are discussed.

Section V then shifts back to the health care delivery system, elaborating upon the current "deontology" of health care in America and the resultant forces driving continuing efforts at health care reform and ever-greater system integration.

Section VI follows on with a more complete discussion of "Accountable Care"—both as a general concept and as the principal mechanism for accomplishment of the ACA's primary aims through development of "Accountable Care Organizations" (ACOs), specifically designed to integrate, coordinate, and eventually finance the delivery of health care services.

Section VII then returns to and elaborates further upon three topics that are considered to be essential predicate objectives for the HCBC—"mission primacy," "fiduciary duty," and "medical trust."

Lastly, Section VIII explicates the proposed HCBC legal structure in far-greater detail than our initial article, explaining the specific features necessary for it to provide a viable and preferred corporate framework for the operation of institutional health care providers.

Section IX concludes with the optimistic expectation that the HCBC (so structured) could bring about "a broad new composite reality" for institutional health care delivery, wherein the legitimate interests of multiple stakeholders are better acknowledged and the professional culture of medicine—and patient trust therein—are fully restored.

## II. CORPORATE LAW IN THE AMERICAN TRADITION

> "[O]ver the past century we have lived with a 'schizophrenic conception of the business corporation,' in which a property model, which depicts the corporation as the property of its shareholders and run for their benefit, has lived uneasily alongside a 'social' conception, which sees the corporation as an institution 'tinged with a public purpose.'"[10]

[10] Harwell Wells, *"Corporation Law Is Dead": Heroic Managerialism, Legal Change, and The Puzzle of Corporation Law at The Height of The American Century*, 15 U. PA. J. BUS. L. 305, 311 (2013) (citing William T. Allen, *Our Schizophrenic Conception of the Business Corporation,* 14 CARDOZO L. REV. 261, 264–65 (1992)).

### *A. The Legacy of the Berle-Dodd Debate*

During the Great Depression (and the same year that he published *The Modern Corporation and Private Property* (1932)), Adolf A. Berle, then a professor at Columbia Law School, "engaged in a classic scholars' debate" with Professor E. Merrick Dodd of Harvard in a series of articles published in the Harvard Law Review.[11] In reaction to Professor Berle's assertion in an earlier article that "managerial powers are held in trust for stockholders as sole beneficiaries of the corporate enterprise,"[12] Professor Dodd initiated the debate by contending:

> [this writer] believes that public opinion, which ultimately makes law, has made and is today making substantial strides in the direction of *a view of the business corporation as an economic institution which has a social service as well as a profit-making function*, that this view has already had some effect upon legal theory, and that it is likely to have a greatly increased effect upon the latter in the near future.[13]
>
> Professor Berle [then responded]: "Now I submit that you cannot [sic] abandon emphasis on '*the view that business corporations exist for the sole purpose of making profits for their stockholders'* until such time as you are prepared to offer a clear and reasonably enforceable scheme of responsibilities to someone else."[14]

Professor Jill E. Fisch observes that Berle and Dodd were actually arguing two different points: what was corporate law's developing structure, and what should it be in the future?[15] To her view, Berle's concept of shareholder primacy was basically a "variant of trust law," premised upon the then-prevailing property law notion of managers properly fulfilling fiduciary duties to the "owners" of the corporation by

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[11] *See* A. A. Sommer, Jr., *Whom Should The Corporation Serve? The Berle-Dodd Debate Revisited Sixty Years Later*, 16 DEL. J. CORP. L. 33, 36–37 (1991).

[12] *Id.* at 37 (citing E. Merrick Dodd, Jr., *For Whom Are Corporate Managers Trustees?*, 45 HARV. L. REV. 1145, 1147 (1932) (summarizing the position of Professor Berle in *Corporate Powers As Powers in Trust,* 44 HARV. L. REV. 1049 (1931))).

[13] *Id.* (citing Dodd, Jr., *supra* note 12, at 1148) (emphasis added).

[14] *Id.* (citing A.A. Berle, Jr., *For Whom Corporate Managers Are Trustees: A Note,* 45 HARV. L. REV. 1365, 1367 (1932)) (emphasis added).

[15] *See* Jill E. Fisch, *Measuring Efficiency in Corporate Law: The Role of Shareholder Primacy*, 31 J. CORP. L. 637, 647 (2006).

acting as their trustees or agents.[16] By contrast, Dodd advanced what she characterizes as an "essentially normative and largely aspirational argument" that corporate managers "should concern themselves with the interests of employees, consumers, and the general public, as well as of the stockholders."[17] Berle essentially rejected Dodd's argument with the rejoinder that: "When the fiduciary obligation of the corporate management and 'control' to stockholders is weakened or eliminated, the management and 'control' become for all practical purposes absolute."[18]

If one could leave the Berle-Dodd debate here, the positions of these two scholars and their contributions to the development of modern corporate law would be relatively simple and straightforward. However, such is not the case. The implications of their 1932 debate are confounded by the fact that both men's positions were apparently somewhat malleable, each having changed their positions repeatedly over time as their thinking continued to evolve.[19] However, it remains true that most scholars today continue to look to their 1932 debate as the progenitor of a conflict in American corporate law that persists to this time—"whether corporations should only serve shareholders or other groups."[20]

### 1. *The Continuing Shareholder-Stakeholder Debate*

> Over the course of the past century, the famous debate between Adolph Berle and Merrick Dodd in the Harvard Law Review over the nature and purpose of the corporation has been traced and retraced in a pendulum swing between two fundamental positions. First is the shareholder-oriented view, that the corporation is formed

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[16] *See id*.

[17] *Id.* (quoting Dodd, Jr., *supra* note 12, at 1156).

[18] *Id.* (quoting Berle, Jr., *supra* note 14, at 1367).

[19] *See* William W. Bratton & Michael L. Wachter, *Shareholder Primacy's Corporatist Origins: Adolf Berle and The Modern Corporation*, 34 J. CORP. L. 99, 124 (2008). Not surprisingly, Professors Bratton and Wachter conclude that Berle and Dodd's historic debate is easily and often misread. *See id.* at 134. To their view, Berle "ended up as the putative great-grandfather of shareholder primacy . . . only because Dodd's attack placed him in that position." *Id.* at 135. While Berle did support shareholder primacy, he did so "only prior to his political metamorphosis and only in the strict confines of corporate law." *Id.* Similarly, while Dodd is generally viewed as a supporter of modern day "corporate social responsibility," he too succumbed over time to major shifts in perspective. *See id.* It appears, then, that neither were permanently committed to the positions they took during their 1932 debate, but were rather responding "to the politics of their day." *See id.*

[20] *See* Lisa M. Fairfax, *The Rhetoric of Corporate Law: The Impact of Stakeholder Rhetoric on Corporate Norms*, 31 J. CORP. L. 675, 682 (2006).

> from the nexus of private contracts (or is, alternatively, a private entity) whose primary purpose is to maximize shareholder wealth. Second is the stakeholder view, that the corporation has both public and private roles and must therefore be managed in the interests of a broader range of stakeholders, including employees, consumers, and even the public at large. Corporate law in most of the rest of the world follows a stakeholder approach, while dominant understandings of the corporation's role and purpose in the United States remain decidedly shareholder-oriented.[21]

Generally speaking, proponents of shareholder primacy view the corporation as no more than a vehicle through which shareholding individuals may freely associate for the sole, unimpeded purpose of increasing their wealth.[22] "They have a liberal view of property rights[,] . . . oppose government efforts at redistribution," and see the accumulation of wealth as the only reason for the corporation's existence.[23] Such attitude necessarily raises the predicate question of "why shareholders should have their privileged position in the first place."[24] Corporate law scholar Janet Dine argues that once the corporation is "up and running"—with shareholders having then completed their foundational role in providing initial start-up funding and organization—their claim to "primacy on that basis . . . loses significance."[25] Thereafter, "[f]rom an operational perspective," they are no more than "an additional," and probably "least preferred source of capital," with (except for their voting power) "no privileged position or interest."[26]

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[21] Virginia Harper Ho, *"Enlightened Shareholder Value": Corporate Governance Beyond the Shareholder-Stakeholder Divide*, 36 J. CORP. L. 59, 71–72 (2010). *See also* Colombo, *supra* note 1, at 832 (arguing that the shareholder-stakeholder debate reflects "a profound difference in normative world view . . . between communitarians and contractarians[:] . . . Contractarians start from the presumption that people ought to be free to make their own choices about how to live their lives . . . Communitarians [believe] . . . individuals owe obligations to each other that exist independently of contract . . . . The state acts appropriately when it enforces such duties." (quoting David Millon, *New Directions in Corporate Law: Communitarians, Contractarians, and the Crisis in Corporate Law,* 50 WASH. & LEE L. REV. 1373, 1382–83 (1993))).

[22] *See* Benedict Sheehy, *Scrooge – The Reluctant Stakeholder: Theoretical Problems in the Shareholder-Stakeholder Debate*, 14 U. MIAMI BUS. L. REV. 193, 213 (2005).

[23] *Id.*

[24] *Id.* at 220.

[25] *Id.* (citing JANET DINE, THE GOVERNANCE OF CORPORATE GROUPS 24 (2000)).

[26] *Id.*

The "stakeholder model"—in direct contrast to the "shareholder primacy model"—has sometimes been referred to as a "multi-fiduciary approach" that requires directors and management to fulfill fiduciary obligations to *all* of the corporation's significant constituencies.[27] The fundamental idea is that the affairs and activities of public corporations (particularly today's modern ones) are of such broad public concern and social impact that these entities cannot continue to be managed exclusively for shareholder benefit.[28] Variously called "the stakeholder framework," "stakeholder management," or "stakeholder theory," it is in fact more a "genre of . . . theories" than "just one basic theory."[29] For ease of discussion, we will nonetheless refer to the idea henceforth as simply the "stakeholder theory."

The history of stakeholder theory predates considerably Dodd's 1932 arguments. According to Professor Andrew Keay, the concept can be found in the work of "seventeenth century German social theorist, Johannes Althusius," with "incipient forms" of the theory having existed "since the advent of industrialism."[30] However, Professor Keay attributes the theory's development in "organi[z]ed modern form" to R. Edward Freeman's 1984 book, *Strategic Management: A Stakeholder Approach*.[31]

From a normative or moral perspective, stakeholder theory views shareholders as only one among many legitimately competing "contributors" to the success of the corporate enterprise.[32] *All* such contributors, as a matter of human rights and social justice, "have a right to be regarded as an end, and not a means to an end."[33] It is incumbent upon the corporation, therefore, to: create value for all stakeholders; be accountable to, and be managed for the benefit of, all stakeholders; coordinate the interests of all stakeholders and resolve conflicts between them; and, minimize the adverse effects of "externalities"[34] upon all stakeholders.[35] Simply put, *"[u]nder stakeholder theory, the duty of*

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[27] *See* 1 PUBLICLY TRADED CORPORATIONS: GOVERNANCE & REGULATIONS §2:5 (2014).

[28] *See* Andrew Keay, *Stakeholder Theory In Corporate Law: Has It Got What It Takes?*, 9 RICH. J. GLOBAL L. & BUS. 249, 252 (2010).

[29] *Id.* at 252–53.

[30] *Id.* at 253.

[31] *Id.* at 254.

[32] *See id.* at 255–56.

[33] *Id.* at 257.

[34] "Externali[z]ing is the practice of managers transferring the costs of the corporation to stakeholders and retaining resulting benefits for shareholders. This occurs, for example, where a corporation makes workers redundant so that dividends can be paid to shareholders and the share price will increase." *Id.* at 256.

[35] *See id.* at 256–57.

*managers of corporations is to create optimal value for all social actors who might be regarded as parties who can affect or are affected by a corporation's decisions."*[36] Accordingly, stakeholder theory tends to reconcile the traditional ambiguity between economics and ethics; that is to say, unlike the singular focus of shareholder wealth-maximization under "shareholder primacy," the focus of stakeholder theory is far broader—attempting to "do justice to the panoply of human activity that is value creation and trade, i.e., business."[37]

Beyond such normative arguments, adherents to the stakeholder theory offer several pragmatic justifications for their position. One of the most compelling is the "classic statement" made by R. Edward Freeman:

> Business is about putting together a deal so that suppliers, customers, employees, communities, managers and shareholders all win continuously over time. In short, at some level, stakeholder interests have to be joint—they must be traveling in the same direction—or else there will be exit, and a new collaboration formed.[38]

In other words, unless "cohesion among stakeholders" is maintained, the corporation ultimately will be unable to "satisfy customers in order to produce profits, recruit and motivate excellent employees, and build successful relationships with suppliers."[39] Lenders, suppliers, employees––all are stakeholders who have a legitimate (even if in some cases non-contractual or otherwise extralegal) "claim on the corporation's property and profits" by virtue of their individual and firm-specific "investments" in the corporation.[40] The *quid pro quo* for their continued support and cohesion is necessarily an acceptable level of fair treatment by the corporation.[41]

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[36] *Id.* at 256 (emphasis added).

[37] *Id.* at 262 (quoting R. Edward Freeman, *Stakeholder Theory and "The Corporate Objective Revisited"*, 15 ORG. SCI. 364, 364 (2004)).

[38] *Id.* at 264 (quoting Freeman, *supra* note 37, at 365).

[39] *Id.* at 265.

[40] *See id.* at 266 (i.e. lenders through their extension of credit, employees who may have undertaken specialized training, suppliers who may have acquired unique and specialized equipment, etc.).

[41] As Professor Keay notes:

> The theory posits that many stakeholders—who cannot obtain protection for reasons such as lack of bargaining power, ignorance, or insufficient funds to pay necessary costs (e.g. legal costs)—must rely on fair treatment. In actuality, contractual arrangements between equals occurs infrequently. Many contracts assume a "take it or leave it"

(*continued*)

Moreover, some proponents of stakeholder theory go considerably beyond the idea of providing all stakeholders with the kind of "fair treatment" described above. Desiring to "situate corporations more dynamically within a broader social, political, and economic context," Professor Kent Greenfield proposes a "conceptual innovation" that requires "the fiduciary obligations of management to run to the firm as a whole."[42] He does so in acknowledgment of the fact that "the interests of shareholders at best align only haphazardly with the interests of other stakeholders and of society as a whole, and at worst align not at all."[43]

Other proponents of stakeholder theory argue simply that the increasing complexity of the world at large necessarily means that corporations both affect, and are affected by, ever more individuals and groups of people.[44] A prominent modern example is the issue of environmental degradation—another "externality" not, until recently, seen as a major and proper concern of corporations.[45] "Stakeholder theorists often argue that their theory takes into account the complexity of the world, whereas shareholder primacy is far too glib."[46]

*2. A Pox on Both Your Houses*

To Professor Lyman Johnson, shareholder primacy and stakeholder theory are both problematic due to their grounding in a human anthropology "that remains [too] individualistic and self-interested."[47] Neither advances what he would suggest is the proper "vision of human role and motivation within an institutional setting"—"to advance the larger, common good of the company's mission."[48] He sees both theories as failing to promote "pursuit of an all-embracing corporate 'common good'" and as reducing to no more than "analytical and semantic

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> approach with the result that costs are imposed on third parties with whom the corporation does business. Several scholars have reported that contracts involving stakeholders are "neither complete nor perfectly priced."

*Id.* at 269 (citing Jill E. Fisch, *Measuring Efficiency in Corporate Law: The Role Of Shareholder Primacy*, 31 J. CORP. L. 637, 659 (2006)).

[42] Kent Greenfield, *The Third Way*, 37 SEATTLE U. L. REV. 749, 751 (2014).

[43] *Id.* at 750.

[44] *See* Keay, *supra* note 28, at 269.

[45] *See id.*

[46] *Id.*

[47] *See* Lyman Johnson, *Unsettledness In Delaware Corporate Law: Business Judgment Rule, Corporate Purpose*, 38 DEL. J. CORP. L. 405, 445 (2013).

[48] *Id.*

trope[s]."[49] He concludes: "This is odd, and a loss, given the very etymology of 'company' as meaning 'breaking bread' together, and of 'corporation' meaning 'body,' of which many parts are integral."[50]

### B. *The Corporation's Existential Nature—The Fiction, Aggregate & Real Entity Views*

Separate and apart from such fundamental questions as "for whose benefit does the firm operate" and "who should be in charge of corporate decision-making" is the even more basic question of "what" the firm (or corporation) actually "is." That is to say, what is its existential nature? Serious attempts to answer this question and to properly place the corporation within the legal system really began in the nineteenth century.[51] Out of those attempts came three distinct existential views of the corporation: the "fiction" theory, the "aggregate" theory, and the "real entity" theory.[52]

Development of "the Roman law inspired 'fiction theory,'" was most influenced by German jurist Friedrich Carl von Savigny.[53] Savigny contended that: because the rights and duties of "legal persons" solely derived from "an act of the State," they were necessarily "nothing but artificial beings or fictions";[54] such rights and duties were generally limited to "those pertaining to property"; such legal personality "did not allow for recognition of non-monetary rights and duties"; and, such fictional entities themselves could not ("apart from instances of strict liability") be held either civilly or criminally liable since they (in contrast to their "representatives or agents") could not be found "culpable" or capable of a "*mens rea*."[55] This view is said to "have governed American corporate theory 'from the Founding to the mid-nineteenth century.'"[56]

The "aggregate" or "contractualist" theory initially competed with the fiction theory, but gained greater prominence in the United States during

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[49] *Id.*

[50] *Id.*

[51] *See* Martin Petrin, *Reconceptualizing the Theory of the Firm—From Nature To Function*, 118 PENN ST. L. REV. 1, 4 (2013).

[52] *See generally id.* at 4–16.

[53] *See id.* at 5.

[54] *Id.* at 5, 7. This is essentially the "concession theory," sometimes also called the "communitarian" or "grant" theory. It holds that the "concessionary nature of the corporation" dictates that the government retains certain rights over the corporation's governance and operations. *See* Sheehy, *supra* note 22, at 230.

[55] Petrin, *supra* note 51, at 6.

[56] *Id.* at 5 (citing Darrell A.H. Miller, *Guns, Inc.: Citizens United, McDonald, and the Future of Corporate Constitutional Rights*, 86 N.Y.U. L. REV. 887, 916 (2011)).

the latter part of the nineteenth century.[57] It posited that the corporate entity consists of no more than mutual agreements binding "aggregations of natural persons . . . 'united for some legitimate business,'" the rights and duties of which entity arise—indirectly or derivatively—from its shareholders or other constituent individuals.[58] As such, as stated by the court in *San Mateo v. Southern Pacific Railroad*: '"whenever a provision of the constitution, or of a law, guaranties [sic] to persons the enjoyment of property . . . the benefits of the provision extend to corporations, . . . [but] the courts will always look beyond the name of the artificial being to the individuals whom it represents."'[59]

The Germanic "real entity" or "organic" theory was also developed in the late nineteenth century by other German scholars and led by "historian and legal academic" Otto von Gierke.[60] In contrast to the fiction and aggregate theories, advocates of this theory saw the legal entity as a "pre-existing reality" that was '"found' and recognized" rather than "created" by the law, and that possessed both its "own mind and will" as well as "any rights and duties" that it could exercise.[61] Such entity was a "composite, social organism[]"—autonomous, distinct, and separate from "the sum of its individual (human) parts."[62] This entity itself could only be held criminally or civilly liable for the actions of its senior, controlling individuals "acting within their official capacities."[63] By the beginning of the twentieth century, with a growing number of corporations, and increasing "hostility toward liability of legal entities," the real entity theory gained increasing ascendance in the United States.[64] Eventually, it came to be generally accepted that corporations are "conceptually and legally distinct from investors, managers, and other participants."[65]

So what, in the final analysis, is the existential nature of the firm or corporation in the American tradition, and for whose benefit does or should it operate? Perhaps Professor Petrin gives the most realistic, if not entirely satisfying, answer:

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[57] *Id.* at 9.

[58] *Id.* at 9–10 (citing The Railroad Tax Cases, 13 F. 722, 743–44 (C.C.D. Cal. 1882)).

[59] *Id*. at 10 (citing *The Railroad Tax Cases*, 13 F. at 744).

[60] *See id.* at 6.

[61] *Id.* at 6–7.

[62] *Id.* at 7.

[63] *Id.* at 7–8.

[64] *Id.* at 10.

[65] *See* Lyman Johnson, *Law and Legal Theory in the History of Corporate Responsibility: Corporate Personhood*, 35 SEATTLE U. L. REV. 1135, 1154 (2012).

> Ultimately, however, it becomes apparent that recourse to either of the traditional theories of the firm cannot provide a coherent answer to the shareholder primacy versus stakeholderism debate. Whether a legal entity is a fiction, a (social) reality, or an aggregate is a question that cannot be answered conclusively. More than 150 years of unresolved academic debate—the product of which one commentator has labeled a "confused mass of absurd literature"—should be sufficient evidence of the impossibility of answering that question (as this Article argues, the question itself also does not matter). The choice of which particular theory of the firm and its interpretation are a function of convictions, values, and policy goals that may well be arbitrary. . . .[66]

### *C. American Corporations—Limited to a "Binary" Choice of Form*

One thing about American corporations does appear clear—they have "bifurcated" into for-profit (*i.e.*, "business") and nonprofit organizational forms due in large part to the somewhat unique history of charitable activity in the United States. This bifurcation has become firmly entrenched—and in recent years, increasingly problematic—due to long-standing public policies regarding the tax exemptions afforded to certain nonprofit corporations:

> It is self-evident that the activities in § 501(c)(3)—religion, education, charity including health services, etc.—are valuable to a community. The critical issue is whether public charitable tax exempt corporations, by performing these activities, provide added value to the public, as compared to their for-profit counterparts. Good behavior of directors, careful and loyal—at least to the degree of their colleagues in the for-profit sector—does not necessarily meet the legitimate expectations of the public regarding the added community benefits of public benefit charitable tax exempt corporations. *The claims of the value of the independent sector to civil society and the justification of the privileged tax status become less credible when the corporate culture, the duties of*

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[66] Petrin, *supra* note 51, at 26 (citing FRITZ SCHULZ, CLASSICAL ROMAN LAW 87 (1951)).

> *directors, and the effect of the activities of the charitable corporations in the community are not substantially different from those of for-profit corporations performing the same activities.* The public expects different benefits to the community from the public benefit charitable corporation.[67]

Historically, charitable nonprofits were distinguished from for-profits primarily by their sources of operational funding—*i.e.*, private donations, foundation and government grants, and (to a lesser extent) fees for services.[68] However, this distinction has lessened as nonprofits increasingly pursue "a more commercialized approach" in competition with for-profits for limited economic resources.[69] In fact, Professor Christyne J. Vachon has gone so far as to say that "[c]ommercialization may be the strongest force shaping Nonprofit business these days."[70]

This trend necessarily creates tension and confusion in the traditional role of the charitable nonprofit corporation. It has been said that "[f]or charities, all private goals are subordinated to mission and there can be no compromise between the private interests and the public interests that the charity serves."[71] In their understandable efforts to ensure their continued financial stability, however, many charitable nonprofits risk crossing the line of exclusive organization and exclusive operation for one or more exempt purposes. Nowhere, perhaps, is this more clearly seen than in today's "dominant species of nonprofit health care organizations" (*i.e.*, "nonprofit hospitals and health plans").[72] Significantly, these particular commercial nonprofits operate with the premise that they will receive most of their tax-exempt funds "from the sale of services with an expectation that [they] will return societal benefits in the form of charitable services or 'community benefits' from [their] profits."[73]

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[67] Melanie DiPietro, *Duty of Obedience: A Medieval Explanation for Modern Nonprofit Governance Accountability,* 46 DUQ. L. REV. 99, 103–04 (2007) (emphasis added).

[68] *See* Christyne J. Vachon, *Scratch My Back, And I'll Scratch Yours: Scratching The Surface of The Duty of Care in Cross Sector Collaborations—Are For-Profits Obligated to Ensure the Sustainability tf Their Partner Nonprofits?*, 8 HASTINGS BUS. L.J. 1, 6 (2012).

[69] *See id.*

[70] *Id.* at 7.

[71] Linda Sugin, *Resisting the Corporatization of Nonprofit Governance: Transforming Obedience into Fidelity*, 76 FORDHAM L. REV. 893, 918 (2007).

[72] *See* Thomas L. Greaney & Kathleen M. Boozang, *Mission, Margin and Trust in the Nonprofit Health Care Enterprise*, 5 YALE J. HEALTH POL'Y, L. & ETHICS 1, 3 (2005).

[73] *Id.* at 3 n.4.

In our initial article, we have already discussed at length the problems attendant to undue commercialization of health care services and the questions increasingly being raised about the appropriateness of continued tax-exemption of large, commercial nonprofit health care providers.[74] It will here only be further emphasized that

> [t]hese nonprofit hospitals constitute a large proportion of the nation's hospital capacity, representing billions of dollars of charitable assets. As nonprofit health care enterprises also constitute a substantial percentage of the nation's nursing homes and comprise many of the nation's largest health insurers and managed care entities, these firms play a central role in providing much of the nation's safety net services; as a result, they take on added significance (and earn regulatory scrutiny).[75]

Moreover, these particular commercial nonprofits share an important characteristic common in the American health care system—they provide services to what are essentially "third-party beneficiaries." That is to say, the vast majority of patients receiving health care services in the United States do not themselves pay for those services under the currently predominating third-party payment system of private and public health insurance. This creates a problem with one of the "key functions" of the nonprofit organization—"protecting against the kind of contract failure liable to occur in situations where the purchasers of a service are not the group receiving that service."[76] Specifically, "[i]n such third-party beneficiary situations, purchasers are unable to determine the quality of the product that they purchase because they are not the consumers; beneficiaries are in no position to object to a lesser-quality product, since they have not given anything in return."[77]

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[74] *See* Corbett, *supra* note 3, at Sections III(A), (B) & (D).

[75] Greaney & Boozang, *supra* note 72, at 3.

[76] Jeremy Benjamin, *Reinvigorating Nonprofit Directors' Duty of Obedience*, 30 CARDOZO L. REV. 1677, 1686 (2009).

[77] *Id*. The author goes on to note:

> The nondistribution constraint means nonprofits have less incentive than their for-profit counterparts to exploit this asymmetry. The nondistribution constraint, coupled with the requirement that all activities be in furtherance of a nonprofit's charitable purpose, makes the philanthropic public more likely to turn to these organizations to fulfill their altruistic ends. Fidelity to charitable purpose is therefore essential to establishing donors' trust and protecting against contract

(*continued*)

The presence of this third-party beneficiary characteristic, and its effect upon the usual dynamic of free-market economics, makes it all too easy for health care commercial nonprofits to sometimes lose sight of their charitable purpose and confound "business objectives" with corporate "mission." In addition, there remains the question of to whom, ultimately, are nonprofit boards (commercial or otherwise) accountable: to some, the "most realistic answer" is that "they are accountable to multiple stakeholders—beneficiaries, donors, taxpayers, bondholders, licensing agencies, the IRS, and the state attorney general";[78] to others, such as scholar Geoffrey A. Manne, the charitable nonprofit sector is '"largely unaccountable to anyone"' by virtue of being '"large, barely amenable to suit, and ineffectively reined in by the nondistribution constraint[79] and the fiduciary rules under corporate and trust law . . . ."'[80]

## III. MORAL AND SOCIAL CONSIDERATIONS

> It has been said that the devil's greatest accomplishment was to convince the world that he doesn't exist. Analogously, perhaps it has been the greatest accomplishment of law-and-economics scholars to convince the world that efficiency and economics are value neutral. For it is exactly this perspective that has helped further the notion that corporate officers and directors ought not interject their values into corporate decision-making, but should, rather, adhere to the purportedly value-neutral program of maximizing profits for the benefit of the corporation's shareholders. This awful myth has had profoundly negative consequences.[81]

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> failure. Failure to act in accordance with the charter is essentially a breach of the broader contract.

*Id.*

[78] Kathleen M. Boozang, *Does an Independent Board Improve Nonprofit Governance?*, 75 TENN. L. REV. 83, 129 (2007).

[79] That is, the constraint legally imposed on the nonprofit form that the organization retain and reinvest all net earnings rather than distribute them to any private parties.

[80] Boozang, *supra* note 78, at 116 (citing Geoffrey A. Manne, *Agency Costs and the Oversight of Charitable Organizations*, 1999 WIS. L. REV. 227, 252 (1999)).

[81] Colombo, *supra* note 1, at 824 (noting that "I don't mean to compare those in the law-and-economics movement to the devil."). *Id.* at 824 n.56.

Twenty-first century history seems replete with instances of "morally questionable business practices" on the part of corporations.[82] Prominent examples include: the "Exxon Valdes disaster in Prince William Sound," the "Royal Dutch Shell controversy over the disposal of the Brent Spar in the North Sea," the "apparent complicity" of Royal Dutch Shell in "the execution of Ogoni indigenous leaders in Nigeria," and the backlash against Nike for alleged "sweatshop" operations in Southeast Asia between 1992 and 1997.[83] More recent, and closer to home, are the obvious examples of British Petroleum's Deepwater Horizon oil spill and the commercial bank failures during the 2007–08 financial crisis.[84] Further available examples would only belabor the point. All are emblematic of "the entrenched metaphor that sees corporations as amoral profit machines, utterly devoid of moral character or probity."[85] Such attitude is perpetuated by many modern business schools, where such "ideologically inspired amoral theories . . . have actively freed their students from any sense of moral responsibility."[86]

The idea that "commerce is somehow a morality-free zone of human endeavor"[87]—that there is a necessary separation between "private" and "corporate" morality[88]—runs deep and persistent. As early as 1926, critic R.H. Tawney observed:

> To argue, in the manner of Machiavelli, that there is one rule for business and another for private life, is to open the door to an orgy of unscrupulousness before which the mind recoils. To argue that there is no difference at all is to lay down a principle which few men who have faced the difficulty in practice will be prepared to endorse as of invariable application, and incidentally to expose the ideas

[82] *See* Kevin T. Jackson, *Global Corporate Governance: Soft Law and Reputational Accountability*, 35 BROOK. J. INT'L L. 41, 50 (2010).

[83] *See id.* at 51.

[84] *See* Leo E. Strine, Jr., *Our Continuing Struggle with the Idea that For-Profit Corporations Seek Profit*, 47 WAKE FOREST L. REV. 135, 136 (2012).

[85] Jackson, *supra* note 82, at 45.

[86] Justin Blount & Patricia Nunley, *What is a "Social" Business and Why Does the Answer Matter?*, 8 BROOK. J. CORP. FIN. & COM. L. 278, 315, 316 n.223 (2014) (quoting Sumantra Ghoshal, *Bad Management Theories Are Destroying Good Management Practice*, 4 ACAD. MGMT. LEARNING & EDUC. 75, 76 (2005)).

[87] *See* Julie A. Nelson, *Does Profit-Seeking Rule Out Love? Evidence (or Not) from Economics and Law*, 35 WASH. U. J. L. & POL'Y 69, 72 (2011).

[88] *See* Ronald J. Colombo, *Toward a Nexus of Virtue*, 69 WASH. & LEE L. REV. 3, 48 (2012).

> of morality itself to discredit by subjecting it to an almost intolerable strain.[89]

Yet, as late as 1970, Milton Friedman argued:

> What does it mean to say that "business" has responsibilities? Only people have responsibilities. A corporation is an artificial person and in this sense may have artificial responsibilities, but "business" as a whole cannot be said to have responsibilities, even in this vague sense. The first step toward clarity in examining the doctrine of the social responsibility of business is to ask precisely what it implies for whom.[90]

While it may be both reasonable and expedient to conclude that "fictional" corporate entities cannot be held accountable for decisions that only "individual human actors" can make, such conclusion offers little to improve corporate conduct. By denying that the corporation can have a "moral character of its own," moral responsibility is necessarily "diffused via the dispersion of ownership and the processes of board decision making, and . . . is muted via the large gulf between corporate decision-makers and the individuals and communities that may be harmed by these decisions."[91] Unlike the "economic actors" of Adam Smith, whose "pursuit of individual self-interest" assertedly promoted the public good, the shareholders, directors, and officers of today's modern business corporation—"with its amorphous ownership/management structure"—no longer regard themselves as having personal responsibility for their decisions.[92] As Professor Colombo observes: "From Hannah Arendt to Stanley Milgram, scholars have observed how bureaucracies can give rise to 'a process of moral proxy' in which the individual 'delegate[s] his moral

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[89] *Id*. at 49 (quoting R.H. TAWNEY, RELIGION AND THE RISE OF CAPITALISM 184 (1926)).

[90] Caroline Van Zile, *India's Mandatory Corporate Social Responsibility Proposal: Creative Capitalism Meets Creative Regulation in the Global Market*, 13 ASIAN-PAC. L. & POL'Y J. 269, 278 (2012) (quoting Milton Friedman, *The Social Responsibility of Business is to Increase its Profits*, N.Y. TIMES (Sept. 13, 1970), https://www.nytimes.com/1970/09/13/archives/a-friedman-doctrine-the-social-responsibility-of-business-is-to.html [https://perma.cc/RCX8-72QM]).

[91] Ronald J. Colombo, *Ownership, Limited: Reconciling Traditional and Progressive Corporate Law via an Aristotelian Understanding of Ownership*, 34 J. CORP. L. 247, 288 (2008).

[92] *See id.* at 288–89.

authority' to 'hierarchical structures' that 'tend to suppress the psychological and moral controls of autonomous persons.'"[93]

Colombo characterizes the idea "that one's moral obligations change when one is no longer deciding for himself or herself, but on behalf of a group for which he or she is responsible" as giving rise to a form of philosophical "casuistry."[94] He goes on to conclude that

> although casuistry can be justifiably defended in principal, on a practical level it suffers from a serious defect: it largely enables those in positions of responsibility to evade traditional notions of morality and define for themselves what their moral obligations are given their particular situation. A more direct conflict of interest is difficult to find.[95]

Such casuistry in the context of the modern business corporation has two profound ill effects:

> First, it lets shareholders, directors, and managers of corporations morally "off the hook" for the social and environmental consequences of business decisions. Second, it places the entire burden of maintaining the moral order onto non-business entities, such as government, nonprofits, and families. But these entities may be (and too often are) overwhelmed, lack resources, or be problematic themselves (e.g., corrupt, mismanaged, or abusive).[96]

Nonetheless, there are those who believe that the corporation *can exist* "as a moral organism with social and ethical responsibilities"—not as "merely a legal fiction," but " as 'an entity existing in time'" and/or "as a 'distinct person.'"[97] Further, that "[a]s a 'real person in society,' the corporation should bear a citizen's duties to have regard to a broad range

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[93] *Id*. at 289 (citing Robert J. Rhee, *Corporate Ethics, Agency, and the Theory of the Firm*, 3 J. BUS. & TECH. L. 309, 324–25 (2009)).

[94] Colombo, *supra* note 88, at 48.

[95] *Id.* at 48–49.

[96] Nelson, *supra* note 87, at 71–72. Although Professor Nelson is, in this quote, speaking of "the belief that there is something intrinsic in the economic or legal structure of commerce that forces firms, inexorably, as if run on rails, to neglect values of care and concern in order to strive for every last dollar of profits," her conclusion applies equally to the untoward effects of such casuistry in general. *See id.* at 71.

[97] Petrin, *supra* note 51, at 24 (internal citations omitted).

of parties that are affected by its presence."[98] The view of those who accept the legitimacy of such "institutional morality" as a coherent concept is well expressed by Professor Jill R. Horwitz:

> But, can [an] organization hold moral duties? The answer is complicated and controversial. In brief, I believe an organization can do so because once formed, it constitutes an agency that is distinct from the aggregation of individuals associated with it. There are several characteristics that contribute to our intuitive understanding that corporations are real things, existing beyond the collection of people who populate them, such as: an ongoing identity that outlives a particular group of employees, a complex decision-making structure, large size and anonymity, formal relationships, the capability of holding resources, and a shared mission. They can cause outcomes, and they can intend actions.[99]

It is often said that morality must be voluntary. In the context of institutional morality, "we want companies to be responsible not merely in the sense of following the rules, but also in the more productive sense of 'using autonomy to make moral decisions.'"[100] The problem seems to lie at the juncture where institutional morality meets the seemingly immutable wealth-maximization norm of the modern business corporation, particularly the publicly-financed ones. As Professor Strine, Jr. points out, "the idea of a public corporation with outside investors pursuing a controversial political or moral agenda is intrinsically problematic because that is not why investors invest nor is that the basis on which boards are elected."[101] Professor Colombo puts the point even more starkly:

> There are some who have argued that such a firm would "rapidly perish" due to the competitiveness of the marketplace. Indeed, many companies that pursue a balanced approach to profits, that is, an approach that takes into serious consideration other, noneconomic values, eschew public company status because of the pressures of

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[98] *Id.* at 24–25.

[99] Jill R. Horwitz, *Why we Need the Independent Sector: The Behavior, Law, and Ethics of Not-for-Profit Hospitals*, 50 UCLA L. REV. 1345, 1387–88 (2003).

[100] Van Zile, *supra* note 90, at 281 (quoting CHRISTOPHER D. STONE, WHERE THE LAW ENDS: THE SOCIAL CONTROL OF CORPORATE BEHAVIOR 116 (1975)).

[101] Strine, Jr., *supra* note 84, at 154–55.

> the capital markets. "And since no one knows when 'enough is enough,' the drive for increased profitability remains a key corporate objective [for the public company]. Hence, the inherent tendency to avarice continues to exist, exacerbated by the power of the financial markets."[102]

This reality, then, tends to further "lock in" the limited, binary choice of organizational forms available to American corporations—*i.e.*, either for-profit "business corporations" or nonprofit (usually charitable) public mission-driven corporations. It is largely only the latter that are generally perceived to operate with due regard for moral mandates—a phenomenon that scholars often refer to as the "halo effect."[103] The real question, then, appears not to be so much whether a corporation can have a "moral character of its own," but rather whether it is inclined to act like it does and whether such inclination depends solely on its nonprofit versus for-profit status.

### *A. The Need for a "Broad New Composite Reality"*

> In his 2009 Encyclical Letter, *Caritas in Veritate*, Pope Benedict XVI considered the relationship between business and ethics and concluded that "the traditionally valid distinction between profit-based companies and nonprofit organizations can no longer do full justice to reality or offer practical direction for the future," and called for the recognition of *"a broad new composite reality embracing the public and private spheres, one which does not exclude profit, but instead considers it a means for achieving human and social ends."*[104]

Many observers are coming to feel that the unrestrained pursuit of economic efficiency and wealth-maximization by free-market capitalism has become suboptimal and "counterproductive to society as a whole" as a result of growing disproportionality in relative bargaining powers, limited

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[102] Colombo, *supra* note 88, at 84 (citing Geoff Moore, *Humanizing Business: A Modern Virtue Ethics Approach*, 15 BUS. ETHICS Q. 237, 240 (2005)).

[103] *See* Lloyd Hitoshi Mayer & Joseph R. Ganahl, *Taxing Social Enterprise*, 66 STAN. L. REV. 387, 436 (2014).

[104] Mystica M. Alexander, *Benefit Corporations—The Latest Development in the Evolution of Social Enterprise: Are They Worthy of a Taxpayer Subsidy?*, 38 SETON HALL LEGIS. J. 219, 223–24 (2014) (emphasis added).

choices, and externalized costs.[105] Moreover, some believe that current legal structures affirmatively discourage—if not in fact prohibit—corporations from giving due consideration to the effect of their actions on third-parties.[106] Accordingly, it is increasingly being suggested that "'[t]he discipline of corporate law should acknowledge the richness and complexity of commercial endeavor,' and eschew an approach that unrealistically constricts our understanding of the corporation (and its various actors)."[107]

As Professor Arthur Acevedo has observed: It is an "indisputable premise of American society" that "[e]very person, individual and corporation alike . . . has the right to earn a profit"; however, a corporation's possession of capital does not give it "the unfettered right to take risks or engage in conduct that creates an uncompensated cost to society" simply for its benefit and that of its shareholders.[108] As a result, the ideas of "Corporate Social Responsibility" (CSR), "Socially Responsible Investing" (SRI), "Social Entrepreneurship," and "Social Enterprise"—all terms variously reflecting Pope Benedict's concept of a "broad new composite reality"—are starting to take hold.

*1. Corporate Social Responsibility*

CSR, broadly stated, "simply asks companies to consider both the social and financial impacts of their decisions."[109] The idea is sometimes expressed as the pursuit of a "triple bottom line," simultaneously encompassing "social, environmental, and financial outcomes."[110] CSR rejects a "single-minded focus on wealth maximization" and argues that "corporations should take responsibility for externalities inflicted and individuals injured in the course of business."[111] It inserts "social welfare enhancements" into the corporation's objectives and focuses more "on the interests of corporate constituents other than shareholders and managers."[112] It has been the subject of "serious scholarly attention" since

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[105] *See* Arthur Acevedo, *Responsible Profitability? Not on my Balance Sheet*, 61 CATH. U. L. REV. 651, 696 (2012).

[106] *See id.*

[107] Colombo, *supra* note 1, at 818, (quoting Lyman Johnson, *The Delaware Judiciary and the Meaning of Corporate Life and Corporate Law,* 68 TEX. L. REV. 865, 936 (1990)).

[108] Acevedo, *supra* note 105, at 696–97.

[109] Van Zile, *supra* note 90, at 277.

[110] *Id.*

[111] Bratton & Wachter, *supra* note 19, at 146.

[112] *Id.*

the 1970s.[113] A 2012 Google search for CSR "yielded over twenty-one million hits" and a 2011 Westlaw search turned up "over two thousand articles."[114] Moreover, one recent survey revealed that "seventy percent of global CEOs" believe that CSR is critical "to their companies' profitability"; similarly, another survey found that "seventy-six percent of CEOs" believe that "socially responsible and sustainable spending creates long-term shareholder value."[115]

*2. Social Entrepeneurship/Social Enterprise*

One of the leading scholars in the developing field, Professor J. Gregory Dees, has broadly defined the role of social entrepreneurs as:

> Adopting a mission to create and sustain social value (not just private value), [r]ecognizing and relentlessly pursuing new opportunities to serve that mission, [e]ngaging in a process of continuous innovation, adaptation, and learning, [a]cting boldly without being limited by resources currently in hand, and [e]xhibiting heightened accountability to the constituencies served and for the outcomes created.[116]

While Dees acknowledges that this definition is a broad, somewhat "idealized" one,[117] it shares with other formulations the commonality of differentiating the "social mission" of "social entrepreneurship"[118] from the

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[113] Van Zile, *supra* note 90, at 275.

[114] *Id.* at 275 n.31 & n.32.

[115] *Id.* at 281.

[116] Blount & Nunley, *supra* note 86, at 283 (quoting J. GREGORY DEES, THE MEANING OF "SOCIAL ENTREPRENEURSHIP" 2–3 (May 30, 2001) (unpublished manuscript)).

[117] *See id.*

[118] *See* Steven J. Haymore, *Public(ly Oriented) Companies: B Corporations and The Delaware Stakeholder Provision Dilemma*, 64 VAND. L. REV. 1311, 1317–18 (2011). Steven J. Haymore notes:

> The language of "social entrepreneurship" emerged in the 1980s from the work of Bill Drayton at Ashoka and Ed Skloot at New Ventures. The phenomenon of social entrepreneurship, however, existed before the 1980s. One prime example of a pre-1980s social entrepreneur is Muhammad Yunus, recipient of the 2006 Nobel Peace Prize. In 1974, while visiting a poor village in his home country of Bangladesh, Yunus started making very small loans to impoverished women in need of capital for activities ranging from making bamboo stools to buying a dairy cow. In so doing, Yunus discovered that he could alleviate the burdens weighing on the impoverished while making a profit. After local banks refused his requests to make the loans, Yunus

(*continued*)

sole "creation of 'private benefits"' that characterizes regular business entrepreneurship.[119] By way of example, another formulation makes the same differentiation in a slightly different fashion:

> Similar to conventional entrepreneurship, [social entrepreneurship] involves the provision of goods or services. However, *the provision of the product or service is not an end in itself, but an integral part of an intervention to achieve social objectives*, thereby contributing to social change. Thus, rather than being only economic endeavors, SE initiatives aim primarily to pursue a social mission and to ultimately transform their social environment.[120]

"Social enterprise" is a common synonym for, or corollary to, social entrepreneurship.[121] As with the various formulations of social entrepreneurship, differing definitions of social enterprise focus on different aspects of the concept. For example, the following definition focuses on the "hybrid aspect" of the enterprise having both for-profit and nonprofit characteristics:

> [A] social enterprise, for purposes of identifying an appropriate legal structure, is (1) an organization that serves first and foremost a social mission, (2) through the use of sophisticated business models typically associated

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> founded Grameen Bank in 1976 in an attempt to provide credit to Bangladeshis who needed capital the most. Since its inception, Grameen has extended uncollateralized small loans (referred to as microcredit) to 8.35 million borrowers, most of whom are women. Grameen claims a ninety-seven percent repayment rate, and has been profitable nearly every year.

*Id.*

[119] *See* Blount & Nunley, *supra* note 86, at 283. The authors go on to note:

> Under Dees' broad definition, a social entrepreneur could operate solely within the non-profit sector, seeking grants or donations to fund its mission; could operate within the business sector and fund its mission using an earned income strategy; or could operate as a hybrid organization with characteristics of both a non-profit and a for-profit business.

*Id*. at 284.

[120] *Id*. at 284 (citing Johanna Mair et al., *Organizing for Society: A Typology of Social Entrepreneuring Models*, 111 J. BUS. ETHICS 353, 353 (2012)) (emphasis added).

[121] *Id.* at 285–86.

> with traditional corporate activity, (3) pursuing multiple financing options, and (4) facing novel governance challenges when balancing the interests of donors and investors.[122]

Needless to say, while all of these various terms are subject to different academic interpretation, we shall for our purposes henceforth use the singular term "social enterprise" to refer collectively to the "broad new composite reality" of "social-mission-oriented entities that employ market-based strategies to simultaneously return a profit and achieve their mission."[123] It is important to note that these entities include both "nonprofits with business models" and for-profits "with social responsibility missions."[124] As one writer observes, "the 'social enterprise ideal' typically involves blending traditional business methods with a 'deep and particular commitment to philanthropic endeavor.' Achieving this ideal requires the pursuit of the so-called double bottom line, which contemplates both financial and social success."[125]

A persistent challenge to the financial success of social enterprises, however, is access to investment capital.[126] As Steven J. Haymore points out:

> On the one hand, if social enterprises form as tax-exempt nonprofits, they must reinvest all profits into the organization and there is no straightforward way for venture capitalists or other for-profit investors to receive a return on their investment. On the other hand, if social enterprises form as for-profit entities, they gain more access to investors, but may subject their directors to fiduciary duty liability for failing to maximize financial returns. Thus, according to many social entrepreneurs, corporate laws inhibit social enterprises' ability to creatively and profitably solve society's challenges.[127]

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[122] *Id.* at 286 (citing Keren G. Raz, *Toward an Improved Legal Form for Social Enterprise*, 36 N.Y.U. REV. L. & SOC. CHANGE 283, 287–88 (2012)).

[123] Haymore, *supra* note 118, at 1317.

[124] *Id.*

[125] Joseph M. Binder, *A Tax Analysis of the Emerging Class of Hybrid Entities*, 78 BROOK. L. REV. 625, 629 (2013) (citing Dana Brakman Reiser, *For-Profit Philanthropy*, 77 FORDHAM L. REV. 2437, 2450 (2009)).

[126] Haymore, *supra* note 118, at 1319.

[127] *Id.* at 1320.

Further, as Dilpreet K. Minhas observes, problems with their "resources and funding streams" (*e.g.*, "donors' typical refusals to help entrepreneurs cover overhead costs") causes nonprofit social enterprises in particular to get stuck "in a perpetual state of fundraising," with resultant difficulty scaling their operations.[128]

### 3. *Constituency Statutes*

Although generally not considered to be "social enterprise legislation," one corporate law innovation that arguably attempts to "tam[e]" the "harsher aspects of capitalism" is the proliferation of state "constituency statutes"—an outgrowth of stakeholder theory.[129] Variously called "constituency," "stakeholder," or "nonshareholder" statutes by some[130]—"directors' duties statutes," "multiconstituency statutes." or "nonstockholder constituency statutes" by others[131]—such statutes initially arose as "one of several novel forms of takeover defenses that were developed in the heat of the takeovers that have come to symbolize the 'take and break' days of the 1980s."[132]

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[128] Dilpreet K. Minhas, *Enhancing the Legal and Regulatory Environment for Investment in Social Enterprise*, 3 MICH. J. PRIVATE EQUITY & VENTURE CAP. L. 257, 259–60 (2014).

[129] *See* Keay, *supra* note 28, at 264.

[130] *See* Corbett, *supra* note 3, at 168.

[131] *See* BRENT A. OLSEN, 2 PUBLICLY TRADED CORPORATIONS HANDBOOK §18:6, *available at* Westlaw (database updated October 2018).

[132] *See* JAMES D. COX & THOMAS LEE HAZEN, 1 TREATISE ON THE LAW OF CORPORATIONS §4:10 (3d ed.), *available at* Westlaw (database updated December 2017). Even prior to such statutes, some corporations were reacting to the growing threat of hostile takeovers by adopting "charter amendments" that would authorize their directors "to consider interests other than shareholders." *Id.* The 1978 amendment adopted by Control Data Corporation was typical:

> The Board of Directors of the Corporation, when evaluating any offer of another party to (a) make a tender or exchange offer for any equity security of the Corporation, (b) merge or consolidate the Corporation with another corporation, or (c) purchase or otherwise acquire all or substantially all of the properties and assets of the Corporation, shall, in connection with the exercise of its judgment in determining what is in the best interests of the Corporation and its stockholders, give due consideration to all relevant factors, including without limitation the social and economic effects on the employees, customers, suppliers and other constituents of the Corporation and its subsidiaries and on the communities in which the Corporation and its subsidiaries operate or are located.

(*continued*)

Pennsylvania is generally acknowledged to have passed the first state constituency statute in 1983.[133] As with those that followed, it has been characterized as "primarily created as a mechanism for corporations to defend against a hostile takeover" and as explicitly permitting "directors . . . to consider interests other than the interests of the shareholders."[134] Its original provision has been called "the most common formulation":[135]

> In discharging the duties of their respective positions, the board of directors, committees of the board, and individual directors may, in considering the best interests of the corporation, consider the effects of any action upon employees, upon suppliers and customers of the corporation and upon communities in which offices or other establishments of the corporation are located, and all other pertinent factors.[136]

Another early such statute that reportedly "became a model for many of those that followed" was Ohio Rev. Code Ann. § 1701.59(E): [137]

> For purposes of this section, a director, in determining what the director reasonably believes to be in the best interests of the corporation, shall consider the interests of the corporation's shareholders and, in the director's discretion, may consider any of the following:
>
> (1) The interests of the corporation's employees, suppliers, creditors, and customers;
>
> (2) The economy of the state and nation;
>
> (3) Community and societal considerations;

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Sommer, Jr., *supra* note 11, at 39 (citing 1 R. WINTER, M. STUMPF & G. HAWKINS, SHARK REPELLANTS AND GOLDEN PARACHUTES: A HANDBOOK FOR THE PRACTIONER 200–01 (Supp. 1988)).

[133] *See* Steven Munch, *Improving The Benefit Corporation: How Traditional Governance Mechanisms can Enhance the Innovative New Business Form*, 7 NW J. L. & SOC. POL'Y 170, 181 (2012).

[134] COX & HAZEN, *supra* note 132, at §2:14.

[135] Sommer, Jr., *supra* note 11, at 41.

[136] Directors' Liability Act, 1986 Pa. Laws 1462, Act 1986-145.

[137] *See* MARK A. SARGENT & DENNIS R. HANOBACH, D&O LIAB. HDBK. §OH:4, Nonshareholder constituencies, Comment (database updated October 2018).

> (4) The long-term as well as short-term interests of the corporation and its shareholders, including the possibility that these interests may be best served by the continued independence of the corporation.

According to author Anna R. Kimbrell, there are currently (as of 2013) thirty-two states that "have some version of a constituency statute that permits corporate directors to consider the interests of non-shareholder stakeholders."[138] While all of these different versions contain similar language, "they exhibit several variations" including:

> (1) the breadth of factors directors may consider;
>
> (2) the applicable contexts in which nonshareholder interests may be considered (*e.g.*, some states limit application to takeover contexts);
>
> (3) the corporate fiduciaries protected by the statute (*e.g.*, Illinois' statute protects officers of a corporation);
>
> (4) the nonshareholders specifically protected (*e.g.*, Wyoming's statute provides for specific protection to bondholders in a takeover context);

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[138] Anna R. Kimbrell, *Benefit Corporation Legislation: An Opportunity For Kansas To Welcome Social Enterprises*, 62 U. KAN. L. REV. 549, 558 n.45 & n.48 (2013). The thirty-two states include: ARIZ. REV. STAT. ANN. § 10-2702 (2008); CONN. GEN. STAT. § 33-756(d) (2008); FLA. STAT. ANN. § 607.0830(3) (2007); GA. CODE ANN. § 14-2-202(b)(5) (2003); HAW. REV. STAT. § 414-221(b) (2004); IDAHO CODE ANN. §§ 30-1602, 1702 (2008); 805 ILL. COMP. STAT. ANN. 5/8.85 (2004); IND. CODE ANN. § 23-1-35-1(d) (2008); IOWA CODE ANN. § 491.101B (1999); KY. REV. STAT. ANN. § 271B.12-210(4) (2003); LA. REV. STAT. ANN. § 12:92(G)(2) (2008); ME. REV. STAT. ANN. TIT. 13-C, § 831(6) (2009); MD. CODE. ANN., CORPS. & ASS'NS § 2-104(b)(9) (2007); MASS. GEN. LAWS CH. 15D §8.30 (2004); MINN. STAT. ANN. § 302A.251(5) (2004); MISS. CODE ANN. § 79-4-8.30(d) (2000); MO. ANN. STAT. § 351.347 (2001); NEV. REV. STAT. §78.138 (1999); N.J. STAT. ANN. §§ 14A:6-1(2), 6-14(4) (2003); N.M. STAT. ANN. § 53-11-35(D) (2004); N.Y. BUS. CORP. LAW § 717(b) (2003); N.D. CENT. CODE § 10-19.1-50(6) (2007); OHIO REV. CODE ANN. § 1701.59(E) (2009); OR. REV. STAT. § 60.357(5) (2009); 15 PA. CONS. STAT. ANN. § 1715 (1995); R.I. GEN. LAWS ANN. § 7-5.2-8(a) (2009); S.D. CODIFIED LAWS § 47-33-4(1) (2007); TENN. CODE ANN. §§ 48-103-202, 204 (2008); VT. STAT. ANN. TIT. 11A, § 8.30(A)(3) (2007); VA. CODE ANN. §13.1-727.1 (1999); WIS. STAT. ANN. § 180.0827 (2002); WYO. STAT. ANN. § 17-16-830(g) (2009).

Constituency statutes that apply only in the context of a takeover include: IOWA CODE ANN. § 490.1108 (1999); LA. REV. STAT. ANN. § 12:92(g) (1994); MD. CODE ANN. CORPS. & ASS'NS § 2-104(9) (2007); MO. ANN. STAT. § 351.347(1) (2001); N.J. STAT. ANN. § 14A:6-1 (Supp. 2001); OR. REV. STAT. § 60.357 (1988); and TENN. CODE ANN. § 48-103-204 (1995). Constituency statutes that apply in the broader change of control context include: CONN. GEN. STAT. §33-756 (2008); IDAHO CODE ANN. §§ 30-1602, 1702 (2008); and S.D. CODIFIED LAWS §47-33-4(1) (2007).

> (5) opt in requirements (*e.g.*, Georgia requires that shareholders elect to be covered in the articles of incorporation);
>
> (6) mandatory versus permissive considerations (*e.g.*, Connecticut requires directors to consider nonshareholder interests);
>
> (7) the enhanced protection of a board's decision (Indiana and Pennsylvania have enacted such statutes).[139]

*a. Critics of Constituency Statutes*

Despite their clear potential for promoting corporate responsibility—and perhaps even initiating larger needed reforms—constituency statutes remain subject to a variety of criticisms. Professor J. Haskell Murray notes that they "do not seem to have been very effective in combating the shareholder wealth maximization norm"—which he attributes to the fact that they are usually only "permissive" and do not "give non-shareholder stakeholders standing to sue."[140] Professor Brett H. McDonnell observes that constituency statutes leave "both legal and business practitioners" in doubt about the extent of legal protection they really provide, given that they "have been [rarely] used in court and have received almost no judicial interpretation."[141]

For us, at least, the best summary and conclusion on constituency statutes perhaps can be found in our own initial article:

> These statutes permit, but do not require, [with the exception of very few states] directors to make decisions based on considerations other than strictly shareholder interests. The statutes then shield the directors from at least some personal liability for doing so. However, while such statutes may be a way to encourage corporations to balance the interests of multiple stakeholders, they have been largely discredited (at least in their current forms) for being discretionary and lacking any clear-cut enforcement mechanisms. Moreover, they have been used mostly in connection with takeover defenses, serving merely to

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[139] OLSEN, *supra* note 131.

[140] J. Haskell Murray, *Defending Patagonia: Mergers and Acquisitions with Benefit Corporations*, 9 HASTINGS BUS. L.J. 485, 504 (2013).

[141] Brett H. McDonnell, *Committing to Doing Good and Doing Well: Fiduciary Duty in Benefit Corporations*, 20 FORDHAM J. CORP. & FIN. L. 19, 29 n.28 (2014).

> entrench the interests of existing management rather than to defend the interests of other stakeholders. This has prompted Jonathan Springer, acknowledged to be the preeminent scholar on constituency statutes, to suggest: *'[I]f there is any fundamental change in corporate law that will address constituency interests, it will be only as the result of a direct engagement of the legal and economic underpinnings of corporate law.' That is, the norm of shareholder wealth maximization must be challenged outright.*[142]

## IV. DEVELOPMENT OF THE "BENEFIT CORPORATION" CONCEPT

Before discussing benefit corporations in detail, it is necessary first to discuss the origin and mission of B Lab as an organization, to explain the differences between a "B Corporation" and a "benefit corporation," and to identify some of the criticisms that have been leveled at B Lab for its lobbying and other activities.

### *A. The Origin and Mission of B Lab*

Benefit corporations were first conceptualized by B Lab, a nonprofit corporation formed in June 2006 "to promote a new type of corporation that uses the power of business to solve social or environmental problems."[143] The three cofounders of B Lab were Jay Coen Gilbert, Andrew Kassoy, and Bart Houlahan. They worked closely with William Clark "to draft the Model Benefit Corporation Legislation" (*i.e.,* "The Model Act").[144] Clark was a partner at Drinker Biddle & Reath and had been the "drafting author of the Model Business Corporations Act (MBCA)."[145]

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[142] Corbett, *supra* note 3, at 168 (quoting Jonathon D. Springer, *Corporate Constituency Statutes: Hollow Hopes and False Fears*, 1999 N.Y.U. ANN. SURV. AM. L. 85, 124 (1999)) (emphasis added).

[143] Kyle Westaway & Dirk Sampselle, *The Benefit Corporation: An Economic Analysis with Recommendations to Courts, Boards, and Legislatures*, 62 EMORY L.J. 999, 1011 (2013).

[144] *See iud.* at 1010–11.

[145] *Id.* at 1010. The following information is taken from the B Lab website:

> Jay Coen Gilbert, Bart Houlahan, and Andrew Kassoy [the "Co-Founders"] share passion for creating a better world through business and have been friends for over 20 years. Prior to B Lab, Jay and Bart were Co-Founder and President, respectively, of AND 1, a $250 million basketball footwear and apparel business. Andrew has spent his entire career as a private equity investor; most recently as a Partner at MSD

(*continued*)

Assertedly, B Lab conceived of the "B Corporation" to "address two problems:"

> i. [T]he existence of shareholder primacy which makes it difficult for corporations to take employee, community, and environmental interests into consideration when making decisions; and
>
> ii. [T]he absence of transparent standards which makes it difficult for all of us to tell the difference between a "good company" and just good marketing.[146]

Initially, B Lab pursued its mission in two ways: "First, B Lab promotes the adoption of its Model Legislation that allows the formation of *[statutory] benefit corporations*; and second, B Lab certifies a qualifying corporation as a *'Certified B Corporation,'* meaning that the corporation has met B Lab's standards as a socially responsible corporation."[147] More recently, B Lab added a third major initiative—development of the "Global Impact Investing Ratings System (GIRRS)."[148]

The B Lab website describes a multi-step B Corporation certification process,[149] beginning with "a self-assessment by the applicant of its

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> Real Estate Capital, a $1 billion real estate fund controlled by MSD Capital, the investment vehicle for the assets of Michael Dell and the Michael and Susan Dell Foundation.

Mark J. Loewenstein, *Benefit Corporations: A Challenge in Corporate Governance*, 68 BUS. LAW. 1007, 1012 n.18 (2013) (citing *Our Team*, B LAB, http://www. bcorporation. net/what-are-b-corps/the-non-profit-behind-b-corps/ourteam (last visited Aug. 10, 2013)).

[146] *Introducing the B Corporation*, B REVOLUTION CONSULTING 4 (May 15, 2012), http://www.brevolutionconsulting.com/assets/BCorp-Intro-pack.pdf/ [https://perma.cc/HWS2-WLW3].

[147] Mark J. Loewenstein, *Benefit Corporations: A Challenge in Corporate Governance*, 68 BUS. LAW. 1007, 1013 (2013).

[148] *See* Briana Cummings, *Benefit Corporations: How to Enforce a Mandate to Promote the Public Interest*, 112 COLUM. L. REV. 578, 594 n.111 (2012).

[149] Binder summarizes the certification process as follows:

> The certification process requires businesses to satisfy three requirements. The applicant must: (1) pass a scored impact assessment on its commitment to social good, (2) amend[] its articles of incorporation and other governing documents to institutionalize its [social] commitment, and (3) submit reporting documents and fees to B Lab, which audits the businesses. The impact assessment—which has been continuously revised—is developed by an independent Standards Advisory Council tasked with developing rigorous standards for social and environmental performance. Once a business passes the threshold

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'overall impact . . . on its stakeholders,"' followed by "a review by the B Lab staff, the submission of supporting documentation, and the payment of a fee to B Lab."[150] Although the website indicates that an applicant—if not a benefit corporation at the time of application—must become one "as a condition to certification,"[151] Professor Murray has noted that "B Lab certifies C-Corporations, S-Corporations, LLCs, LLPs, LPs, Benefit Corporations, Sole Proprietors, and entities formed outside of the U.S. and Canada."[152] B Lab certification enables an entity to promote itself as such, ostensibly enhancing its ability "to market its goods and services and to attract capital."[153]

### 1. *Distinguishing a "Certified B-Corporation" from a "Benefit Corporation"*

Thankfully, some authors have addressed the confusion that seems to persist in the literature between "Certified B Corporations" and "statutorily formed benefit corporations"—both of which have been mistakenly referred to as "B Corps."[154] Professor Murray notes that B Lab likens its Certified B Corporations "to the certification of coffee as 'Fair Trade' or the certification of buildings as 'LEED [Leadership in Energy and

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> score on the impact assessment, B Lab verifies its responses by reviewing documentation for a portion of the applicant's responses.

Binder, *supra* note 125, at 650 (internal citations omitted).

[150] Loewenstein, *supra* note 147, at 1013. (citing *How to Become a B Corp*, B LAB, http://www.bcorporation.net/become-a-b-corp/how-to-become-a-b-corp/ (last visited Aug. 10, 2013) [https://perma.cc/LN3G-A9BC]).

[151] *See id.* The author notes that

> [i]t appears that an entity (corporation or limited liability company) may obtain the B Lab certification even if, in the case of a corporation, it does not incorporate under the state's benefit corporation statute, at least if such a statute is unavailable when certification from B Lab is sought. This is an inference from the fact that several Colorado corporations have received B Lab certification notwithstanding the fact that Colorado had not [at the time] adopted benefit corporation legislation. Moreover, anecdotal evidence suggests that B Lab does not, in fact, take any action if a certified corporation fails to adopt benefit corporation status.

*Id*. at 1013 n.23.

[152] J. Haskell Murray, *Social Enterprise Innovation: Delaware's Public Benefit Corporation Law*, 4 HARV. BUS. L. REV. 345, 345 n.4 (2014).

[153] Loewenstein, *supra* note 147, at 1013.

[154] *See* J. Haskell Murray, *Choose Your Own Master: Social Enterprise, Certifications, and Benefit Corporation Statutes*, 2 AM. U. BUS. L. REV. 1, 21 (2012).

Environmental Design] certified.'"[155] He goes on to explain that, by contrast: benefit corporations are actual new legal entities formed under state "benefit corporation statutes"; unlike statutory benefit corporations, Certified B Corporations must be subject to random on-site B Lab review; and, companies can be both a benefit corporation and a Certified B Corporation, or simply "one but not the other."[156] Lofft *et al*. succinctly explain that "[a]ny company that meets the standards of overall social and environmental performance established by B Lab may request certification as a B Corporation . . . but a benefit corporation . . . is not automatically considered a B Corporation, or vice versa."[157] Kathryn Acello identifies some additional differences: that Certified B Corps "assume the same additional duties as benefit corporations," but such duties "are not statutorily binding"; that B Corp certification brings enhanced "brand visibility for both consumers and sustainable investors" by virtue of available "marketing on B Lab's website"; and, that benefit corporations generally have minimally-enforced statutory standards compared to the B Corps' requirements of an "annual benefit report," an "Impact Assessment Test," possible periodic audits, and a limited two-year certification period.[158] Finally, it should be noted that "B Corp certifications began in 2007, three years before the first benefit corporation statute was passed."[159]

Significantly, B Corp Certification applies to the company itself, not just its individual products or services.[160] The certification process measures "impact on non-shareholder stakeholders," scoring each business "on a range of categories in four primary impact areas: employees, consumers, the community, and the environment."[161] As of 2013, there were reported to be "910 certified B Corps in twenty-nine countries, representing 60 industries."[162] In addition, in September 2011, B Lab

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[155] *Id.*

[156] *See id*. at 21–22.

[157] Katherine R. Lofft et al., *Are Hybrids Really More Efficient? A 'Drive-By' Analysis of Alternative Company Structures*, ABA BUS. L. TODAY (September 2012), https://www.ebglaw.com/content/uploads/2014/06/53119_Lofft-Maniar-Rosenberg-ABA-Business-Law-Today-Hybrid-Structures.pdf/ [https://perma.cc/2W6K-SX3D].

[158] *See* Kathryn Acello, *Having Your Cake and Eating it, too: Making the Benefit Corporation Work in Massachusetts*, 47 SUFFOLK U. L. REV. 91, 112–13 (2014).

[159] Jacob E. Hasler, *Contracting for Good: How Benefit Corporations Empower Investors and Redefine Shareholder Value*, 100 VA. L. REV. 1279, 1283 n.26 (2014).

[160] *See* Kimbrell, *supra* note 138, at 551.

[161] *Id.*

[162] *Id.* at 551–52. The author also notes: "Notable B Corp certified companies include: Patagonia, Ben & Jerry's, Seventh Generation, Method Products, Plum Organics, Etsy,

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launched the "Global Impact Investing Ratings System (GIIRS) that provides rating and analytics for social and environmental impact of companies and funds similar to financial ratings and analytics."[163] The GIIRS now has "over $4 billion impact assets under management, provides ratings for 246 companies and 32 funds, and has an additional 103 companies and 28 funds in the works."[164]

Since B Corp Certification is "self-imposed and privately regulated by B Lab," it "does not entitle companies to any special tax treatment"—rather, it is essentially "a branding tool for companies that wish to be perceived by investors and the public as genuinely socially-minded businesses."[165] At the end of the day, as writer Sarah Thornsberry opines, "[t]he B Corp status is an asset to companies for three main reasons: marketing, consumer trust, and performance improvement."[166]

*2. B Lab Lobbying*

> B Lab co-founder Jay Coen Gilbert . . . during his 2010 TEDx Talk in Philadelphia . . . discussed the companies that B Lab certifies, called certified B corporations, and criticized corporate law for not focusing on societal good.

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Klean Kanteen, King Arthur Flour, UncommonGoods, Dansko, Cabot Creamery Cooperative, New Belgium Brewing Co., and Couch Surfing International." *Id.* at 552.

[163] *Id.* at 572.

[164] *Id.*

[165] Minhas, *supra* note 128, at 279.

[166] Sarah Thornsberry, *More Burden Than Benefit? Analysis of the Benefit Corporation Movement in California*, 7 J. BUS. ENTREPRENEURSHIP & L. 159, 166 (2013). The author goes on to note:

> One survey found that 52% of consumers rely on certification seals when buying products. With the B Corp label attached to its brand, businesses can leverage their marketing power to reach such consumers that share their values, especially as entities like Method and Seventh Generation build notoriety for the label's branding power. Since the B Corp label backs up this marketing power with third-party accountability, consumers can trust the label and the company. In addition, with the B Corp label, benefit corporations are given free publicity through featured articles about B Lab and the burgeoning movement. B Corps are offered discounted service partnerships, networking opportunities, and can more easily attract talent with their visible commitment to the triple bottom line. Also, by using the B Impact Assessment tool, businesses can compare themselves against an average score of other businesses who have used the tool and identify ways to improve."

*Id.*

> Since Gilbert's talk in 2010, B Lab has been active. Not only has the non-profit organization privately certified over 900 companies, but B Lab has also taken the lead in convincing more than twenty states and the District of Columbia to pass benefit corporation statutes, in Mr. Gilbert's words, "chang[ing] the rules of the game."[167]

As initially noted, one of B Lab's three major initiatives has been promotion of its Model Act as the preferred paradigm for state legislation permitting the formation of benefit corporations. It should come as no surprise, therefore, that B Lab has come to be called "a vocal, connected, persistent, and well-funded advocate for the Model."[168] According to Acello, "B Lab in fact lobbied for the passage of benefit corporation statues in the seventeen states that currently recognize them, and continues to pursue legislation in dozens of others."[169] Steven Munch has gone so far as to opine that "B Lab has led the most concerted effort to promote the effective and legal pursuit of corporate social enterprise in recent years"; further, that B Lab's early success and continued lobbying "makes the benefit corporation arguably the most ascendant innovation in social enterprise organizations today, and one that is likely to alter the nature of mission-driven corporations in the United States."[170]

*a. B Lab Critics*

Predictably, such lobbying success has not been without its critics. One such prominent critic[171] is attorney and author J. William Callison, a partner in the Denver office of Faegre Baker Daniels LLP. Mr. Callison has described in detail a protracted political battle that took place from 2009 to 2013 in the Colorado legislature between B Lab advocates of the Model Act, and local Colorado supporters of alternative benefit corporation legislation.[172] While Mr. Callison's recounting of this affair is too long and detailed to go into here, he does succinctly summarize the substance of his opinions about it:

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[167] Murray, *supra* note 152, at 345–46.
[168] *Id.* at 369.
[169] Acello, *supra* note 158, at 104.
[170] Munch, *supra* note 133, at 183, 186.
[171] While several other critics with different criticisms of B Lab can be found in other literature, we will here confine ourselves to Mr. Callison and his central concern with the inflexibility of the B Lab Model approach, which is also our concern.
[172] *See* J. William Callison, *Benefit Corporations, Innovation, And Statutory Design*, 22 J. AFFORDABLE HOUSING & COMMUNITY DEV. L. 239, 256–60 (2014).

> *In my view, a major impediment to the development and use of benefit corporations has been the friction induced by Blab and its supporters between forward-looking, active, and creative design on a state level and a rigid orthodoxy embodied in a politically correct Model Approach from which there can be no meaningful deviation.* In a nutshell, this is the lesson from Colorado, in which Blab actively prevented a thoughtful alternative approach to benefit corporations from becoming law. It is also the lesson from Delaware, in which the corporate drafting committee had a direct path to legislative enactment and Blab could not create large obstacles. As I have noted above, there are significant problems with the Model Approach, many of which have been alleviated in the Delaware Approach, and many more of which might have been alleviated by the Colorado Approach.[173]

### *B. The Benefit Corporation—Overview and Rationale*

To repeat an earlier-cited quote from Ian Kanig, *statutory benefit corporations*:

> are dual purpose, blended entities, adhering to the mold of Dodd's social enterprise theory and the social entrepreneurship movement, *with a legal structure that embraces both the pursuit of profit and the material enhancement of the public good*. This general legal structure provides a benefit corporation with two distinct advantages over non-profits and traditional corporate entities. First, unlike non-profits, the board of directors may issue dividend payments to shareholders. *Escaping the non-distribution constraint is essential to accessing sufficient financing to compete with traditional corporate entities, while also attracting management talent who desire wealth. Second, the benefit corporation also possesses an affirmative statutory mandate to pursue the general public benefit, in addition to any specific public benefits included within the articles of incorporation*. This enables benefit corporations to transcend the efforts of corporate social responsibility because they are manifestly

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[173] *Id.* at 259–60 (emphasis added).

> enabled to construct positive externalities. *The express statutory purpose of the benefit corporation is to distance itself from the shareholder wealth maximization norm that has dominated traditional corporations, to increase transparency in corporate decision-making, and to increase accountability for promised social outcomes.*[174]

Statutory benefit corporations arguably "remove any lingering doubt left by constituency statutes" regarding directors' decision-making liability in both "the ordinary course of business and in the context of takeovers."[175] They accomplish more than typical constituency statutes because they are mandatory rather than permissive, and because they expressly provide the option of giving "standing to non-shareholder stakeholders."[176] Further, they provide "a framework for 'mission accountability'—that is, for monitoring and enforcing effective pursuit of their public interest mission."[177] While some have characterized these new hybrid corporate forms as "an entirely new 'fourth sector,' joining the ranks of the 'big three' sectors of 'government, business and nonprofits,'[178] others describe them as 'a convergence of the three.'"[179]

Professor Lyman Johnson summarizes well the position assumed by benefit corporations in the overall historical context of American corporate law:

> Thus, Benefit Corps. in one sense represent a twenty-first century return to early U.S. expectations of corporate activity, as leavened by a long period from the early nineteenth century to the present when corporations organized for private gain became predominant due to undoubted overall social utility. And this turn toward the "private" corporation was because the corporation was an ideal social as well as business and legal vehicle for propelling industrial growth in a society that organized the bulk of its economic activity in the private sector. *Thus, the pure "for profit" corporation never has been legally mandated but rather evolved as a permitted (and desired) legal form to efficiently serve social and economic*

[174] Kanig, *supra* note 9, at 891–92 (emphasis added).
[175] Cummings, *supra* note 148, at 590. *See also* Corbett, *supra* note 3, at 173.
[176] Murray, *supra* note 140, at 504–05.
[177] Corbett, *supra* note 3, at 173 (citing Cummings, *supra* note 148, at 590).
[178] *Id.* (citing Cummings, *supra* note 148, at 582).
[179] *Id.*

> *functions. Historically, then, the for-profit corporate form stands between early corporations, most of which chiefly advanced public-serving purposes, and Benefit Corp. statutes, which likewise expressly permit (but do not require) the pursuit of profits while mandating the advancement of purposes other than pure profit maximization.*[180]

Professor Johnson believes that legally enabling benefit corporations "to serve mixed purposes" (*i.e.,* permitting corporations that are not nonprofit "to seek profits without having to maximize those profits" and/or to provide "social services of a type the government might typically supply") arguably introduces "a greater measure of institutional pluralism into law and business" that constructively blurs what otherwise might be considered "an overly dichotomous understanding of the 'public' and 'private' spheres of action."[181] He goes on to opine:

> There seems to be no good reason to have only an organizational bi-culture in which, on the one hand, no profit may inure to private persons in a nonprofit corporation and, on the other hand, the singular purpose in a for-profit corporation must be to zealously maximize profits. *On a spectrum where those two institutional objectives occupy polar ends, there lies an intermediate range of possible business purposes that combine some level of return to "private" investors with the simultaneous pursuit of more "public" or "social" benefits. . . .*
>
> In essence, structural pluralism places great weight on the social nature of human beings and emphasizes the existence of a plurality of social structures in society. *And there is no reason why, with respect to business corporations, there cannot be a pluralism of market-oriented entities designed to advance different purposes. . . .*
>
> The Benefit Corp., in other words, is a legal genre in which various "species" of social enterprise may

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[180] Lyman Johnson, *Pluralism in Corporate Form: Corporate Law and Benefit Corps.*, 25 REGENT U. L. REV. 269, 277–78 (2012–13) (emphasis added).

[181] *Id.* at 278–79.

> experiment and operate. *This not only helps dissolve simplistic, categorical thinking about profit/nonprofit and public/private organizational forms, it enriches the available ecology of business ventures*.[182]

Importantly, Professor Colombo observes that *benefit corporations take "a major step toward creating a corporate environment more hospitable to virtue" by inverting "the means-end relationship between product and profit"—that is, by viewing these corporations' production of goods or services not "as a means to the end of profits," but rather by viewing their profits "as a means to the end of [the corporations'] production.*"[183]

*C. Growth of Benefit Corporations*

According to Acello, seventeen states have statutorily-authorized benefit corporations—Arkansas, California, Delaware, Hawaii, Illinois, Louisiana, Maryland, Massachusetts, Nevada, New Jersey, New York, Oregon, Pennsylvania, Rhode Island, South Carolina, Vermont, and Virginia—with several other states having introduced enabling legislation.[184] Robert A. Wexler (in a presumably later article) notes: "As of August 1, 2014, the District of Columbia and at least 26 states[185] have adopted benefit corporation legislation."[186] According to Wexler, while benefit corporation legislation has come to vary significantly among the enacting states, all variations are generally based upon one of two

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[182] *Id.* at 280–81 (emphasis added) (internal citations omitted).

[183] Colombo, *supra* note 88, at 72. Professor Colombo goes on to note:

> As revolutionary and ambitious as this inversion may seem, it is actually not that far removed from the American Law Institute's own formulation of business purpose. In its comments regarding Section 2.01, "The Objective and Conduct of the Corporation," the American Law Institute explicitly recognized that "the corporation is a social as well as an economic institution,' concluding that 'its pursuit of the economic objective must be constrained by social imperatives and may be qualified by social needs."

*Id.* at 73.

[184] *See* Acello, *supra* note 158, at 104. *See also id.* at 104 n.69 (citing state statues and other primary authority on enabling legislation).

[185] The discrepancy in the number of states purportedly having now passed benefit corporation statutes is undoubtedly due to the publication dates of the sources cited.

[186] Robert A. Wexler, *For-Profit Social Enterprise Models Understanding the Legal Landscape*, ADLER & COLVIN (2014), https://zerista.s3.amazonaws.com/item_files/73b9/attachments/32880/original/rules_of_engagement_in_new_social_economy_--_hybrid_models_(00620930).pdf/ [https://perma.cc/HS8C-JJEN].

approaches: the Model Act drafted and aggressively promoted by B Lab, or the more recently-enacted Delaware version (the "Delaware Act") which still derives in part from the B Lab model.[187]

*D. The Model Act*

As previously noted, a white paper authored by Clark, Jr. and Vranka discusses B Lab's rationale for its proposed legislation and includes a copy of the Model Act itself.[188] For our purposes, we will here only attempt to identify the most salient features of the Model Act, referring the interested reader to the white paper and text of the Act itself for comprehensive detail.

Professor Murray identifies the "primary parts of the Model" as including:[189]

> (1) *mandatory "general public benefit" purpose and optional "specific public benefit" purpose(s);*[190]
>
> (2) election or termination of benefit corporation status by an affirmative vote by at least two-thirds of shareholders;[191]
>
> (3) mandatory use of a comprehensive, independent, credible, transparent third-party standard to measure social and environmental performance;[192]
>
> (4) mandatory consideration by directors of seven listed sets of stakeholders;[193]

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[187] *See id.*

[188] *See* Corbett, *supra* note 3, at 172 (citing William H. Clark & Larry Vranka, *The Need and Rationale for the Benefit Corporation: Why it is the Legal Form that Best Addresses the Needs of Social Entrepreneurs, Investors, and, Ultimately, the Public*, BENEFIT CORPORATION (2013), http://benefitcorp.net/sites/default/files/Benefit_Corporation_White_Paper.pdf [https://perma.cc/TM3Z-XL8L].

[189] *See* Murray, *supra* note 152, at 349.

[190] *Id.* (citing MODEL BENEFIT CORP. LEGIS. §§ 102, 201(a)–(b) (2013)) (emphasis added). "General public benefit" is defined as "[a] material positive impact on society and the environment, taken as a whole, assessed against a third-party standard, from the business and operations of a benefit corporation." *Id.* § 102.

[191] *Id.* (citing MODEL BENEFIT CORP. LEGIS. §§ 104–05).

[192] *Id.* (citing MODEL BENEFIT CORP. LEGIS. § 102).

[193] *Id.* (citing MODEL BENEFIT CORP. LEGIS. § 301(a)(1)(i)–(vii)). The author notes:

> The seven groups of stakeholders are: (1) Shareholders; (2) Employees (of the benefit corporation, its subsidiaries, and its suppliers); (3) Customers (as beneficiaries of the general or specific public benefit);

(*continued*)

> (5) provision of a "benefit enforcement proceeding" to be brought by the benefit corporation, shareholders of at least 2% of the benefit corporation stock, a director of the benefit corporation, owner of at least 5% of the parent of a benefit corporation, or any other persons listed in the bylaws or articles of the benefit corporation;[194]
>
> (6) mandatory public posting of an annual benefit report.[195]

He goes on to note that the corporation's articles of incorporation must contain a statement that the entity is a "benefit corporation," but no "special naming requirements" are otherwise called for.[196] Finally, he observes that "[t]he state's general business corporation law applies to benefit corporations; however, the benefit corporation statute controls over the state's general business corporation law in the event of a conflict."[197]

In their own "white paper," the Corporate Laws Committee of the ABA Business Law Section further elaborates on two significant features of the Model Act: that it "includes a specific role for a 'benefit director' who must opine as to the success of the corporation in acting in accordance with its general public purpose and specific public purposes," and that the "*model legislation does not permit charter provisions that are inconsistent with the B Lab provisions.*"[198] The Committee's white paper also includes an Appendix B which discusses "the specific provisions of the B Lab model and *how it has been varied in the legislation adopted in several states* . . . ."[199] Again, we refer the interested reader to the Committee's white paper for comprehensive detail.[200]

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> (4) Community and society; (5) The local and global environment; (6) Short- and long-term interests of the benefit corporation; and (7) Ability to accomplish general and any specific public benefit.").

*Id.*

[194] *Id.* (citing MODEL BENEFIT CORP. LEGIS. §§ 102, 305(c)).

[195] *Id.* (citing MODEL BENEFIT CORP. LEGIS. § 401).

[196] *Id*. (citing MODEL BENEFIT CORP. LEGIS. § 103).

[197] *Id.* (citing MODEL BENEFIT CORP. LEGIS. § 101(c)).

[198] Corporate Laws Committee, ABA Business Law Section, *Benefit Corporation White Paper*, 68 BUS. LAW 1083, 1088 (August 2013) (emphasis added) (*i.e.*, the Act's previously-noted "inflexibility").

[199] *Id.* at 1087 (emphasis added).

[200] *See id.* at 1098–1109.

### 1. *Criticisms of the Model Act—"General" versus "Specific" Public Benefit*

In a further refinement of William Callison's criticism of the Model Act's "inflexibility," Professor J. Haskell Murray has, in our opinion, well summarized the most compelling problems with then existing statutory benefit corporation statutes, as well as the Model Act itself, in 2012 and 2014 articles:

> *Current benefit corporation statutes do not allow directors to abandon the "general public benefit purpose" in favor of a more specific master or mandate.* Rather, the benefit corporation statutes require that any "specific public benefit purpose" be adopted *in addition* to the "general public benefit purpose." The "general public benefit purpose" concept, as used in the current benefit corporation statutes, is both too vague and too confining.[201]
>
> One of this Author's main criticisms of the Model has been, and still is, the lack of guidance it provides for directors in carrying out their responsibilities. The Model requires directors to "consider" seven different stakeholder groups, and directs them to pursue "general public benefit" but does not provide or require the establishment of any priorities to guide directors. The Model *allows* companies to choose one or more "specific public benefit purpose[s]," in addition to the "general public benefit purpose," but does not *require* that any specific public benefit purpose be chosen and states that the specific public benefit purpose cannot displace the requirement to pursue a general public benefit.[202]
>
> *Requiring social enterprise directors to consider an unprioritized group of stakeholders while also requiring a corporate purpose that looks at societal and environmental impact as a whole is not only unworkable, but could also exclude corporations with a more specific mission. A corporation with a focused and specific public purpose at its core is more likely to pursue that purpose*

[201] Murray, *supra* note 154, at 30 (emphasis added).
[202] Murray, *supra* note 152, at 354–55 (emphasis in original).

> *because the objective is more easily identified by directors. A more specific public purpose (or a prioritizing of certain stakeholders within a more general public purpose) would also provide a more workable system of board accountability.*[203]

In like fashion another critic of the Model Act, Professor Mark J. Loewenstein, argues in a 2013 article:

> *The purpose of benefit corporation acts is not just to free up social entrepreneurs from the perceived constraints of profit maximization, but to create a form that mandates non-profit maximizing behavior. The Model Legislation, which has been drafted to achieve that end, is at the same time too broad and too narrow.* It is too broad because it seeks to accomplish too much. Requiring that each corporation has as its purpose a general public benefit in addition to any desired specific public benefit unnecessarily complicates the decision-making process of the board of directors. At the same time, the Model Legislation is too narrow. A social entrepreneur may have a minimal interest in profits and, indeed, so represent the venture to potential investors as one devoted to achieving a specific public benefit. . . . It is understood, however, that the "investor" cannot expect a market return on the investment and, instead, should view the investment, at least in part, as a non-deductible contribution to achieve a favorable social outcome. *Such an investor, however, may not want the goal . . . [of the investment] to be subordinated to a general public benefit or to the interests of other constituencies,* such as employees, suppliers, etc. The Model Legislation is too narrow to permit this deviation; neither the social entrepreneur who created the benefit corporation, nor the board of directors that operates it, has the freedom to vary the rigid requirements of the Model Legislation.[204]

On the inability of social entrepreneurs who may prefer to pursue *only* a specific public benefit under the Model Act, he observes: "This is an

[203] Murray, *supra* note 154, at 32–33 (emphasis added).
[204] Loewenstein, *supra* note 147, at 1036 (emphasis added).

unfortunate byproduct of the rigid approach of the Model Legislation; *the drafters could have provided that benefit corporations have a general public benefit purpose* ***or*** *a specific public benefit purpose or, if a benefit corporation so chooses, both.*"[205]

*E. State Adaptations of the Model Act*

Some states have in fact now adopted adaptations of the Model Act in response to the various criticisms of it. For example, "[t]wo states have enacted statutes that do *not* require the pursuit of a general public benefit broadly defined, but instead focus *only* on specific benefits defined by each company. These are called *flexible purpose corporations* in California[206] and *social purpose corporations* in Washington."[207] Similarly, "Minnesota's statutes provide for both the broad version, called *general benefit corporations*, and the more focused version, called *specific benefit corporations,*"[208] whereas the recently-enacted Delaware *public benefit corporation* statute "introduces a balancing requirement, which at first glance seems to set a tougher standard than the Model Act."[209] We will examine three state adaptations in detail—Delaware, Colorado, and Minnesota.

*1. Delaware and Colorado*

> In 2013, after studying the Model Approach and responding to various criticisms of it, the Delaware Bar Association's Corporation Law Section released a version

[205] *Id.* at 1015 (emphasis added).

[206] It should be noted that the California "Flexible Purpose Corporation" has since been amended and renamed the "Social Purpose Corporation," as in Washington State. *See* Steven R. Chiodini, *Goodbye Flexible Purpose Corporation, Hello Social Purpose Corporation: Governor Brown Signs S.B. 1301*, ALDER & COLVIN (October 6, 2014), http://www.nonprofitlawmatters.com/2014/10/06/goodbye-flexible-purpose-corporation-hello-social-purpose-corporation-governor-brown-signs-s-b-1301/ [https://perma.cc/J6GV-FK5F]. Since all of the authorities cited herein refer to the former name, we shall do likewise.

[207] McDonnell, *supra* note 141, at 30 (emphasis added).

[208] *Id*. at 30–31 (emphasis added).

[209] *Id*. at 35. The author notes that

> [t]he board of directors shall manage or direct the business and affairs of the public benefit corporation in a manner that balances the pecuniary interests of the stockholders, the best interests of those materially affected by the corporation's conduct, and the specific public benefit or public benefits identified in its certificate of incorporation.

*Id.*

> of benefit corporation legislation that is significantly different from the Model Approach (Delaware Approach). The Delaware Approach was enacted in Delaware, without change from the legislature, on July 17, 2013.[210]

So notes B Lab critic J. William Callison in a 2014 article. In that article, Mr. Callison provides a focused summary of the principal elements of the Delaware Approach:

> (1) The name of the entity is a "public benefit corporation."[211]
>
> (2) A public benefit corporation is a "for-profit corporation . . . that is intended to produce . . . public benefits and to operate in a responsible and sustainable manner."[212]
>
> (3) "Public benefit" is defined as "a positive effect (or reduction of negative effects) on [one] or more categories of persons, entities, communities or interests . . . including, but not limited to, effects of an artistic, charitable, cultural, economic, educational, environmental, literary, medical, religious, scientific or technological nature."[213]
>
> (4) To become a public benefit corporation, the certificate of incorporation must (i) "[i]dentify within its statement of business or purpose . . . [one] or more specific public benefits to be promoted," and (ii) "[s]tate within its heading that it is a public benefit corporation."[214] *There is no "**general** public benefit" concept in the Delaware Approach. This is a major change from the Model Approach.*[215]
>
> (5) The name of the public benefit corporation must contain the words "public benefit corporation" or the designations "P.B.C." or "PBC."[216]

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[210] Callison, *supra* note 172, at 251 (citing DEL. CODE ANN. tit. 8, § 362(a)).
[211] *Id.* (citing DEL. CODE ANN. tit. 8, § 362(a)).
[212] *Id.*
[213] *Id.* (citing DEL. CODE ANN. tit. 8, § 362(b)).
[214] *Id.* (citing DEL. CODE ANN. tit. 8, § 362(a)).
[215] *Id.* (emphasis added).
[216] *Id.* (citing DEL. CODE ANN. tit. 8, § 362(c)).

> (6) "[A] public benefit corporation shall be managed in a manner that balances the stockholders' pecuniary interests, the best interests of those materially affected by the corporation's conduct, and the . . . public benefits identified in its certificate of incorporation."[217]
>
> (7) Ninety percent stockholder approval is required for a corporation that is not a public benefit corporation to become a public benefit corporation.[218] Dissenters' rights provisions are applicable for shareholders who do not vote in favor of the change.[219] Further, election out of public benefit corporation status requires a two-thirds stockholder vote.[220]
>
> (8) *The directors of a public benefit corporation shall manage or direct its business in a manner that "balances" three considerations: the stockholders' pecuniary interests, "the best interests of those materially affected by the corporation's conduct, and the* ***specific*** *. . . public benefits identified in its certificate of incorporation.*"[221] Directors do not have any duty to any person on account of that person's interest in the specific public benefits identified in the certificate, or due to any interest that is materially affected by the corporation's conduct.[222] Further, with respect to any decision implicating the tripartite balancing standard, directors are deemed to satisfy their fiduciary duties to stockholders and the corporation if the decision is informed, disinterested, and not one such that no ordinary person of sound judgment would approve.[223] Finally, the certificate of incorporation may provide protective language that a disinterested director's failure to satisfy the tripartite decision-making

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[217] *Id*. (citing DEL. CODE ANN. tit. 8, § 362(a)).

[218] *Id.* at 252 (citing DEL. CODE ANN. tit. 8, § 363(a)) (noting that Colorado went with a two-thirds shareholder vote). *See* COL. REV. STAT. § 7-101-504(1) (2013).

[219] *Id.* (citing DEL. CODE ANN. tit. 8, § 363(b)).

[220] *Id.* (citing DEL. CODE ANN. tit 8, § 363(c)).

[221] *Id*. (citing DEL. CODE ANN. tit. 8, § 365(a)) (emphasis added).

[222] *Id.* (citing DEL. CODE ANN. tit. 8, §365(b)).

[223] *Id.*

> standard shall not constitute an act or omission that is not in good faith or is a breach of the duty of loyalty.[224]
>
> (9) A public benefit corporation shall, at least every two years, provide its stockholders with a statement concerning its promotion of the public benefits specified in the certificate and the best interests of those materially affected by the corporation's conduct.[225] The Delaware Approach contains specific requirements for the stockholder statement.[226] However, there is no requirement for public dissemination of the statement or for use of any third-party standard or certification addressing the corporation's conduct. The certificate may require public dissemination or use of a third-party standard if the stockholders so choose.[227]
>
> (10) Stockholders meeting a 2% ownership requirement may maintain a derivative suit to enforce the directors' duties.[228]

As to Delaware's law, Professor Murray concludes that while it "could have been more clear by expressly stating *that the PBC's* ***top*** *priority is its* ***specific*** *public benefit purpose*, requiring PBCs to identify a specific public benefit purpose is a positive change" which will likely promote greater director decision-making and accountability.[229] As to B Lab, he concludes that it "still appears to be championing the Model and resisting legislation based on Delaware's PBC law."[230] By way of illustration, Professor Murray notes that while "Delaware's new framework has already been largely followed" by Colorado,[231] the state "received significant resistance from B Lab," ultimately passing a statute that contained "B Lab's desired reporting requirements."[232]

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[224] *Id.* (citing DEL. CODE ANN. tit. 8, § 365(c)).
[225] *Id.* (citing DEL. CODE ANN. tit. 8, § 366(b)).
[226] *Id.* (citing DEL. CODE ANN. tit. 8, § 366(b)(1)–(4)).
[227] *Id.* (citing DEL. CODE ANN. tit. 8, § 366(c)(2)–(3)).
[228] *Id.* (citing DEL. CODE ANN. tit. 8, § 367).
[229] Murray, *supra* note 152, at 356 (citing DELAWARE PUBLIC BENEFIT CORPORATIONS: FAQS, at 2 (on file with author)) (emphasis added).
[230] *Id*. at 368.
[231] *Id.* at 351.
[232] *Id.* at 368–69 (explaining that B Lab insisted that Colorado adopt public reporting, even though Delaware's version of the law had not required public reporting). *Id.* at 351. *See also id.* at 351 n.38.

In regard to Colorado and its interaction with B Lab more specifically, Callison notes:

> Although Colorado enacted a modified Delaware Approach in 2013, enactment came only after a three-and-a-half-year, fairly acrimonious debate between Blab-backed supporters of the Model Approach and the Corporate Laws Drafting Committee under the Colorado Bar Association (CBA) . . . . During the course of discussions in an attempt to be proactive, supporters of a workable benefit corporation bill rather than reactive opponents of the Model Approach, the CBA proposed alternative legislation. *Although it did not pass for political reasons, in my view the Colorado Approach works better than either the Model Approach or, although less so, the Delaware Approach. It should be considered in other states.*[233]

For our purposes, we feel it is more useful here to share Mr. Callison's summary of, and opinions about, the "Colorado Approach" that was not finally enacted—both because we agree with it, and because (as will be seen) it has more in common with the last state adaptation we will discuss, the Minnesota "Specific Benefit Corporation."

Mr. Callison summarizes the elements of the Colorado Approach[234] as follows:

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[233] Callison, *supra* note 172, at 255 (emphasis added).

[234] *Id.* (noting: "For the alternative legislation (in other words, the Colorado Approach), see H.R. 1138, 69th Gen. Assemb., 1st Reg. Sess. (as introduced in Colo. House, Jan. 18, 2013)."). The "Colorado Approach" was a model developed by the "Corporate Laws Drafting Committee under the Colorado Bar Association (CBA)." Mr. Callison describes the circumstances in which it was ultimately rejected by the Colorado Legislature:

> When the CBA alternative came to the Colorado Senate, it was clear that there was limited but powerful Democratic opposition to the bill. Fortunately, the Delaware drafting committee had released legislation containing the Delaware Approach immediately before the Colorado Senate opposition was clarified. Blab, also recognizing the political power of the Delaware corporate laws committee, and, in my view, seeking to co-opt the inevitable Delaware Approach as a victory for benefit corporations, announced its full-throated support for the Delaware Approach. The CBA committee decided that the Delaware Approach was far superior to the Model Approach and therefore negotiated a 'strike-below,' replacing the bill embodying the Colorado Approach with a near-clone of the Delaware Approach.

(*continued*)

> (1) *The Colorado Approach allows for-profit corporations to become benefit corporations by selecting either general public benefit (Model Approach) or specific public benefit (the Delaware Approach), or both*. The Colorado Approach neither mandates nor prohibits a general public benefit approach but leaves the decision to the corporation and its shareholders.[235]
>
> (2) In general, under the Colorado Approach, if a benefit corporation elects "general public benefit," the other elements of the Model Approach are mandatory and apply to the benefit corporation. On the other hand, *if the corporation elects to pursue one or more specific public benefits, virtually none of the Model Approach's mandates are forced on the corporation*. Instead, the Model Approach concepts are precatory, and the shareholders can elect which Model elements, if any, to include in their corporate structure. For example, if they seek to apply some third-party standard, shareholders can elect this.[236] If they seek benefit directors, they can create them. If they want the corporation to have periodic benefit reporting, they can require it.[237] If they want public reporting, they can say so.[238]
>
> The basic theme of the Colorado Approach is shareholder choice. The drafters recognized that the cost of benefit corporation status (in other words, potentially reduced profitability) is borne by the shareholders and, therefore, that it is the shareholders and not the legislature

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> Blab then took the profound position that "Colorado is not Delaware" and insisted on public reporting requirements. Recognizing the infirmity of the proposed reporting language, the CBA committee acquiesced and called it a day, and a modified Delaware Approach bill passed the Senate, was adopted by the House, and was signed by the governor.

*Id.* at 258–59.

[235] *Id.* at 255–56 (emphasis added).

[236] *Id.* (citing H.R. 1138 § 7-101-511(1)(a)(II) (allowing, but not requiring, the application of a third-party standard)).

[237] *Id.* (citing H.R. 1138 § 7-101-511(1)(a) (allowing, but not requiring, periodic benefit reporting)).

[238] *Id.* (citing H.R. 1138 § 7-101-511(1)(b)–(d) (allowing, but not requiring, public reporting)).

> or an entity based in Berwyn, Pennsylvania, that should establish the terms. At the same time, the drafters recognized that there might be some constituency of corporations that seek the more rigorous, expensive, and harsh rules of the Model Approach. In keeping with the concept of choice, the Colorado Approach fully enables those for-profit corporations that seek the Model Approach. *The drafters believed they were merging dueling concepts of benefit corporations, and I believe that the Colorado Approach is the best proposed to date*.[239]

*2. The Minnesota "Specific Benefit Corporation"*

The most recent and final state adaptation that we will discuss is that enacted in Minnesota in January 2015.[240] As previously noted, Minnesota's statutes provide for two versions of the benefit corporation: "the broad version, called *general benefit corporations*, and the more focused version, called *specific benefit corporations*."[241] For our purposes, we will focus exclusively on the specific benefit corporation version.

As attorney and member of the drafting committee for the Minnesota Benefit Corporation Statute Deborah J. Walker notes:

> The specific benefit corporation is an altogether different creature. It has the purpose of pursuing one or more specific public benefit purposes stated in its articles. A specific public benefit means "one or more positive impacts (or reduction of a negative impact) on specified categories of natural persons, entities, communities or interests (other than shareholders in their capacity as shareholders) as enumerated in the articles . . . ."[242]

This new type of benefit corporation is permitted "to seek any specific social benefit purpose" without being tied to any statutorily-defined "list or set of goals."[243] Assertedly, "the drafting committee felt it was not up to them to define a public benefit on behalf of others—the market could

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[239] *Id.* (emphasis added).
[240] *See* Minnesota Public Benefit Corporation Act, §304A (2018).
[241] McDonnell, *supra* note 141, at 30–31 (emphasis added).
[242] Deborah J. Walker, *Please Welcome the Minnesota Public Benefit Corporation*, 11 U. ST. THOMAS L.J. 151, 168 (2013) (citing Minnesota Public Benefit Corporation Act, §§304A.104, subd. 9 (2014)) (emphasis added).
[243] *Id.*

decide that by investment."[244] Importantly, Ms. Walker notes that the Minnesota approach constitutes "*a significant and controversial divergence from the Model Legislation*" as well as other state adaptations because *it provides the option*:

> *for a social enterprise to pursue profits and positive social impacts without regard for the corporation's overall effect on the environment* (i.e., a benefit corporation in Minnesota need not be "sustainable"). This is somewhat contrary to the Model Legislation proponents because one of the primary concerns of the first benefit corporation's drafters was sustainability. Most public benefit corporation statutes allow specific benefit purposes only in addition to a general benefit purpose. In other words, every benefit corporation is first and foremost a general benefit corporation. *Colorado experienced resistance when drafting legislation that would have had a similar result.*[245]

In like fashion, Professor McDonnell observes:

> The Minnesota Act has some notable differences in its statement of the core duty and its limitations on liability for damages. As with the Model Act, the core duty is to consider a variety of stakeholder interests. For a general benefit corporation, the enumerated list of interests to consider is quite similar to that in the Model Act *For a specific benefit corporation, however, the only interests the corporation must consider* (it may consider others) *are those of shareholders and the specific benefit to which the corporation has committed to pursuing. Thus, for specific benefit corporations in Minnesota, the scope of what must be considered is much narrower than benefit corporations under the Model Act or Delaware Act, or general benefit corporations in Minnesota.*[246]

*To our way of thinking, by directly confronting and overcoming Callison's (and others') concern with the problematic and inflexible requirement of a "general public benefit," Minnesota's specific benefit*

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[244] *Id.*
[245] *Id.* at 168–69 (emphasis added).
[246] McDonnell, *supra* note 141, at 42 (emphasis added).

*corporation begins to open the door for our proposed Health Care Benefit Corporation (HCBC).* Arguably, as Ms. Walker suggests, "the success of [these] corporate form[s] will depend on investors who are interested [only] in [a] particular benefit or cause and are willing [simply] to accept potentially reduced returns in its pursuit."[247] *Moreover, a variant form of benefit corporation that is able to focus on a public benefit purpose that is narrow and specific (in contrast to broad, vague, and often unquantifiable), can much more readily develop and apply legitimate and truly useful metrics to monitor and evaluate the corporation's performance.*

With this, we are now ready to turn our attention to the questions of why the HCBC is desirable and how, specifically, it might be structured and implemented. To answer these questions, however, we must first set the stage by expanding upon a few issues discussed in our initial article regarding the current status of the healthcare delivery system in this country.

## V. HEALTH CARE DELIVERY TODAY

In our initial article, we noted that "the 'forces of commercialization' in health care have 'coalesced to create a powerful $2.5 trillion industry that, in 2009, constituted greater than 17% of the nation's economy.'"[248] In the United States, "[t]hese forces . . . include more than just doctors and hospitals—they include health insurers, health care manufacturers and suppliers, pharmaceutical companies, all manner of other individual health care professionals who serve patients directly, and other non-health care professionals and industries providing support to the health care sector in general."[249] We went on to note how it has been this entire "web of participants," acting in response to "advances in medical science and technology" that has brought about the commercialization of American health care.[250]

Such "commercialization" has necessarily been accompanied by a large degree of "corporatization," as the scale, complexity, and capital requirements of all health care sub-sectors have grown significantly over

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[247] Walker, *supra* note 242, at 168.

[248] Corbett, *supra* note 3, at 163 (quoting Joshua E. Perry, *An Obituary for Physician-Owned Specialty Hospitals? The Legal and Ethical Prognosis for Market-Driven, Entrepreneurial Medicine in the Wake of 2010 Heal Care Insurance Reforms*, 23 A.B.A. HEALTH LAW (May 13, 2010), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1607029) [https://perma.cc/96GW-SAQP].

[249] *Id.*

[250] *Id.*

time. Generally speaking (and confining ourselves to the "private" sphere), these sub-sector participants almost entirely have been for-profit actors—either individual (*e.g.*, doctors and other licensed professionals) or organizational (*e.g.*, medical suppliers, laboratories, etc.)—each of whom, of course, "help the economy by providing jobs and exports."[251] There is one major and very significant exception to this for-profit dominance—nonprofit general hospitals, which we discussed at length in our initial article. Here, we shall consider further some additional relevant background and context on the nature and scope of American health care "writ large."

*A. The American "Health Care Sector" Broadly*

In the United States, "'[h]ealth care' is no longer a term used merely to describe a venerated profession; today, it is also shorthand for a large and growth-oriented industry."[252] To drive home the point: "[n]ational health expenditures (NHE) in 2010 reached $2,593.6 billion or 17.9% of U.S. gross domestic product (GDP). This NHE was the equivalent of about $8,402 per person in 2010 and was the highest expenditure per capita (even after adjusting for purchasing power parity) among developed countries."[253] Moreover, these expenditures are "projected to grow to nearly 20 percent of GDP, or approximately $4.6 trillion, by 2019."[254] While government programs pay for a majority of these expenditures, about 12% of the total are paid out-of-pocket by American consumers.[255]

Professors Osmonbekov *et al*. have divided the American health care sector into a very conceptually-useful operational taxonomy of sub-sectors:

> [T]he healthcare sector can be divided into three types of companies: development-of-care, delivery-of-care, and financing-of-care. *Development-of-care companies* include pharmaceutical companies and other research companies that create medical devices and medicines for use in the provision of services. *Delivery-of-care companies* include hospitals and physician offices where patients receive the products developed by the development companies.

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[251] *See id.*

[252] KATHERINE R. LOFFT, *Health Care Reform and its Impact on Health Care Merger and Acquisition Activity*, *in* M&A STRATEGIES (2011 ed.), 2011 WL 4454655, at *1.

[253] Talai Osmonbekov et al., *The Affordable Care Act's Impact on Healthcare Marketing*, 20 J. L. BUS. & ETH. 21, 23 (2014).

[254] LOFFT, *supra* note 252, at 1.

[255] Osmonbekov et al., *supra* note 253, at 22–23.

> Finally, *the financing-of-care companies* include insurance companies, health maintenance organizations (HMOs), and government agencies (Medicare, and Medicaid) that subsidize or regulate the payment of services.[256]

Development-of-care companies include massive industries that provide pharmaceuticals (*e.g.*, Merck, Pfizer, and Eli Lilly), medical devices (*e.g.*, Stryker, Boston Scientific, and Medtronic), and a host of other "products" utilized by the entirety of the health care sector.[257] Financing-of-care companies include the huge and seemingly ubiquitous private "health plans" of today[258] that have seen tremendous growth as the health insurance industry has expanded from $9.3 billion in 1980 to $146 billion in 2010.[259] *Delivery-of-care companies—what are perhaps most often referred to as "institutional health care providers"[260]—are our principal focus.* As Lofft observes: "In the United States, there are nearly 11,000 registered and community hospitals with more than 1.7 million beds. The Centers for Disease Control estimates there are more than 34 million hospital discharges and nearly 45 million health care procedures performed annually."[261]

These institutional health care providers are the companies (generally organized as corporations) that are being most directly and significantly impacted by our current "deontological attitudes" toward health care and our continuing attempts at health reform legislation. As we shall see, because this sub-sector of institutional providers—which has grown from "just over $100 billion in 1980 to $814 billion in 2010"[262]—has increasingly embraced the concept of "accountable care"; these are the organizations that may be most benefited by our proposed development of a Health Care Benefit Corporation.

### *B. Why Hospital Governance is Different from Other Business Corporations*

A point made earlier here bears repeating: hospitals—be they for-profit or nonprofit—are unique among corporate enterprises because their

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[256] *Id*. at 23 (emphasis added).

[257] *See id.* at 34.

[258] *Id.* at 39.

[259] *Id.* at 38.

[260] "According to recent US government estimates, there are some 595,800 or more health care providers in the United States, including hospitals, nursing homes, physicians' and dentists' offices, and home health care services." Lofft, *supra* note 252, at 5.

[261] *Id.* at 1.

[262] *See* Osmonbekov et al., *supra* note 253, at 36.

"product" (or more properly, "service") is provided to "third-party beneficiaries" (*i.e.*, patients) who do not order the service, do not (generally) pay for the service (at least directly), and who (more often than not) cannot realistically judge the relative value of the service, either before or after the fact. What has been said by some about the charitable nonprofit sector in general—*i.e.*, that it is "largely unaccountable to anyone" by virtue of being "large, barely amenable to suit, and ineffectively reined in by the nondistribution constraint and the fiduciary rules under corporate and trust law"[263]—seems particularly applicable to today's large commercial nonprofit hospitals.

Hospitals (both for-profit and nonprofit) have another unique feature that complicates their governance—the historical legal role of the independent medical staff:

> The organization and structure of the modern American hospital are driven by a regulatory regime that requires the existence of a separate medical staff within the hospital. The separation between general administrative governance and medical staff governance within the hospital is a tool to ensure that professional autonomy in medical decision making will be free from lay influence or control and has a rationale akin to that of the traditional doctrine that banned or restricted the corporate practice of medicine. That is, physicians must be solely responsible for making scientifically-determined medical judgments without interference with those decisions by hospital administrative officials. In some jurisdictions, the medical staff bylaws constitute binding and enforceable contractual obligations, which limit the authority of the hospital to make decisions about appointing or retaining its medical staff.[264]

Professor John D. Blum has referred to this as the hospital's internal "tripartite arrangement of board, medical staff, and administration"[265] and noted that despite its historical evolution, it is a structure that remains "a

[263] *See supra* Section II.C (internal citations omitted). *See also* Boozang, *supra* note 78, at 116 (*citing* Geoffrey A. Manne, *Agency Costs and the Oversight of Charitable Organizations*, 1999 WIS. L. REV. 227, 252 (1999)).

[264] James F. Blumstein, *Of Doctors and Hospitals: Setting the Analytical Framework for Managing and Regulating the Relationship*, 4 IND. HEALTH L. REV. 211, 222 (2007).

[265] *See* John D. Blum, *Beyond The Bylaws: Hospital-Physician Relationships, Economics, and Conflicting Agendas*, 53 BUFF. L. REV. 459, 460 (2005).

current reality."[266] The structure derives from the "professional/scientific model" of medical care, which is characterized by an "asymmetry of information" between the unknowledgeable patient/consumer and the expert physician.[267] As an obvious result of this asymmetry, patients must rely on their physicians to make decisions on their behalf, which decisions in turn have not only medical consequences for patients, but economic consequences for the hospital.[268] As Professor James F. Blumstein observes: "As substitute decision makers applying professionally-developed norms and practice standards, physicians under the professional/scientific model ultimately determine individual levels of quality and the volume of services for individuals (and ultimately aggregate levels of utilization and costs)."[269] However, as Professor Blumstein goes on to discuss:

> The organization and structure of the hospital . . . seem to reflect an assumed need to insulate the members of the physician staff from the consideration of cost and other non-medical factors in their decision making. [As shown by the case of *Muse v. Charter Hospital of Winston-Salem, Inc.*,][270] . . . any consideration of economic factors in a physician's decision-making process . . . [may be] an

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[266] *Id.* at 498.

[267] Blumstein, *supra* note 264, at 220.

[268] *See id.*

[269] *Id.*

[270] 452 S.E.2d 589 (N.C. Ct. App. 1995) (per curium), *aff'd*, 464 S.E.2d 44 (N.C. Sup. Ct. 1996).

> *Muse* involved a mental health patient with thirty days of inpatient insurance coverage. As the thirty days wound down, the hospital engaged in a process of discharge planning, leading to the patient's discharge to a public mental health authority for outpatient treatment.
>
> Although the doctor signed the patient's discharge papers, the hospital was found liable for wanton and willful conduct since it adopted a policy of discharge planning that seemed to the court to require patient discharge upon the expiration of the patient's insurance coverage. Since the physician actually discharged the patient, the hospital was liable because it adopted a policy or practice that "interfered with the medical judgment" of the patient's attending physician. One interpretation of what it meant for the hospital to "interfere" with the physician's medical judgment was that the hospital expected the physician to include in his decision making the consideration of the economic reality that the patient's insurance coverage was about to (and did) expire.

Blumstein, *supra* note 264, at 222–23.

> impermissible corruption of professional medical judgment.
>
> The separate medical staff contemplates a model of governance in which physicians enjoy medical governance prerogatives akin to the academic freedom of university faculty. This structure suggests very limited control by hospital administration and is consistent with viewing hospitals as a physicians' workshop. . . .
>
> In this vision, hospitals are not seen as having independent institutional interests; they are locations or forums in which patients receive care and physicians practice their profession. This structure, however, *raises questions about routine management decisions that can affect the institutional interest of a hospital.*[271]

*The bottom line is straightforward: hospital governance always needs/wants to control costs; costs cannot be effectively controlled without the ability to control physician behavior—therefore, hospital governance seemingly always will be in conflict with an independent, self-governing medical staff.*

*C. The Current "Deontology" of Health Care in America:*

> In our capitalist society, the marketplace is a primary metaphor by which we understand the world. How, then, do we justify removing a thing from the operation of the marketplace? Professor Radin argues that the answer is related to the nature of the thing itself. *A marketplace operates by reducing the value of things to a common denominator, usually monetary worth.* Commodification inherently assumes that a thing's value can be calculated in money to facilitate evaluation of particular exchanges. *However, some things may be incommensurate with monetary value; that is, their worth cannot, or should not, be expressed in dollars and cents*. Radin holds that things which are inextricably related to our humanity—our personhood—should be outside the scope of the market. Thinking about our humanity in market terms produces, in Radin's words, an "inferior concept of human flourishing"

[271] *Id.* at 223–24 (emphasis added).

> and therefore causes injury to our concepts of ourselves and our society.[272]

In our initial article, we spent considerable time discussing the behavior of nonprofit hospitals from an ethical or "deontological" perspective. "If health care is a commodity"—a good or service whose worth can be reduced to its monetary value alone—"then there is no basis for characterizing much of the []-described [nonprofit] hospital conduct as bad acts."[273] In keeping with the suggested idea that "commerce is somehow a morality-free zone of human endeavor," there is no deontological difference (for example) between collecting on an overdue car loan and collecting on unpaid medical debt.

> Alternatively, if health care is a public good—in either the generic or economic sense of the word—then the public is justified in expecting better behavior from nonprofits as the equitable *quid pro quo* for tax-exemption. If, however, health care is a right to which all Americans are entitled regardless of their ability to pay, then one can fairly ask whether such services can ever be reliably and ethically provided by any institutional provider that is primarily motivated by profit, regardless of that provider's nominal organizational form.[274]

The problem is—from a deontological perspective—health care today is inherently "both a social good and a commercial service,"[275] with increasing calls for it to be deemed a fundamental right.

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[272] Timothy S. Hall, *Bargaining With Hippocrates: Managed Care And The Doctor-Patient Relationship*, 54 S.C. L. REV. 689, 727–28 (2003) (citing Margaret Jane Radin, Market-Inalienability, 100 HARV. L. REV. 1849 (1987)) (emphasis added).

[273] Corbett, *supra* note 3, at 137.

[274] *Id.*

[275] *See* Katherine R. Lofft et al., *supra* note 4, at 9.

### *1. Health Care as a Commodity*[276]

> The sort of commoditization which is to be feared is not the simple entry of prices, money, or market relations into realms of significant human and social meaning. Commercial relations are often themselves saturated with social meaning and relationality. Rather, it is the entry of narrow, profit-maximization *values* and related specific structures that, by reducing the value of everything to its contribution to a "bottom line," threaten to drain human meaning . . . . *To the extent that we teach that firms must maximize profits or shareholder value because that is their "nature" or "purpose," we undermine the very social values that we believe we are defending*. Not only do we perpetuate a myth, we promote a dangerously self-fulfilling prophecy.[277]

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[276] Professor Julie A. Nelson explains:

> *What about the issue of "commodification"? If the economic world is actually highly relational, does that mean there is nothing to fear from the inroads of markets or commercially-oriented values?* Here it is important to distinguish between two quite different meanings of the terms "commodify" or "commoditize."
>
> Within the social science literature, particularly in areas influenced by Marxist thought or dealing with globalization, "commodification" (or, more rarely, "commoditization") generally means the commercialization of something not formerly bought and sold. The connotation is negative, since it is assumed that placing a monetary value on something drains it of its intrinsic value and uniqueness, causing a loss of authentic values.
>
> Within the business literature, on the other hand, "commoditization" (or, more rarely, "commodification") refers to making something into a very specific type of good or service. A good or service is a "commodity" when all units of it are indistinguishable from one another. Raw materials and minerals, for example, are called commodities because one bushel of wheat or bar of gold of a specific type and grade is physically indistinguishable from another**.** *Not all goods and services are commodities, since many recognizably differ from each other along dimensions such as* quality, brand name, reputability of the supplier, or the *relationship between the supplier and purchaser.*

Nelson, *supra* note 87, at 102–03 (emphasis added).

[277] *Id.* at 106 (emphasis added).

As the old saying goes, "to a hammer, everything looks like a nail!" Given the historical and deep-seated American view of the nature and purpose of the corporate form, it should come as no surprise that the wealth-maximization norm has remained so intractably persistent. That such norm has seemingly infiltrated the decision-making of many charitable nonprofit health care providers, we submit, reflects a wholly-untoward victory of "margin" over "mission." That is to say, much of the purported "bad behavior" by nonprofit hospitals that has drawn critical scrutiny "results from misguided efforts to balance the tension between 'mission and margin' inherent in the nonprofit form"; too many organizations have responded "to their increasingly competitive, commercialized environment by over-emphasizing [financial] margin at the expense of their charitable mission."[278] Traditionally, the "threat of losing their tax-exemption has not been an effective deterrent to such conduct."[279]

Professor Julie A. Nelson argues:

> Commentators often use terms like "market values" or "business interests" to point to dehumanizing, social-meaning-depleting values of profit maximization at all costs. The essence of deleterious commoditization, however, is the assumption that everything is interchangeable, commensurable, quality-less and quantifiable into a corporate "bottom line"—not something intrinsic in business or markets per se. We do business leaders, ourselves, and the world an extreme disservice if we impute to all businesses and markets only the "love-less" characteristics and motivations invented by the neoclassical model of economics.[280]

Professor Margaret Jane Radin puts it much more simply: "Indeed, I try to show that the characteristic rhetoric of economic analysis is morally wrong when it is put forward as the sole discourse of human life . . . we must decide when it is morally appropriate to think and speak in market rhetoric and when it is not."[281] She argues:

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[278] Corbett, *supra* note 3, at 179.
[279] *Id.*
[280] Nelson, *supra* note 87, at 106.
[281] Margaret Jane Radin, *Market-Inalienability*, 100 HAR. L. REV. 1849, 1851, 1886 (1987).

> Universal commodification undermines personal identity by conceiving of personal attributes, relationships, and philosophical and moral commitments as monetizable and alienable from the self. . . .
>
> If we accept that the commodified object is different from the "same" thing noncommodified and embedded in personal relationships, then market-inalienability is a prohibition *of the commodified version,* resting on some moral requirement that it not exist. . . . *Something might be prohibited in its market form because it both creates and exposes wealth- and class-based contingencies for obtaining things that are critical to life itself—for example, health care—and thus undermines a commitment to the sanctity of life*.[282]

On the other hand, it clearly makes no sense to argue that modern health care services—given their tremendous scope, complexity, and cost––should be treated as "market-inalienable" (*i.e.*, something that can/should be given away, but not sold).[283] It would be equally senseless to suggest that health care be "universally noncommodified," with all markets therein abolished.[284] Such scenario is simply not plausible, even under the most expansive vision of single-payer or universal health care. The modern healthcare system is obviously so dependent on a multitude of technologies and other professional and commercial inputs that such disengagement from markets would, as a practical matter, be impossible. That said, *it is nonetheless increasingly apparent that a strict "commodified" view of health care that ignores its unique deontological character is neither viable nor just.*

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[282] *Id.* at 1905, 1912 (emphasis added).
[283] *See generally id.*
[284] *See generally id.*

### 2. *Health Care as a Public Good*[285]

Historically, when American courts have used the term "public good," it has come to mean both "the scope of the benefit provided," *and* the nature of the good or property itself; "[t]he term applies where the property is publicly necessary and therefore publicly financed for common use by the public."[286] Accordingly, such goods are viewed as "public assets" when held (for example) by nonprofit health care organizations but "purchased by the community" through "foregone tax revenues."[287]

But what happens when, arguably as now, nonprofit health care organizations begin to too-often emulate the operating characteristics and conduct of for-profits—to the point where their provision of public benefit and their use of public assets is drawn into question; and when, arguably as now, the services that they provide become a "commodified version" that lacks the defining characteristics of a "public good" as described above? Are we left with no choice but to look to the government for "obtaining things that are critical to life itself?" Some have argued:

> Economists recognize there are few examples of pure public goods that are wholly and unequivocally non-

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[285] In our initial article, we explained how:

> The idea of health care as a public good is often used in two different senses: first, is in the generic sense of "public benefit"—the provision of which is deemed to be the justification for granting nonprofit providers tax-exemption; second, is in the economic sense of goods that are both "nonrival and nonexcludable." In this context, such terms are taken to mean goods that can be consumed simultaneously by more than one person at the same level (*i.e.*, nonrival), and that cannot be readily excluded from anyone's consumption (*i.e.,* nonexcludable). Thus, "once the good is provided, all individuals can consume it regardless of their contribution to the good"—giving rise to the so-called "free-rider problem." These characteristics are said to result "in an inefficiently low observable demand for the good (in terms of who is willing to pay for it), and hence a socially suboptimal under-provision of the good." Under a "Public Goods Theory," then, to the extent that government does not provide sufficient quantities of the good, nonprofits arise to do so—again, the arguable justification for their tax-exemption. The point can be illustrated by trauma centers: because they are expensive to develop and typically lose a lot of money, they are rarely established by for-profit hospital organizations.

Corbett, *supra* note 3, at 138–39 (internal citations omitted).

[286] Mark Earnest & Dayna Bowen Matthew, *A Property Right To Medical Care*, 29 J. LEGAL MED. 65, 73 (2008).

[287] *Id.* at 74.

> rivalrous and non-excludable. *However, public goods, like health care services, possess these characteristics to a sufficient degree that markets alone prove insufficient to allocate these goods and services efficiently or fairly*. . . . Thus, public goods are typically the product of collective societal investment.[288]
>
> Moreover, public goods benefit society as a whole in such a fundamental and essential way that the law has traditionally extended protections to ensure the government's ability to distribute the public good equitably and fairly. *Health care* is no different in these essential ways than other recognized public goods. It, too, *must be produced collectively and distributed centrally because of its essential, economic characteristics*.[289]

Further, in what might be considered a prologue to both Accountable Care and the Affordable Care Act, Professor Nathan Cortez notes that:

> *the line between the "public" and "private" sectors is often blurred in health care*. The public and private spheres overlap and dissipate in health care perhaps more than in any other industry. Few, if any, health care systems are internally monolithic. Every country has a mix of public and private participants. Indeed, no purely "private" or purely "public" system has ever existed. *There are an infinite number of permutations for organizing, providing, financing, and regulating health care*. Thus, although it is still possible to differentiate "public" and "private" activities, these activities increasingly occur in both spheres.[290]

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[288] *Id.* at 77 (emphasis added).

> In the case of recognized public goods such as clean water and air, police and fire protection, and public education, no single individual has the means of, or a sufficient stake in, generating public goods efficiently. Therefore, without collective, public intervention, the market alone will not produce clean air or water or fire protection.

*Id.*

[289] *Id.* at 77 (emphasis added).

[290] Nathan Cortez, *International Health Care Convergence: The Benefits and Burdens of Market-Driven Standardization*, 26 WIS. INT'L L.J. 646, 661 (emphasis added).

*3. Health Care as a Right*

Most legal authorities agree that no "explicit right to health care" can be found in the U.S. Constitution.[291] As Professor William P. Gunnar notes in a 2006 article:

> Although the Declaration of Independence proclaimed that all persons have the "unalienable" rights of life, liberty, and the pursuit of happiness, it did not guarantee these rights. In its original form, the U.S. Constitution was a framework of government and not a charter of fundamental rights. The few individual rights outlined in the original document consisted of the right to a jury trial, the writ of habeas corpus, protection for contracts, and protection against ex post facto laws. The Constitution did not explicitly guarantee or promote an individual's right to health care.[292]

Professor Gunnar explains that the 1791 Bill of Rights—establishing the "first ten amendments to the U.S. Constitution"—was primarily concerned with "civil and political rights, rather than social and economic ones."[293] Until 1905, Americans' "fundamental rights" were limited to

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[291] *See* William P. Gunnar, *The Fundamental Law that Shapes the United States Health Care System: Is Universal Health Care Realistic within the Established Paradigm?*, 15 ANNALS HEALTH L. 151, 157 (2006) (citing Anita Pereira, *Live and Let Live: Healthcare is a Fundamental Human Right*, 3 CONN. PUB. INT. L.J. 481, 490 (2004)). *See also* Jason B. Saunders, *International Health Care: Will the United States Ever Adopt Health Care for All?—A Comparison Between the Proposed United States Approaches to Health Care and the Single-Source Financing Systems of Denmark and the Netherlands*, 18 SUFFOLK TRANSNAT'L L. REV. 711, 721–22 (1995) ("The United States recognizes The Charter of the Organization of American States and the American Convention on Human Rights, but is not a member of the American Declaration of Rights and Duties of Man, a positive rights law which recognizes health care as a right.").

[292] Gunnar, *supra* note 291, at 156 (citing W. Kent Davis, *Answering Justice Ginsburg's Charge that the Constitution is "Skimpy" in Comparison to our International Neighbors: A Comparison of Fundamental Rights in American and Foreign Law*, 39 S. TEX. L. REV. 951, 958 (1998)).

[293] *Id.* Professor Gunnar further explains:

> The constitutional guarantees against federal governmental oppression towards state actions were the primary insurers of fundamental rights. Following the Civil War, the adoption of the Thirteenth, Fourteenth, and Fifteenth Amendments, known as the Reconstruction Amendments, brought federal protections against slavery and ensured fundamental rights for all citizens. The effect of the Reconstruction Amendments was to give the federal government the power to supersede state

(*continued*)

those interpreted by the U.S. Supreme Court as being specifically enumerated in the Bill of Rights.[294] That year,

> the theory of substantive due process emerged from the Court's decision in *Lochner v. New York*,[295] which provided for a contemporaneous interpretation of the Constitution and ultimately led to the expansive list of "fundamental rights protected by natural law and social compact in addition to those rights listed in the Bill of Rights."[296]

Subsequently, in the 1965 decision in *Griswold v. Connecticut*, "the Court further expanded the interpretation of the Bill of Rights to guarantee fundamental rights from governmental intrusion."[297]

"In 1973, the Court articulated for the first time that the judicial test for a fundamental right was 'whether there is a right . . . explicitly or implicitly guaranteed by the Constitution.'"[298] The Court has never set forth a "standard" for identifying such "implicit" rights; rather, they have been found to be "grounded" in the right of "'liberty' protected by the Due Process Clause of the Fourteenth Amendment."[299] When the Court does find an implicit fundamental right, any governmental action violative thereof "will only be upheld if the government can show that the action promotes a compelling state interest."[300] Further, "[u]nder the lesser 'mere rationality' standard, the Court has held that welfare benefits, housing, federal employment, a funded education, and pregnancy-related medical

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> authority when state governments acted independently and in violation of individual fundamental rights. From this time forward, fundamental rights of U.S. citizens could be legislated by the authority of Congress.

*Id.* at 156–57

[294] *Id.* at 158.

[295] *Id.* (citing Lochner v. New York, 198 U.S. 45, 53 (1908)).

[296] *Id.* (citing Davis, *supra* note 292, at 962).

[297] *Id.* (citing Griswold v. Conn., 381 U.S. 479, 485 (1965)).

[298] *Id.* (citing San Antonio Indep. Sch. Dist. v. Rodriguez, 411 U.S. 1, 33 (1973)). *See also* Harris v. McRae, 448 U.S. 297, 312 (1980) (noting that if a law impinges upon a fundamental right explicitly or implicitly secured by the Constitution, the law is presumably unconstitutional).

[299] Gunnar, *supra* note 291, at 158 (citing Randall S. Jeffrey, *Equal Protection in State Courts: The New Economic Equality Rights*, 17 L. & INEQ. 239, 260–62 & n.83 (1999)). *See also Harris*, 448 U.S. at 312 & n.18; *id.* at 158–59 ("For example, the Court has held that the Constitution implicitly defines a right to privacy that encompasses the right to have an abortion, use contraception, marry, procreate, have family relationships, control the education of one's children, and maintain bodily integrity.").

[300] Gunnar, *supra* note 291, at 159.

care, including medically necessary abortions, are not fundamental rights."[301] Accordingly, Professor Gunnar concludes (and most legal scholars agree) that:

> The Due Process Clause of the Fourteenth Amendment affords protection against unwarranted government interference with freedom of choice in the context of certain personal decisions, but "does not confer an entitlement to such funds as may be necessary to realize all the advantages of that freedom." The financial condition of the individual is not created by the government and cannot be considered an obstacle in the path of freedom of choice. "Whether freedom of choice that is constitutionally protected warrants federal subsidization *is a question for Congress to answer,* not a matter of constitutional entitlement." *Thus, the Court has determined that under due process, the Constitution imposes no obligation on the States to pay any medical expenses, let alone the costs associated with the health care of the indigent*.[302]

In like fashion, "[t]he United States Supreme Court does not extend the Equal Protection Clause of the Fifth and Fourteenth Amendments to recognize a suspect class based upon wealth."[303] The Court has also held "that the constitutional guarantee of equal protection is *not* a source of substantive rights or liberties, but rather a 'right to be free from invidious discrimination in statutory classifications and other governmental activity.'"[304] While the Court "has never held that financial need alone identifies a suspect class for purposes of equal protection analysis," it has "acknowledged that every denial of federal or state funding to an indigent creates a wealth classification."[305] Nonetheless, the Court has specifically stated that "the Constitution does *not* provide judicial remedies for every social and economic ill."[306]

Needless to say, however, there are countless examples of circumstances where some Americans now have a *de jure "right" to*

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[301] *Id.*

[302] *Id.* at 160 (citing Maher v. Roe, 432 U.S. 464, 469 (1977)) (emphasis added). *See also* Youngberg v. Romeo, 457 U.S. 307, 317 (1982) (supporting the idea that "a State is under no constitutional duty to provide substantive services for those within its border.").

[303] Gunnar, *supra* note 291, at 160.

[304] *Id.* (citing *Harris*, 448 U.S. at 322) (emphasis added).

[305] *Id.* at 161 (citing *Maher*, 432 U.S. at 471 n.6).

[306] *Id.* (quoting Lindsey v. Normet, 405 U.S. 56, 74 (1972)) (emphasis added).

*health care* under a variety of federal and state programs and corresponding laws—*e.g.*, Medicare, Medicaid, the Children's Health Insurance Program (CHIP), the Veterans Administration, the Emergency Medical Treatment and Active Labor Act (EMTALA), and most recently, the Affordable Care Act (ACA). *The significant point here is that all of these and similar programs/laws result from constitutionally-valid federal and/or state legislation, not from a constitutionally-guaranteed "right" to health care that is currently recognized in the United States.*

*D. "Social Responsibility" in Health Care Delivery*

It is not unreasonable to suggest that there are compelling parallels between the so-called "social responsibility movement," and the increasing calls for "health care as a right." Just as today's "social enterprise" seeks to "serve first and foremost a social mission . . . through the use of sophisticated business models typically associated with traditional corporate activity,"[307] so too do the advocates of "health care as a right" seek to undo the ascendant "commercial culture" in American health care that has come to be "characterized by the intrusion of the market domain and the profit motive into the physician-patient dyad" and "by the elevation of commercial interests alongside interests of patient welfare . . . ."[308]

The reasons why such an objective should continue to be confronted by persistent and vocal opposition remains something of a mystery. Perhaps opposition continues in part because people confuse two non-synonymous concepts—that of a "right to health" and of a "right to health care."[309] The distinction, unfortunately, has not always been clear.[310]

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[307] *Supra* Section III.A.2.

[308] Hall, *supra* note 272, at 691.

[309] *See* Kenneth Shuster, *Because of History, Philosophy, The Constitution, Fairness & Need: Why Americans Have a Right to National Health Care*, 10 IND. HEALTH L. REV. 75, 109 (2013) (internal quotations omitted).

[310] For example:

> During the 1960s, the United Nations (UN) developed the International Covenant on Economic, Social and Cultural Rights (ICESCR)—an international covenant under the UN Universal Declaration of Human Rights (UDHR), positing in its Article 12 a "human right to health" that includes "'the enjoyment of the highest attainable standard of physical and mental health.'" Included in the "core content" of the right to health, as outlined in General Comment 14 to the ICESCR, are "essential primary health care, minimum essential and nutritious food, sanitation, safe and potable water, and essential drugs." Similarly, the constitution of the World Health Organization (WHO) "states a right to the 'highest attainable standard of health' and defines health broadly as

(*continued*)

However, it takes only a moment's reflection to realize that "only God or nature, and to some extent, one's own efforts, can assure the state of an individual's health."[311] Nonetheless, as Shuster says:

> This distinction is essential because a mistake in what any given right means and entails not only confuses the issue in the instant case of national health care, but obfuscates important reasons we have rights in the first place, namely the utilitarian basis of rights and society's duty to take care of those who cannot take care of themselves.[312]

That a need exists for a more socially-responsible view of the organizational ways and means by which health care in this country should be delivered is readily shown by a review of the recent history of health care reform.

*E. Health Care Reform*

Since Theodore Roosevelt first proposed a national health insurance plan in 1912, American presidents of both political parties have sought reform of the health care system.[313] While Franklin Roosevelt wanted to include "a version of health reform" in the Social Security Act, he abandoned the idea for fear it would derail adoption of the Act itself.[314] President Richard Nixon proposed a comprehensive but unsuccessful proposal encompassing "a combination of employer-sponsored health insurance, subsidized health insurance, and an expanded Medicare

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> 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.'" In addition, several other international authorities and regional treaties also address a "human right to health" and prohibit conduct by governments detrimental thereto.

Corbett, *supra* note 3, at 139–40 (internal citations omitted).

[311] Shuster, *supra* note 309, at 109–10.

> In fact, because so many variables including food, exercise, genetics, and luck go into determining the state of one's health, it would be absurd to speak of a "right to health." This is equally true of all other areas in which the government provides national assistance to meet the needs of its residents.

*Id.* at 110.

[312] *Id*. at 110.

[313] *See* Lofft, *supra* note 252, at *2 (citing B. Hoffman, *Health Care Reform and Social Movements in the United States*, 93:1 AM. J. PUB. HEALTH 75–85 (Jan. 2003)).

[314] *Id.*

program" in the early 1970s.[315] This was followed by the much-maligned "1,300-page health reform bill" of President Bill Clinton, which arguably fueled the "Republican take-over of Congress in the 1994 mid-term elections."[316]

Even passage of the Affordable Care Act (ACA)[317] —signed into law by President Barack Obama on March 23, 2010—failed to resolve the debate, with that landmark legislation remaining a major issue of continued contention in the 2016 Presidential election cycle. At the time of this writing, under the Administration of President Donald Trump, the ultimate fate of the ACA stands totally uncertain. Nonetheless (and perhaps all the more), the historically-evolved characteristics of the health care delivery system—and the remedial initiatives put in place by the ACA—continue to fuel contentious political debate.

*1. The Drivers of Reform*

> Generally speaking, the current [*i.e.*, pre-ACA] system has been viewed as competitive (in an unhelpful way),[318]

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[315] *Id.* (citing President Richard Nixon's Special Message to the Congress Proposing a Comprehensive Health Insurance Plan (February 6, 1974), *reprinted in Nixon's Plan for Health Reform, In His Own Words*, The American Presidency Project, University of California at Santa Barbara (Sept. 3, 2009)).

[316] *Id.* (citing E. Klein, *The Lessons of '94*, AM. PROSPECT (Jan. 22, 2008), http://prospect.org/article/lessons-94 [https://perma.cc/FL23-4QZG]).

[317] *See* Corbett, *supra* note 3, at 145.

> On March 23, 2010, Congress enacted the Patient Protection and Affordable Care Act (PPACA). . . . Congress, recognizing there were a number of provisions in the PPACA that needed further refinement, enacted the Health Care and Education Reconciliation Act of 2010 (HCERA) on March 30, 2010. *Together, PPACA and HCERA are referred to as the Affordable Care Act.* On June 28, 2012, the Supreme Court upheld the PPACA, holding that it is constitutional."

*Id.* at 145, n. 224 (emphasis added) (citing *Medicare Certified Accountable Care Organizations*, 2013 HEALTH LAW AND COMPLIANCE UPDATE 1 (John Steiner ed., 2013)). *See also* Pub. L. 111–148, *as amended by Health Care and Education Reconciliation Act of 2010*, Pub. L. 111–152; Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. (2011), *available at* http://www.govtrack.us/congress/bill.xpd?bill=h111-3590. [https://perma.cc/B76Z-S4FZ].

[318] Corbett, *supra* note 3, at 145 n.225 (quoting Robin Locke Nagele, *Hospital-Physician Relationships After National Health Reform: Moving from Competition to Collaboration*, 82 PA. B. ASS'N Q. 1, 2 (2011)) ("'Unhelpful' in the sense that physicians have increasingly come to compete with hospitals to provide such things as ambulatory surgery centers and various advanced technologies and diagnostics, resulting in 'over-utilization, higher complication rates, and escalating charges.'").

> fragmented, and driven by counterproductive financial incentives. These features have resulted in growing concerns over poor quality, spiraling costs, and rising barriers to access . . . . *There is seemingly broad consensus, professional and academic if not political, that the solution lies with transition to an "integrated and coordinated care model" that is predicated upon "systems-based care management" that will consistently produce efficient, high quality services through greater collaboration among system participants.*[319] While this new focus is readily described, it is somewhat more complicated to bring about, constituting what some have called a "battle for the soul of American medicine,"[320] as well as the "'biggest transformation of government since World War II.'"[321] Moreover, it involves far more than simply modifying the "broad, complex, and indirect regulatory approaches that inevitably have unintended consequences"[322]—it involves quite literally reforming the entire health system.[323]

So we wrote in our initial article. Here, we will undertake to delve more deeply into the three principal and closely-interrelated drivers of health care reform—the *cost, fragmentation,* and *quality* of the American health care delivery system.

*a. Escalating Cost*

The fact that health care costs in the United States are "spiraling out of control" can be seen "at both the macro- and microeconomic levels."[324] At the macro level, total expenditures on health care in 1998 were $1.208

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[319] *Id.* at 145–46 (citing Nagele, *supra* note 318, at 1–2) (emphasis added).

[320] *Id.* at 146 (citing Nagele, *supra* note 318, at 2).

[321] *Id.* at 146 (quoting Gary S. Davis & Michael L. Silhol, *Healthcare Reform: The Law and Its Implications*, 20101206 AHLA Seminar Papers 24 (2010)).

[322] *Id*. For example, "fraud and abuse laws and regulations that become significant obstacles to the adoption of 'potentially cost-reducing or quality-enhancing innovation.'" Kristin Madison, *Rethinking Fraud Regulation by Rethinking the Health Care System,* 32 HAMLINE J. PUB. L. & POL'Y 411, 415–16 (2011).

[323] Corbett, *supra* note 3, at 146.

[324] Christopher Smith, *Between the Scylla and Charybdis: Physicians and the Clash of Liability Standards and Cost Cutting Goals within Accountable Care Organizations*, 20 ANNALS HEALTH L. 165, 167 (2011).

trillion; by 2009, the figure had reached $2.486 trillion.[325] "This 2009 statistic represents 17.6% of the Gross Domestic Product (GDP) and a spending growth rate of 4%."[326] This rate of growth exceeded "both the rate of inflation and the growth rate for national income."[327] Moreover, this level of national spending on health care is expected to increase to $4.482 trillion by 2019—a level that represents "19.3% of the GDP"[328] and reflects an increase "between 3.9% and 7% every year between 2010 and 2019."[329]

The picture looks no better at the microeconomic level. "For example, in 1999, the average family employer sponsored health plan cost $5,791 per year in premiums and by 2009, that same plan cost $13,375 per year, an increase of 131%."[330] Additionally, "the average employee's contribution increased from $1,543 per year in 1999 to $3,515 per year in 2009, while the average employer's contribution increased from $4,247 per year in 1999 to $9,860 per year" in that same period.[331] Between the cost of insurance premiums and "other out-of-pocket expenses," the typical individual with employer-sponsored health coverage was spending $2,827 in 2001—a figure that would increase 30% to $3,744 by 2006.[332]

Neither is the story encouraging when the United States is compared to other industrialized countries. "A recent study found that the United States

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[325] *See id.* at 167–68 (citing Ctrs. for Medicare and Medicaid Servs., Dep't of Health & Human Servs., *National Health Expenditures Aggregate, Per Capita Amounts, Percent Distribution, and Average Annual Percent Growth, by Source of Funds: Selected Calendar Years 1960-2009*, Table 1 (2009), *available at* http://www.cms.gov/ NationalHealthExpend Data/downloads/tables.pdf.).

[326] *Id.* at 168.

[327] *Id.* (citing Eric Kimbuende et al., *U.S. Health Care Costs* (2010), *available at*: http://www.kaiseredu.org/topics_im.asp?imID=1&parentID=61&id=358 (noting that health care expenditures have outpaced inflation and income growth). *See also* Mark A. Hall & Carl E. Schneider, *When Patients Say No (To Save Money): An Essay on the Tectonics of Health Law*, 41 CONN. L. REV. 743, 747 (2009) (noting that "Medical spending has outstripped inflation for decades.")).

[328] *Id.* (citing Ctrs. for Medicare & Medicaid Servs., Dep't of Health & Human Servs., *National Health Expenditure Projections 2009-2019*, Table 1 (2009), *available at*: http://www.cms.gov/NationalHealthExpendData/ downloads /proj2009.pdf.).

[329] *Id.* (citing Ctrs. for Medicare, *supra* note 328, Table 2).

[330] *Id.* at 168–69 (citing GARY CLAXTON ET AL., EMPLOYER HEALTH BENEFITS 2009 ANNUAL SURVEY 21, 32 (2009), *available at* http://ehbs.kff.org/pdf/2009/7936.pdf. [https://perma.cc/RXG7-VLPM].

[331] *Id.* at 169 (citing CLAXTON, *supra* note 330, at 71).

[332] *Id.* (citing Michael Halle & Meena Seshamani, Office of Health Reform, *Hidden Costs of Health Care: Why Americans are Paying More but Getting Less*, Hidden Costs of HealthCare Report (2010), *available at* http://www.healthreform.gov/reports/hiddencost s/index.html.).

spent $7,290 per capita on healthcare in 2007"—far "more than Australia, Canada, the Netherlands, Germany, United Kingdom and New Zealand," each of which "spent less than $4,000 per capita" that same year.[333] In GDP terms, the U.S. spent "around 16%" compared to "between 8.4% and 10.4%" by these other countries.[334]

Thus, it should come as no surprise that "[s]hortly after Wall Street collapsed in 2008, rapidly sending the United States into economic downturn, President Obama warned that '[b]y a wide margin, the biggest threat to our nation's balance sheet is the skyrocketing cost of health care.'"[335]

*b. System Fragmentation*

> Characterized as "a railroad whose tracks change gauge every few miles," the Institute of Medicine has described America's healthcare delivery system as "composed of a large set of interacting systems—paramedic, emergency, ambulatory, inpatient, and home health care; testing and imaging laboratories; pharmacies; and so forth—that are connected in loosely coupled but intricate networks of individuals, teams, procedures, regulations, communications, equipment and devices. These systems function within such diverse and diffuse management, accountability, and information structures that the overall term *health system* is today a misnomer."[336]

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[333] *Id.* at 168 (citing KAREN DAVIS ET AL., MIRROR, MIRROR ON THE WALL: HOW THE PERFORMANCE OF THE U.S. HEALTH CARE SYSTEM COMPARES INTERNATIONALLY 2 (2010), *available at* http://www.commonwealthfund.org/~/media/Publicationshttp://www.commonwealthfund.org/~/media/PublicationsFund%20Report/2010/Jun/1400_Files/Davis_Mirror_Mirror_on_the_wall_2010.pdf) (noting that the other countries studied had per capita expenditures between $2,454 and $3,895).

[334] *Id.* at 168 n.22.

[335] Elizabeth L. Rowe, *Accountable Care Organizations: How Antitrust Law Impacts the Evolving Landscape of Health Care*, 2012 U. ILL. L. REV. 1855, 1856 (2012) (citing Atul Gawande, *The Cost Conundrum: What a Texas Town Can Teach Us About Health Care*, NEW YORKER, June 1, 2009, at 36).

[336] Thomas L. Hafemeister & Joshua Hinckley Porter, *Don't Let Go of the Rope: Reducing Readmissions by Recognizing Hospitals' Fiduciary Duties to Their Discharged Patients*, 62 AM. U. L. REV. 513, 520 (2013) (citing COMM. ON QUALITY HEALTH CARE IN AM., INST. OF MED., CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY 78 (2001)). *See also* EINER ELHAUGE, THE FRAGMENTATION OF U.S. HEALTH CARE: CAUSES AND SOLUTIONS 1–3 (Einer Elhauge ed., 2010) (discussing the need for greater integration to produce more unified decision making within the healthcare system); François de Brantes et al., *Building a Bridge from Fragmentation to Accountability: The*

(*continued*)

The second principal driver of health care reform—system fragmentation—presents problems additional to and separate from cost escalation; but, nonetheless contributes to it. Just as market forces have not been strong enough to deliver cost control, market forces have seemingly "failed to counteract organizational fragmentation . . . ."[337] In a 2009 article, Professor Thomas Greaney suggests that understanding this failure "requires an understanding of why *competition policy is inexorably linked to the organizational structures of health care providers and payers and how the fragmentation that bedevils those arrangements has undermined its success*."[338]

There has been considerable research pointing to "fragmentation as a main impediment to" significant health care reform.[339] The current health care system is "one dominated by small, fragmented practices" that have "every financial incentive . . . to be inefficient."[340]

> Atul Gawande, reporting on the inefficiency of medical care for *The New Yorker*, provided the following apt analogy to demonstrate the way health care is administered in this country: instead of hiring a contractor to assemble and supervise a team to make all of the necessary home improvements, you hire each individual separately and, for example, pay the electrician for every single outlet he recommends and the plumber for every single faucet he installs, and so on.[341]

Predictably, the result is "as many outlets and faucets as possible."[342] The arguable solution is to hire a "general contractor" to control the actions of

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*Prometheus Payment Model*, 361 NEW ENG. J. MED. 1033, 1033 (2009) (imparting the positive effects of a payment model that incentivizes provider collaboration and "efforts to reduce avoidable complications of care"); Randall D. Cebul et al., *Organizational Fragmentation and Care Quality in the U.S. Healthcare System*, 22 J. ECON. PERSPECTIVES 93, 93 (2008) (noting that a fragmented healthcare system "lead[s] to disrupted relationships, poor information flows, and misaligned incentives . . . .")).

[337] Thomas (Tim) Greaney, *Competition Policy and Organizational Fragmentation in Health Care*, 71 U. PITT. L. REV. 217, 218 (2009).

[338] *Id.* (emphasis added).

[339] *See* Rowe, *supra* note 335, at 1869 (citing Taylor Burke & Sara Rosenbaum, *Accountable Care Organizations: Implications for Antitrust Policy*, 19 HEALTH L. REP. (BNA) 358, at 1 (2010) (noting that "[m]ost observers agree that the fractured and fragmented state of American health care is both a cause of poor quality and inefficient care as well as a barrier to improvement.")).

[340] *Id.*

[341] *Id.* at 1869–70.

[342] *Id.* at 1870.

the electricians and plumbers—just as in health care it would be to hold "someone accountable for the totality of care given to patients."[343]

The degree to which the American health care system is fragmented is further demonstrated by the "2300 separate entities" that make up "the general acute-care industry."[344] "One study concluded that '[n]o other industry, particularly one so vital to the broader economy, even closely approaches this level of fragmentation.'"[345] Such fragmentation results in "inefficiency, duplication, and higher cost," as well as lost "economies of scale and bargaining power . . . ."[346] Moreover, unlike countries with "all-payer regulation," the American system of multiple, mixed private and public payers cannot "bargain effectively with doctors, hospitals, and pharmaceutical companies" or "set enforceable spending targets."[347] As a result, providers "become quality-insensitive and income-sensitive," charging higher prices, but not providing higher-quality care.[348]

Such system fragmentation—at both the provider and payer level—had much to do with the failure of efforts to develop a competitive system of managed care. Professor Greaney notes the result at the provider level:

> For the large percentage of physicians practicing in small groups or single specialty practices, adapting to managed care's incentives for risk sharing and economizing practices was extraordinarily difficult. Many physicians proved inept in assessing risk. In both clinical and

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[343] *See id.*

[344] *See* Barry R. Furrow, *Cost Control and the Affordable Care Act: Cramping Our Health Care Appetite*, 13 NEV. L.J. 822, 841 (2013).

[345] *Id.* (citing JAMES BURGDORFER ET AL., GOVERNANCE INST., HOSPITAL CONSOLIDATION TRENDS IN TODAY'S HEALTHCARE ENVIRONMENT 11 (2010)).

[346] *Id.*

[347] *Id.* Noting that

> [t]he authors observe that "[o]ther nations achieve lower prices by paying for health services through either a single-payer or coordinated, multi-payer systems that set or negotiate fees with all providers. Analysts who seek greater productivity in medical care should recognize that productivity can be increased simply by paying less per service. Other OECD health systems also spend much less on administration, both because insurance is simpler and because providers do not face the burden of dealing with myriad payers and payment rules."

*Id.* at 841 n.124 (citing Jonathan Oberlander & Joseph White, *Public Attitudes Toward Health Care Spending Aren't the Problem; Prices Are*, 28 HEALTH AFF. 1285, 1289 (2009)).

[348] *Id.* at 842.

> economic decision-making such as dealing with capitation, physicians are subject to problems of over optimism, endowment bias, and other departures from rational choice models as identified by behavioral decision theorists. At the same time, physicians jealously guarded their independence and were resistant to undertaking employment relationships or joining staff model HMOs or large practice groups.[349]

At the payer level, these physicians' contracting with multiple payers "undermined managed care's incentives to promote development of efficient delivery organizations."[350] With physicians having multiple contracting options, they lacked sufficient incentives "to change practice styles or adopt other methods for controlling cost or improving quality to conform to protocols of any single payor."[351]

Finally, it should be noted that the existing "regulatory environment governing providers" also has served to reinforce system fragmentation.[352] To again quote Professor Greaney:

> Several significant legal regimes directly impede efficiency-enhancing cooperation among rivals. The federal anti-kickback and Stark laws bar many forms of vertical and horizontal cooperation that can improve efficiency.[353] Consequently, the fragmented community of physicians and hospitals is prevented from responding to competitive market incentives to integrate via joint ventures and contractual arrangements. More than any other regulatory obstacle, the inability of hospitals to share efficiency and cost-effective improvements with physicians who order services impedes effective deployment of health resources.[354]

Similarly,

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[349] Greaney, *supra* note 337, at 226.

[350] *Id.*

[351] *Id.* at 226–27.

[352] *Id.* at 228.

[353] *Id.* at 228–29 (citing James F. Blumstein, *The Fraud and Abuse Statute in an Evolving Health Care Marketplace: Life in the Health Care Speakeasy*, 22 AM. J. L. & MED. 205 (1996); David A. Hyman, *Health Care Fraud and Abuse, Social Norms, and "The Trust Reposed in the Workmen"*, J. Legal Studies 531 (2001)).

[354] *Id.* at 228–29 (citing Gail Wilensky et al., *Gain Sharing: A Good Concept Getting a Bad Name?*, 26 HEALTH AFF. 58 (2007)).

a network of other laws and regulations, including the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) certification standards,[355] and those governing physician responsibilities and rights in hospital management,[356] solidify professional autonomy within hospitals and reinforce barriers to hospitals asserting greater control to integrate their operations in a cost-effective manner.[357]

*c. Compromised Quality*

Patients suffer unnecessary injuries and death at the hands of health care providers, both because they receive substandard care and because they fail to get necessary and effective treatments. The Institute of Medicine's now familiar 1999 projection of up to 98,000 deaths per year, and hundreds of thousands of avoidable injuries and extra days of hospitalization,[358] has been enlarged by more recent analyses. A HealthGrades analysis of Medicare data projected a casualty rate almost twice the Institute of Medicine figures, or 195,000 deaths per year attributable to adverse medical events.[359] The Centers for Disease Control and Prevention (CDC) has estimated that medical

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[355] *Id.* (citing James F. Blumstein, *Of Doctors and Hospitals: Setting the Analytical and Regulatory Framework for Managing the Relationship*, 4 IND. HEALTH L. REV. 211, 222–25 (2007)).

[356] *Id.* at 229–30 (citing John D. Blum, *Beyond the Bylaws: Hospital-Physician Relationships, Economics, and Conflicting Agendas*, 53 BUFF. L. REV. 459 (2005)). *See also* John P. Marren et al., *Hospital Boards at Risk and the Need to Restructure the Relationship with the Medical Staff: Bylaws, Peer Review and Reloated Solutions*, 12 ANNALS HEALTH L. 179, 207–12 (2003).

[357] Greaney, *supra* note 337, at 229–30.

[358] Barry R. Furrow, *Patient Safety and the Fiduciary Hospital: Sharpening Judicial Remedies*, 1 DREXEL L. REV. 439, 456–57 (2009) (citing Comm. on Quality of Health Care in Am., Inst. Of Med., *To Err is Human: Building a Safer Health System* (Linda T. Kohn, Janet M. Corrigan, & Molla S. Donaldson eds., 2000) *at* 26–27, *available at* http://www.nap.edu/books/0309068371/html [https://perma.cc/5FRL-W4YM]. *But see* Susan Dentzer, *Media Mistakes in Coverage of the Institute of Medicine's Error Report*, 6 EFFECTIVE CLINICAL PRAC. 305, 305 (2000), *available at* http://www.acponline.org (noting that the statistic of 98,000 deaths per year, an extrapolation from a New York study, received all the media attention, while the much less newsworthy estimate of 44,000 deaths per year, an extrapolation from a Utah-Colorado study, received much less media attention).

[359] Furrow, *supra* note 358, at 305 (citing Healthgrades, Inc., *HealthGrades Quality Study: Patient Safety in American Hospitals* (2004), *available at* http://www.healthgrades.com/media/DMS/pdf/HG_Patient_Safety_Study_Final.pdf).

> errors, if ranked as a disease, would be the sixth leading cause of death in the United States, outranking deaths due to diabetes, influenza and pneumonia, Alzheimer's disease, and renal disease.[360] Others rank health care, more generally defined, as the third leading cause of death in this country.[361]

Just as system fragmentation contributes to continuing cost escalation, so too does it contribute to our third and final principal driver of health care reform—compromised quality. In fact, "[m]ost health policy experts attribute the poor quality of health care to the fragmentation resulting from the lack of coordination among providers."[362] According to one 2003 study, "the appropriate level of care was received by patients in the United States a mere fifty-five percent of the time."[363] "It is only since 1999 with the Institute of Medicine report *To Err is Human* that policymakers have started to pay serious attention to the extent of patient injury at the hands of the American health care system."[364]

According to Professor Barry R. Furrow, "[t]he law needs to provide incentives toward the goal of 'flawless execution,' the health care equivalent of zero defects in industrial production generally."[365] Such phrase has been used by Professor Robert M. Wachter, who notes that the need for coordination has grown commensurate with the increasing complexity and sophistication of medicine: "It should come as no surprise, then, that without a culture, procedures, and technology focused on flawless execution, errors would become commonplace. One study found that the average ICU patient experiences 1.7 errors per day, nearly one-

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[360] *Id.* (citing HealthGrades, Inc., *HealthGrades Quality Study: Second Annual Patient Safety in American hospitals Report* (2005), *available at* http://www.healthgrades.com/media/DMS/pdf/HG_Patient_Safety_Study_Final.pdf). *See also* Centers for Disease Control & Prevention, Department of Health & Human Services, National Vital Statistics Reports, *Deaths: Preliminary Data for 2002* 4 (2004), *available at* http://www.cdc.gov/nchs/data/nvsr/nvsr52/nvsr52_13.pdf.

[361] Furrow, *supra* note 358, at 305 (citing Bruce Spitz & John Abramsoon, *When Health policy Is the Problem: A Report from the Field*, 30 J. HEALTH POL'Y & L. 326, 329 (2005)).

[362] Rowe, *supra* note 335, at 1857.

[363] *Id.*

[364] Furrow, *supra* note 361, at 456 (emphasis added). *See also* Hafemeister & Porter, *supra* note 336, at n.155 ("Although this report, with its emphasis on dysfunctional health care delivery 'systems,' has tended to be the central focus of efforts to improve health care quality, the issuance of the report was preceded and followed by a number of influential accounts.").

[365] Furrow, *supra* note 361, at 458.

third of which are potentially life-threatening. Most involve communication problems."[366]

Again, it must be noted that—just as with the fragmentation problem—the existing regulatory environment tends to further impede resolution of quality problems in the health care delivery system. In a 2012 report, no lesser authority than the Government Accountability Office (GAO) concluded that "important aspects of the fraud and abuse laws must change to accommodate reform" and that "stakeholders' concerns may hinder implementation of financial incentive programs to improve quality and efficiency on a broad scale."[367] More specifically, the report stated:

> Some legal experts we spoke with . . . consider the CMP law a major hurdle to the development and implementation of financial incentive programs that allow the hospital to reward physicians for lowering hospital costs and improving quality by reducing medically unnecessary services. . . . Another industry group stakeholder, in a May 2008 statement, asserted that the CMP law has dissuaded providers from pursuing financial incentive programs using specific practice protocols, even those based on clinical evidence and recognized as best practices, because of provider concern that OIG might find that the program provided an incentive to reduce or limit services.[368]

*2.* System Integration—The Current Focus of Reform

> Viewed from the Panglossian perspective of some market theorists, competition inexorably drives suppliers to form firms or joint ventures and to adopt organizational forms that enable them to provide their services efficiently. *But in health care, we have learned that market failure complicates things enormously*. Agency issues, information deficits, and moral hazard alter incentives and interfere with rational choice. *Managed care once seemed*

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[366] *Id.* at 458 n.74 (quoting Robert M. Wachter, *The End of the Beginning: Patient Safety Five Years After 'To Err Is Human'*, HEALTH AFF. (Nov. 30, 2004), *at* W4-535, http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.534v1 [https://perma.cc/T6WZ-5WKD]).

[367] Jean Wright Veilleux, *On One Hand and the Other: How Competing Goals Imperil the Affordable Care Act's Success*, 38 VT. L. REV. 385, 401 (2013).

[368] *Id.* at 408 (quoting U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-12-355, MEDICARE: IMPLEMENTATION OF FINANCIAL INCENTIVE PROGRAMS UNDER FEDERAL FRAUD AND ABUSE LAWS 1–2 (2012)).

> *capable of helping to overcome those difficulties, and competition policy sought, sometimes quite explicitly, to aid that enterprise. For a variety of reasons antitrust came up short, and managed care fell into disfavor*. The lesson for policymakers and law enforcers is that the success of a competitive strategy in health care is highly contingent. *Supportive measures in law and financing are required to create an infrastructure that counters market failure and incentivizes the private sector to glue together its fragmented elements*.[369]

Others have spent much time and printed space discussing the history of and reasons for the rise and fall of "Managed Care." We will not repeat those efforts here. Suffice it to note that "[a] unique convergence of severe political and financial pressures in the late 1990s ended the nation's brief experiment with restrictive managed care; it also ended its longest sustained period of below-average growth in per capita national health spending."[370] As Professor Timothy S. Hall said in 2003: "As the cost savings realized by managed care wane and the political backlash against many MCO practices continues, many have begun to wonder whether the managed care revolution is effectively over and, if so, what sort of health care system will replace managed care."[371]

As the country drew near to enactment of the ACA, many new approaches to physician/hospital integration were initiated in an attempt to obtain the benefits initially promised, but not delivered, during the era of managed care. All attempt, to a greater or lesser degree, to respond to what many see as new "system" imperatives for institutional providers:

> To be successful in this new economy, healthcare organizations must consider how they can (1) facilitate alignment between physicians and hospitals; (2) develop a compensation or employment model that will align the incentives of productivity, quality, cost and outcome; (3) ensure physician engagement and leadership within the organization; (4) develop data systems that support data

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[369] Greaney, *supra* note 337, at 239 (emphasis added).

[370] Rick Mayes, *Medicare and America's Healthcare System in Transition: From the Death of Managed Care to the Medicare Modernization Act of 2003 and Beyond*, 38 J. HEALTH L. 391, 421 (2005) (citing Stuart H. Altman et al., *Escalating Health Care Spending: Is It Desirable or Inevitable?*, HEALTH AFFAIRS W3, 4–5 (Jan. 8, 2003)).

[371] Hall, *supra* note 272, at 740 (citing Arnold S. Relman, *Dealing with Conflicts of Interest*, 313 NEW ENG. J. MED. 749, 750 (1985)).

> exchange, co-management, and measurement of longitudinal outcomes and costs; and (5) retain an element of flexibility that will allow the model to adapt as the rules of the game continue to change. These organizations must have the flexibility and financial wherewithal to manage a transition through multiple payment methodologies, changing incentives, and new care delivery models. Additionally, organized physician entities that are self-governed will drive individual physician performance to meet both group and system-wide goals. Old healthcare organization models may be modified in several ways to achieve these goals.[372]

We will next identify and briefly describe four prominent approaches.

*a. Hospitalist Programs*

Hospitalist programs are examples of a physician/hospital integration strategy designed to "align incentive payments with decision-makers," thereby permitting "hospitals to shape treatment decisions."[373] While some argue that adoption of the hospitalist model is motivated solely by hospitals' drive for cost-efficiencies, others contend that the momentum for their development derives instead from the number of primary care physicians abandoning their hospital admitting privileges.[374] As this trend increasingly becomes the norm, it is giving rise to a "new sub-discipline of general internal medicine,[375] what Wachter and Goldman have called the "site-defined generalist specialist."[376] Unlike traditional specialists, however, "most hospitalists help manage patients throughout the [entire] continuum of hospital care,"[377] functioning essentially as "impatient care specialists."[378]

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[372] Bill Asyltene et al., *Accountable Care Organizations—Physician/Hospital Integration*, 21 THE HEALTH LAW. 1, 7–8 (Aug. 2009).

[373] *Id.* at 4.

[374] Robert M. Wachter, *Response to David Meltzer's Paper "Hospitalists and the Doctor-Patient Relationship"*, 30 J. LEGAL STUD. 615, 617 (2001).

[375] Harold C. Sox, *Commentary of "Hospitalists and the Doctor-Patient Relationship"*, 30 J. LEGAL STUD. 607, 608 (2001).

[376] *See* Robert M. Wachter & Lee Goldman, *The Hospitalist Movement 5 Years Later,* 287 JAMA 487, 493 (Jan. 2002) (quoting Robert M. Wachter, *An Introduction to the Hospitalist Model*, 130 ANNALS INTERNAL MED. 338, 338 (1999)).

[377] Richard Kusserow, *Understanding the Complexities of Subsidy Payments for Hospitals*, 10 J. HEALTH CARE COMPLIANCE 59, 59 (2008).

[378] *See Jeffrey* P. Harrison & Lorrie Curran, *The Hospitalist Model: Does it Enhance Health Care Quality?*, 35 J. HEALTH CARE FIN. 22, 22 (Jan. 2009).

Access to such inpatient care expertise is becoming of particular importance to American hospitals due to increasing pressures put upon them to evaluate and control the care provided by *their* physicians.[379] Unlike the traditional model where *outside* medical staff hold admitting privileges at multiple hospitals, hospitalists are usually directly employed or contracted individually or in groups to practice in a single institution.[380] As such, they are often viewed as "captive audiences" who are more receptive to new medical and information technologies (*e.g.*, "computerized physician order entry") and better positioned to communicate with hospital staff in a timely manner.[381] Ultimately, such attributes are expected—or at least hoped—to result in better clinical outcomes.[382]

*b. Clinical Co-Management*

> Vasquez and Van Leer provide an excellent, concise summary: At the most basic level, clinical co-management is a means for the hospital and its medical staff to share responsibility of the administrative and clinical oversight of a hospital service line or facility. In return, the hospital provides financial incentives for improving the service line's performance. A CCMA [(Clinical Co-Management Agreement)] is the legal mechanism used to form the collaborative relationship and consists of a contract between the hospital and a number of physicians who agree to manage the clinical outcomes of a hospital service line or facility. Typically, the physicians form a separate co-management company that contracts with the hospital to provide management services directly related to the service line or facility at issue. The hospital also may or may not have an ownership interest in the co-management company, but will always maintain ownership of the clinical service line, beds, space, facility, provider numbers, and resulting revenue stream. In return for the day-to-day management services, the hospital pays the co-management company base compensation. Base

[379] *See id.* at 25.
[380] *See* Hoangmai H. Pham et al., *Health Care Market Trends and the Evolution of Hospitalist Use and Roles*, 20 J. GEN. INTERNAL MED. 101, 103 (2005).
[381] *Id.*
[382] *Id.*

> compensation is comprised of a fair market value hourly fee paid for the time the physicians devote to the co-management project. If certain performance benchmarks are met, the co-management company also receives added incentive payments from the hospital. Typically, the performance benchmarks focus on quality measures, operational efficiency gains, patient/staff satisfaction, and new program development. CCMAs may also include cost savings measures commonly referred to as gainsharing.[383]

*c. Patient-Centered Medical Homes (PCMH)*

The National Committee for Quality Assurance (NCQA) has defined the PCMH as "a model of care in which 'patients have a direct relationship with a provider who coordinates a cooperative team of healthcare professionals, takes collective responsibility for the care provided to the patient and arranges for appropriate care with other qualified providers as needed.'"[384] Professor Blum has described the concept this way:

> The medical home concept has evolved into a tool linking various patient populations (including the elderly) to a primary care physician who acts both as a coordinator and a gatekeeper for those he or she is assigned to treat and manage. A major focus of the medical home is to act as a

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[383] Kyle Vasquez & Joseph Van Leer, *Co-Managing Your Way to Optimal Quality and Efficiency—A Guide to Clinical Co-Management Agreements*, 1 ANNALS OF HEALTH L. INFORMED CONSENT 1, 6 (2011).

> Gainsharing is a method to share in cost savings directly attributable to a change in a physician's behavior. For example, if a hospital provides a physician with 50% of the cost savings resulting from changing the type of stent he or she uses, this would qualify as gainsharing. Although there have been recent advisory opinions that permit gainsharing, the concept still carries with it a high degree of regulatory risk, and an OIG advisory opinion is recommended prior to implementing a gainsharing model.

*Id.* at 6 n.16.

[384] Paul R. DeMuro, *Accountable Care*, 24 THE HEALTH LAW. 1, 3 (Aug. 2012) (quoting David L. Longworth, *Accountable Care Organizations, the Patient-Centered Medical Home, and Health Care Reform: What Does it All Mean?*, 78 CLEVELAND CLINIC J. MED. 571, 576 (2011)).

> bridge into a disparate system and match patient care with appropriate needs and levels of treatment.[385]

Professor Sallie Thieme Sanford asserts that the PCMH may well provide the "solid primary care foundation" required by "Accountable [C]are."[386] Specifically, she suggests: "'The PCMH is reflective of coordination of care; the ACO is reflective of the continuum of care'"—"[t]he two have the potential to be mutually supportive."[387]

*d. Provider Clinical Integration*

> *For health reform to succeed, much depends on provider integration*. Indeed, a great deal of the Affordable Care Act (ACA) addresses the twin problems that bedevil the American health care system: fragmented delivery of services and payment incentives that fail to encourage provision of cost effective care. The law's goal is to foster integration, as evidenced by provisions directly sponsoring development of new organizational arrangements such as accountable care organizations and patient centered medical homes and relaxation of laws and regulations that might inhibit integration. *Critical to achieving this goal are the law's provisions designed to spur the formation of entities capable of receiving global payments or shared savings, delivering seamless and cost-effective services, and doing so in a competitive market*.[388]

This final approach to physician/hospital integration is generally the most comprehensive. According to prominent health care attorney John J. Miles:

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[385] John D. Blum, *Variables of Health Reform and Their Impacts on the Elderly*, 12 MARQ. ELDER'S ADVISOR 85, 96 (2010) (citing Sheri Porter, *Medical Home Success Depends on Core Primary Care Attributes*, AM. ACAD. FAM. PHYSICIANS (Mar. 30, 2010), http://www.aafp.org/online/en/home/publications/news/news-now/practice-management/20030330pcmhattributes.html [https://perma.cc/8D8R-GVBV]).

[386] Sallie Thieme Sanford, *Designing Model Homes for the Changing Medical Neighborhood: A Multi-Payer Pilot Offers Lessons for ACO and PCMH Construction*, 42 SETON HALL L. REV. 1519, 1519 (2012).

[387] *Id.* at 1520 (citing Gary Scott Davis & Julie Brillman, *Innovative Approaches to Care: Accountable Care Organizations and Medical Homes*, AM. HEALTH LAW. ASS'N, *at* 8 (June 29, 2010)).

[388] Thomas L. Greaney, *The Tangled Web: Integration, Exclusivity, and Market Power in Provider Contracting*, 14 HOUS. J. HEALTH L. & POL'Y 59, 60 (2014) (citing Thomas L. Greaney, *The Affordable Care Act and Competition Policy: Antidote or Placebo?*, 89 OR. L. REV. 811, 825–36 (2011)) (emphasis added).

> most clinical-integration programs contain many of the following elements: (1) a method, preferably electronic, by which network providers can exchange information regarding network patients, such as diagnoses, tests, and procedures; (2) development of practice protocols, guidelines, or parameters sufficient to improve quality and utilization, sufficient to apply to all medical specialties in the network, and sufficient to cover a majority of services provided by participants; (3) adoption of the protocols by the network's board of directors and dissemination of the protocols to participating providers; (4) agreement among the participating providers and between them and the network to abide by the protocols; (5) development of a methodology and process by which participants report their compliance with the protocols to the network; (6) development of network goals or benchmarks relating to quality, utilization, efficiency, and cost that the network seeks to achieve and that reflect improvement over current performance; (7) review by the network of the individual performance of participants under the protocols; (8) review by the network of the aggregate performance of the network in relation to the benchmarks; (9) a method for identifying participating providers who fail to achieve the network performance goals; (10) development and implementation of corrective-action plans for providers failing to achieve the network's goals; (11) a program for the network's monitoring of those participants' performance; and (12) in the case of participants who either refuse to abide by the protocols or habitually fail to meet network-performance goals, sanctions, including ultimate expulsion from the network.[389]

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[389] John J. Miles, 2 HEALTH CARE & ANTITRUST L.: PRINCIPLES & PRAC. § 15A:8, *at* 76–77 (2016).

> There is no "cookie-cutter" approach to clinical-integration programs. But the *Joint Report* [of the FTC and DOJ] explains that "[c]ommentators primarily focus on four indicia of clinical integration: (1) the use of common information technology to ensure exchange of all relevant patient data; (2) the development and adoption of clinical protocols; (3) care review based on the implementation of protocols; and (4) mechanisms to ensure adherence to the protocols." The *Joint Report* also notes that "[p]anelists and industry experts also have

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Mr. Miles goes on to say: "The ultimate goal is to generate substantial interdependence among network providers in the way they provide care."[390] Mr. Miles also notes that "Medicare Shared Savings Program (MSSP) accountable care organizations under the Affordable Care Act[391] are, in substance, clinically integrated provider-controlled contracting networks."[392]

## VI. ACCOUNTABLE CARE: FROM CONCEPT TO IMPLEMENTATION

> In the culmination of a decades-long struggle for the soul of the Democratic party, realists routed idealists during the ACA legislative process. They pushed the public option off the table, assuring that *public-private partnerships like ACOs and insurance exchanges would be the ACA's primary mechanisms for delivering access to care*. . . .
>
> By passing the ACA's technocratic and business-centered solutions, Democrats jettisoned populism for an early-twentieth-century progressive vision of technocratic alliances between corporate and government experts. As HHS implements the ACA, we are commencing an endless argument . . . over what constitutes an adequate baseline of coverage, what is the fair share of revenue for middlemen like insurers, and what regulatory infrastructure can best

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> discussed other indicia of clinical integration including physician credentialing, case management, preauthorization of medical care, and review of associated hospital stays." One FTC commissioner has indicated that the network's willingness to "discipline or terminate physicians who did not fully participate in the program or adhere to its standards" is the most important characteristic. Another commissioner has noted that health information technology "typically is a critical element" of clinical integration.

*Id.* at 78 n.24 (internal citations omitted).

[390] *Id*. at 78–79. "Their sharing financial risk in financially integrated networks serves this purpose." *Id.* at 79 n.25 (citing COMM'R PAMELA JONES HARBOUR, FED. TRADE COMM'N, CLINICAL INTEGRATION: THE CHANGING POLICY CLIMATE AND WHAT IT MEANS FOR CARE COORDINATION (Apr. 27, 2009) ("The essence of clinical integration is the creation of interdependence among health care providers. Put simply, each provider must have a vested interest in the performance of the other providers, such that their financial and other incentives are closely aligned . . . .")).

[391] *See* 42 U.S.C. § 1395jjj (2012).

[392] Miles, *supra* note 389, at 81.

> vindicate the entitlements (and impose the burdens) specified by the bill. But the fundamental victory of reform—the national commitment that no one should have to choose between death or bankruptcy when confronted with a serious illness—will also endure. *That commitment will only prove effective, though, if reforms like ACOs manage to improve quality and access*.[393]

For the reasons so eloquently summarized by Professor Frank Pasquale above, we will here make a prediction: the ACA may well be "repealed," "replaced," or subjected to political "repairs" that change it beyond current recognition, but providers' adoption of "Accountable Care"—as promoted and operationalized under the ACA—will necessarily continue in response to the evolutionary forces we have described that are promoting structural change in the health care delivery system and driving it toward ever-more provider coordination and integration.[394]

*A. The Concept*

Most authors credit "Professor Elliott Fisher and his colleagues at the Dartmouth University Center for Health Policy and Clinical Practice" for first introducing the modern ACO concept.[395] Under their model,[396] ACOs:

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[393] Frank Pasquale, *Accountable Care Organizations in the Affordable Care Act*, 42 SETON HALL L. REV. 1371, 1382–83 (2012) (emphasis added).

[394] That is, unless or until a single-payer universal-coverage system becomes politically acceptable.

[395] *See* Andrew A. Kasper, *Antitrust Review of Accountable Care Organizations: An Assessment of FTC and DOJ's Relaxed Approach to Regulating Physician-Hospital Networks*, 90 N.C. L. REV. 203, 209–10 (2011).

[396] *See* Robert A. Berenson & Rachel A. Burton, *Accountable Care Organizations in Medicare and the Private Sector: A Status Update*, URB. INST.: TIMELY ANALYSIS OF IMMEDIATE HEALTH POL'Y ISSUES 1, 2 (Nov. 2011), http://webarchive.urban.org/UploadedPDF/412438-Accountable-Care-Organizations-in-Medicare-and-the-Private-Sector.pdf [https://perma.cc/2P3B-6NSE] (Berenson & Burton note that Fisher "introduc[ed] the concept of an 'extended hospital medical staff' at a 2006 meeting of the Medicare Payment Advisory Commission (MedPAC).").

> Fisher presented findings showing that Medicare beneficiaries received most of their care from relatively stable sets of local physicians and hospitals; he argued that these providers could be grouped together to form "virtual organizations" that could be held accountable for the cost and quality of the full continuum of care delivered to these patients. In the course of discussion, MedPAC Chair Glenn Hackbarth referred to Fisher's model as an "accountable organization." Fisher apparently liked the term; he adopted it when he published his proposed

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> were originally designed to reduce Medicare spending growth in certain hospital services areas by leveraging the fact that *Medicare beneficiaries tend to receive "most of their care from relatively coherent local delivery systems comprising physicians and the hospitals where they work or admit their patients*." Professor Fisher realized that *this group of providers, or "extended hospital medical staff,"* which the authors identified empirically through beneficiary claims data, could be used as *a "locus of accountability"* for quality and cost performance. His team envisioned savings accruing through more coordinated care and more efficient capacity decisions by local providers, which would then slow the growth in use of expensive discretionary "supply-sensitive" services such as imaging and testing, frequently offered by hospitals.[397]

Health care commentator Jackson Williams has identified two additional sources contributing to the evolution of the accountable care concept: (1) the Institute of Medicine, in a 2006 report, called for payment incentives to be structured so as to "stimulate collaboration and shared accountability among providers across care settings for better patient-centered health outcomes," as well as for "longitudinal, population-based measures that foster shared accountability of providers" aggregated into "virtual groups";[398] and, (2) a 2007 Medicare Payment Advisory Commission (MedPAC) report that

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> "accountable care organization" model in *Health Affairs* shortly thereafter. His and others' ACO models have since evolved to require actual organizations, rather than virtual organizations, but the term has stuck.

*Id.*

[397] Kasper, *supra* note 395, at 210 (citing Elliot S. Fisher et al., *Creating Accountable Care Organizations: The Extended Hospital Medical Staff*, 26 HEALTH AFF. WEB EXCLUSIVE w44, w44–53 (2007)) (emphasis added). "The authors found that on average 72.7% of beneficiaries' physician visits and 63.5% of beneficiaries' hospital admissions fell within these limited networks of physicians and hospitals." *Id.* at 210 n.32.

[398] Jackson Williams, *The "Shared Accountability" Approach to Physician Payment: Four Options for Developing Accountable Care Organizations*, 7 IND. HEALTH L. REV. 185, 188 (2010) (quoting Steven A. Schroeder et al., *Pathways to Quality Health Care, Rewarding Provider Performance: Aligning Incentives in Medicare*, INST. OF MED. OF THE NAT'L ACADS., *at* 8, 18, 118 (National Academies Press 2007) (internal quotation marks omitted)).

> sketched out an "alternate path" to physician payment . . . "[that would] involve[] setting targets for geographic units and then permitting the fullest possible array of alternative—and voluntary—organizational approaches within that geographic framework. . . ." This report [also] emphasized "shared savings"—rewarding physicians [with] bonuses when good preventive care averts more expensive acute care downstream—as driving re-aligned incentives for efficiency.[399]

In a subsequent 2009 article, Elliott Fisher also acknowledged the value of incorporating physician payment reform into the ACO concept "through the use of population-based shared savings payments."[400]

*B. Accountable Care Organizations (ACOs)*

> The accountable care organization superficially resembles Independent Practice Associations and Physician Hospital Organizations, entities that sprang into being during the heyday of managed care. The ACO is seen as having the potential to harness some of the positive characteristics of managed care—such as a measure of financial risk assumed by physicians, the ability to coordinate care, and the infrastructure of an integrated delivery system—without the negative characteristics, such as a loss of physician autonomy, potentially harmful financial risk to physicians, or incentives to stint on care. This is because *it remains a fee-for-service system, retaining independent proprietorships*, and any financial incentives to stint on care can be counterbalanced, or outweighed, by incentives to improve patient outcomes.[401]

*1. Essential Features, Requirements, and Rationale*

Although it has been suggested that HMOs "are the most recognizable ACO precursors," there is an important distinction between the two models: "HMOs focus on the modification of reimbursement only" (*i.e.*, by

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[399] *Id.* at 189 (quoting MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: ASSESSING ALTERNATIVES TO THE SUSTAINABLE GROWTH RATE SYSTEM 188 (Mar. 2007), *available at* http://www.medpac.gov/docs/default-source/reports/Mar07_SGR_mandated_report.pdf?sfvrsn=0 [https://perma.cc/G54V-US86]).

[400] Kasper, *supra* note 395, at 210.

[401] Williams, *supra* note 398, at 190 (emphasis added).

"provid[ing] comprehensive health care to [voluntary enrollees] . . . that is financed by fixed periodic payments determined in advance"), whereas ACOs "*address modification of both delivery structure and reimbursement*."[402] Health care author Wasif Ali Khan argues that ACOs avoid the '"chicken or the egg' conundrum," which has historically "sidetracked and derailed" previous efforts at healthcare reform; that is, an ACO is a "healthcare delivery *and* cost-control model" that simultaneously reforms both.[403] He notes that proponents identify three characteristics as being essential to an ACO:

> (1) the ability to provide, and manage with patients, the continuum of care across different institutional settings, including ambulatory and inpatient hospital care, and possibly post acute care; (2) the capability of prospectively planning budgets and resource needs; and (3) sufficient size to support comprehensive, valid, and reliable performance measurement.[404]

Similarly, DeMuro emphasizes the importance of what might be considered the "process elements" of an ACO:

> The emergence of accountable care and a system's ability to embrace it today seems to require the ability to manage risk, effectively employ electronic health records ("EHRs"), report performance measures, implement standardized care management protocols, engage patients in self-care management and self-determination, and balance the interests of hospitals, primary care physicians and specialists in creating governance and management processes to adjudicate differences.[405]

Bernadette Broccolo puts it simply: "On the most basic level, ACOs are organizations that connect *groups of providers* that are willing and able to take responsibility for improving the health status, efficiency and

[402] Justin Kearns, *Rural Roads to ACOs: Inter-Community Collaboration is Key to Rural Accountable Care Organizations' Success Under Medicare's Shared Savings Program*, 116 W. VA. L. REV. 425, 433 (2013) (quoting *HMO*, MERRIAM-WEBSTER ONLINE, https://www.merriam-webster.com/dictionary/HMO [https://perma.cc/Z5JZ-ZCE7]) (internal quotation marks omitted) (emphasis added).

[403] Wasif Ali Khan, *Accountable Care Organizations: A Response to Critical Voices*, 14 DEPAUL J. HEALTH CARE L. 309, 310 (2012) (emphasis added).

[404] *Id.* at 311.

[405] Demuro, *supra* note 384, at 3.

experience of care for a defined patient population."[406] She goes on to note that effective ACOs necessarily include the following elements:

> 1. Patient-centered "medical homes" that deliver primary care and coordinate with other providers;
>
> 2. Aligned networks of specialists, ancillary providers and hospitals focused on enhanced outcomes;
>
> 3. Emphasis on effective clinical care integration and coordination mechanisms;
>
> 4. Payor-provider contracted relationships and reimbursement models that facilitate and reward cost-effective high-value (not high-volume) health care; and,
>
> 5. Population health information infrastructure to enable community-wide care coordination, including integrated electronic health records (EHRs).[407]

Professor Furrow identifies the operational requirements for a successful ACO:

> *ACOs will most likely* "*operate as mini-health plans*, building the infrastructure to manage utilization and insure [sic] quality-care delivery. To establish targets, cost trends, and provider payment and incentive distribution models, ACOs will require sophisticated financial and actuarial analyses. To control demand and improve the quality of care delivery, ACOs will need to have the tools, processes, and reporting for chronic-disease management, complex case management, and wellness/prevention services. To control medically unnecessary services, ACOs will need to have the tools, processes, and reporting for preauthorization, hospital utilization review, high-tech radiology management, specialty referral management, and pharmacy management."[408]

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[406] Bernadette M. Broccolo, *Toward Accountable Care: How Healthcare Reform will Shape Provider Integration*, HEALTH L. PRAC. GUIDE HRS § 6:1, *available at* Westlaw, *at* 5 (2010) (emphasis added).

[407] *Id.*

[408] Furrow, *supra* note 344, at 857 (quoting Robert Parke & Kate Fitch, *Accountable Care Organizations: The New Provider Model?*, MILLIMAN INSIGHT (Oct. 13, 2009), (*continued*)

> From [all of] these conceptual bases—[particularly] the establishment of a multiprovider locus of accountability and physician payment reform through shared savings—four [apparent] policy rationales for ACOs [emerge]. First, ACOs are intended to decrease provider fragmentation and foster improved coordination of care among providers.[409] Second, this improved coordination is expected to create more robust mechanisms for provider performance measurement.[410] Third, the ACO shared savings payment method is designed to align the utilization incentives facing different groups of providers, particularly physicians and hospitals. . . .[411]
>
> [Fourth,] ACOs are constructed to shift patient care away from hospitals to the primary care setting. . . .[412]

*2. ACOs Under the MSSP (Medicare Shared Savings Program)*

Professor Thomas L. Greaney opines:

> Of the many elements animating structural change under health reform, Accountable Care Organizations (ACOs) have drawn the greatest attention. Supported by scholarship from health policy experts and *positioned as the Affordable Care Act's centerpiece for systemic reform*, the concept came to represent a potential cure-all for the disorders plaguing American health care. While the program, entitled the Medicare Shared Savings Program (MSSP), focuses on Medicare payment policy, its objectives extend much farther. *The ACO strategy entails regulatory interventions that at once aim to reshape the health care delivery system*, improve outcomes, promote adoption of evidence-based medicine and supportive

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http://www.milliman.com/insight/healthreform/Accountable-care-organizations-The-new-provider-model/ [https://perma.cc/84AK-4X3Y]) (emphasis added).

[409] Kasper, *supra* note 395, at 211 (citing Stephen M. Shortell et al., *How the Center for Medicare and Medicaid Innovation Should Test Accountable Care Organizations*, 29 HEALTH AFF. 1293, 1294 (2010)).

[410] *Id.* (citing Mark McClellan et al., *A National Strategy to Put Accountable Care into Practice*, 29 HEALTH AFF. 982, 985–87 (2010)).

[411] *Id.* (citing Shortell, *supra* note 409, at 1294).

[412] *Id.* at 211–12 (Although, we should note that hospitals remain among the biggest participants in ACO development).

> technology, and create a platform for controlling costs under payment system reform.
>
> Moreover, the ACO strategy calls upon disparate governmental entities to cooperate (and in many cases, cede regulatory turf), and asks the private sector to respond responsibly to changes that are rife with possibilities for opportunistic behavior. The regulatory undertaking itself is far reaching—perhaps unprecedented––in its goal of "nation building": *fostering institutions that will counter market failure and shift embedded incentives and practices in medicine. Given the abject state of health care markets, a central question is whether implementing regulations and legal standards are adequate to achieve the hoped-for rationalization of health care delivery and financing*.[413]

The Medicare Shared Savings Program (MSSP) is clearly the most important among several initiatives in the ACA attempting to implement "value-based purchasing"—a reform strategy linking "payment more directly to the quality of care provided."[414] It is also "the latest in a long line of efforts to develop *integrated delivery systems that bear financial responsibility for treatment decisions*."[415] It is unique, however, in its attempt to leverage "Medicare policy to transform health delivery and payment practices in the private sector"—giving rise to its "considerable promise and its most vexing regulatory challenges."[416] "[F]rom a market perspective," ACOs under the MSSP attempt to address "[m]arket imperfections—including imperfect agency, information distortions and asymmetry, moral hazard, and monopoly"—that have historically pervaded the delivery and financing of health care in the United States.[417]

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[413] Thomas L. Greaney, *Regulators as Market-Makers: Accountable Care Organizations and Competition Policy*, 46 ARIZ. ST. L.J. 1, 1 (2014) (emphasis added).

[414] *Id.* at 3.

[415] *Id.* at 3–4 (emphasis added). Noting that "[p]olicies encouraging integrated delivery of health services through managed care can be traced back to the work of Dr. Paul Elwood and others in the 1960s, which culminated in the passage of the Health Maintenance Act in 1973." *Id.* at 4 n.6. *See also* 42 U.S.C. § 280(c) (1973) (requiring employers offering health insurance to offer an HMO option).

[416] Greaney, *supra* note 413, at 3–4.

[417] *Id.* at 4 (citing Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 947 (1963) ("The failure of one or more of the competitive preconditions has as its most immediate and obvious consequence a reduction in welfare below that obtainable from existing resources and technology, in the sense of a

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For our present purposes, one of the most important features of these ACOs is *the enlarged and meaningful organizational involvement of* "*multiple 'stakeholders,' including both individual professionals (e.g., physicians) and institutions (e.g., hospitals, group practices, payors, etc.).*"[418] Significantly, although the ACA requires "shared governance" of the ACO by its stakeholders, *it has not—by design—required that such governance be accomplished through any particular functional or legal organizational form*.[419] That is to say, so long as all relevant statutory and regulatory requirements are met,[420] "the ACO itself can be a nonprofit

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failure to reach an optimal state in the sense of Pareto."). *See also* David Dranove & Mark A. Satterthwaite, *The Industrial Organization of Health Care Markets*, *in* 1B Handbook of Health Economics 1093, 1095 (Anthony J. Culyer & Joseph P. Newhouse eds., 2000) (describing market imperfections in health care); Greaney, *supra* note 388, at 817.

[418] Corbett, *supra* note 3, at 160 (emphasis added).

[419] *Id.* (emphasis added).

[420] *Id.* at 160 n.296.

> Section 1899(b)(2) of the SSA establishes the following requirementa for an ACO to participate in the program: (1) The ACO shall be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it. (2) The ACO shall enter into an agreement with the HHS Secretary to participate in the program for not less than a 3-year period (the MSSP agreement period). (3) *The ACO shall have a formal legal structure that would allow the organization to receive and distribute payments for shared savings under § 1899(d)(2) to participating providers of services and suppliers.* (4) The ACO shall include primary care ACO professionals that are sufficient for the number of Medicare fee-for-service beneficiaries assigned to the ACO under § 1899(c). At a minimum, the ACO shall have at least 5,000 such beneficiaries assigned to it under § 1899(c) in order to be eligible to participate in the MSSP. (5) The ACO shall provide the HHS Secretary with such information regarding ACO professionals participating in the ACO as the Secretary determines necessary to support the assignment of Medicare fee-for-service beneficiaries to an ACO, the implementation of quality and the other reporting requirements under§ 1899(b)(3), and the determination of payments for shared savings under § 1899(d)(2). (6) The ACO shall have in place a leadership and management structure that includes clinical and administrative systems. (7) The ACO shall define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies. (8) The ACO shall demonstrate to the HHS Secretary that it meets patient-centeredness criteria specified by the Secretary, such as the use of patient and caregiver assessments or the use of individualized care plans.

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corporation, a for-profit corporation, [or] some other type of legal business entity (*e.g*., limited liability company, partnership, etc.) . . . ."[421]

*3. Tax Considerations in ACO Organization*

What, then, *should* be the preferred legal form for an ACO organization? If the ACA seeks to simultaneously improve quality while reducing cost, how is such goal to be reconciled with the still-dominate "*corporate*" ethos of profit-maximization? Moreover, what are we to make of the government's seeming willingness to clear the way for development of private, presumably profit-making ACOs that are not designed or intended to participate in the MSSP? Additionally, what about the continuing criticism of large, commercial nonprofit organizations in the health care sector whose actual conduct seems increasingly indistinguishable from that of their for-profit counterparts?

Health Care Attorney Scott Shimick notes:

> The Service [IRS] anticipates that tax-exempt organizations typically will be participating in the MSSP through an ACO along with private parties, including some that might be considered insiders with respect to the tax-exempt organization. It also anticipates that a tax-exempt organization's participation may take a variety of forms, including membership in a nonprofit membership corporation, ownership of shares in a corporation, ownership of a partnership interest in a partnership (or a membership interest in an LLC), and contractual arrangements with the ACO and/or its other participants.[422]

However, as we observed in our initial article, "if tax-exempt nonprofits participate in an ACO, they must be concerned with the possibility that their involvement will run afoul of the private inurement doctrine."[423] As noted by Johnson and Moroney:

> In Notice 2011-20 (03/31/11), the IRS announced that, *under certain conditions*, it generally would not consider a tax-exempt organization's participation in the MSSP through an ACO to result in inurement or substantial

*Id.* (citing IRS Notice 2011-20, *Background on ACOs and thee MSSP*, at 2) (emphasis added).

[421] *Id.* at 160–61.

[422] Scott Shimick, *Accountable Care Organizations*, 9 MERTENS L. OF FED. INCOME TAX'N § 34:23.50, 75 (2014).

[423] Corbett, *supra* note 3, at 161.

> private benefit. . . . [T]he IRS stated its expectation that MSSP payments would be derived from activities that are *substantially related* to the performance of the *charitable purpose* of lessening the burdens of government within the meaning of Treas. Reg. § 1.501(c)(3)-1(d)(2). . . .
>
> 'Congress established the MSSP to be conducted through ACOs in order to promote quality improvements and cost savings, thereby lessening the government's burden associated with providing Medicare benefits.' . . . *The IRS cautioned, however, that not every activity that promotes health is considered to be a charitable purpose. Accordingly, ACO arrangements entered into outside the MSSP (e.g., with commercial payors) are unlikely to lessen the burdens of government and conceivably may not further any other charitable purposes*.[424]

At present, then, tax-exempt organizations that participate in an MSSP ACO must do so through a structure that does not result in net earnings

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[424] *Id.* at 161–62 (emphasis added). Generally speaking, the "certain conditions" under which the IRS finds such participation *not* to result "in inurement or impermissible private benefit" include:

> (1) The terms of the tax-exempt organization's participation in the MSSP through the ACO (including its share of MSSP payments or losses and expenses) are set forth in advance in a written agreement negotiated at arm's length.
> (2) CMS has accepted the ACO into, and has not terminated the ACO from the MSSP.
> (3) The tax-exempt organization's share of economic benefits derived from the ACO (including its share of MSSP payments) is proportional to the benefits or contributions the tax-exempt organization provides to the ACO. If the tax- exempt organization receives an ownership interest in the ACO, the ownership interest received is proportional and equal in value to its capital contributions to the ACO and all ACO returns of capital, allocations and distributions are made in proportion to ownership interests.
> (4) The tax-exempt organization's share of the ACO's losses (including its share of MSSP losses) does not exceed the share of ACO economic benefits to which the tax-exempt organization is entitled.
> (5) All contracts and transactions entered into by the tax-exempt organization with the ACO and the ACO's participants, and by the ACO with the ACO's participants and any other parties, are at fair market value.

*Id.* at 161 n.297 (noting that "[i]n the Notice, the Service solicited comments on this issue to help formulate future regulations.").

"inuring to the benefit of its insiders" or other "private parties participating in the ACO"—a determination made by the the Service "on a case-by-case basis, based on all the facts and circumstances."[425] As regards this requirement, Shimick further summarizes the Service's position:

> An additional issue raised by the participation of tax exempt organizations in ACOs is whether the share of the MSSP payments received by a tax-exempt organization will be subject to unrelated business income tax (UBIT). Whether the MSSP payments will be subject to UBIT depends on whether the activities generating the MSSP payments are substantially related to the exercise or performance of the tax-exempt organization's charitable purposes constituting the basis for its exemption under § 501. The Service has stated that, absent inurement or impermissible private benefit, any MSSP payments received by a tax-exempt organization from an ACO would derive from activities that are substantially related to the performance of the charitable purpose of lessening the burdens of government *as long as the ACO meets all of the eligibility requirements established by CMS for participation in the MSSP*.[426]

A final point perhaps worth making is that noted by Tax Attorney Michael A. Lehmann:

> Another surprising thing about Notice 2011-20 is the striking absence of a requirement that tax-exempt participants control the ACO either wholly or in part. Traditionally, control by a tax-exempt participant in a joint business venture—if not of the entire business, then at least of the core business at issue—has been a lynchpin for any Service finding that the business venture has no adverse consequences for the tax-exempt participant. Even where a tax-exempt participant does not have complete, overall control over a venture, the Service looks to see if the tax-exempt participant at least has control over the aspects of the venture that relate to the participant's tax-exempt purposes. . . . [N]either the PPACA nor the CMS

[425] Shimick, *supra* note 422, at 75.

[426] *Id.* at 76 (citing Treas. Reg. § 1.501(c)(3)-1(d)(2); REV. RUL. 81-276) (emphasis added).

> regulations include an element of control by tax-exempt participants, and the Service has not attempted to add such a requirement. The Service explicitly confirmed this in question and answer 9 of Fact Sheet 2011-11, issued on 10/20/11 for the purpose of clarifying certain portions of Notice 2011-20.[427]

*All of the above, then, seems to comprise an extraordinarily complex and convoluted way to attempt reconciliation of the inherent tension in existing for-profit and nonprofit corporate forms between "mission and margin"—a tension that appears clearly to be exacerbated in the context of health care delivery under the new imperatives of the ACA in general, and ACO development in particular.*

Nonetheless, as suggested by Professor Greaney:

> *Proponents of the ACO strategy argue forcefully that the experiment is the last best hope for a market-driven rationalization of the health care system.* Jay Crosson, for example, contends that the ACO concept is "too vitally important to fail," predicting that the likely alternative if ACOs do not take root could be indiscriminate, across-the-board cuts to provider payment rates.[428] *Optimistic observers suggest that ACOs will improve the dynamics of competition*[429] *and may ultimately displace private insurance altogether.*[430] *Other prominent health policy experts are less sanguine about the compatibility of ACOs and a competition-driven marketplace*, offering scenarios

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[427] Michael A. Lehmann, *Service Defers (Generally) To HHS On Accountable Care Organizations*, 24 TAXATION OF EXEMPTS 44, 47 (2013).

[428] Greaney, *supra* note 413, at 10 (citing Francis J. Crosson, *The Accountable Care Organization: Whatever its Growing Pains, the Concept is too Vitally Important to Fail*, 30 HEALTH AFF. 1250, 1254 (2011)).

[429] *Id.* (citing Ezekiel J. Emanuel & Jeffrey B. Liebman, *The End of. Health Insurance Companies*, N.Y. TIMES OPERATOR BLOG (Jan. 30, 2012, 9:00 PM), http://opinionator.blogs.nytimes.com/2012/01/30/the-end-of-health-insurance-companies/ [https://perma.cc/WK3K-L7XW] (emphasis added) (stating that ACOs offer "a better form of competition" because consumers are better able to choose physicians than dal with a "bewildering array of copayments, deductibles and annual out of pocket maximums" in selecting a health plan). *See also* Stephen M. Shortell et al., *How the Center for Medicare and Medicaid Innovation Should Test Accountable Care Organizations*, 29 HEALTH AFF. 1293 (2010), *available at* http://content.healthaffairs.org/content/29/7/1293.full.html)).

[430] Greaney, *supra* note 413, at 10–11 (citing Emanuel & Liebman, *supra* note 429 (predicting that "by 2020, the American health insurance will be extinct" because ACOs will replace private health insurance companies)) (emphasis added).

> in which the failure of competition to restrain cost increases driven by dominant providers ultimately leads to rate regulation,[431] or fails to achieve critical mass because of the intransigence of entrenched providers.[432]

*To our view, a potential problem with the organizational flexibility currently afforded to ACOs (and particularly private, non-MSSP ACOs) is that these new organizations may well develop with a continued "margin over mission" mindset that fails in fact to prioritize health care cost-containment, enhanced access, and quality improvement over the continual growth of corporate profits.*

## VII. THE NEED FOR MISSION PRIMACY, FIDUCIARY DUTY, AND MEDICAL TRUST

In regards to the viability of a "rationalized market-driven health care system," it is perhaps worth noting John Paul II's view of "free markets" as expressed by Professor Coverdale:

> He points out . . . that many vital human needs are not endowed with purchasing power and would therefore go unmet if we were to rely exclusively on market mechanisms. "[T]here are many human needs which find no place on the market." If markets cannot meet such needs, other mechanisms must be found to meet them; *the rationality of the market is not the ultimate criterion of justice*. Society should try to regulate markets in such a way as to maximize the efficiency they can produce while ensuring that the needs of all its members, including the weakest, are met.[433]

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[431] *Id.* at 11 (citing Hearing on Health Care Indistry Consolidation Before the Subcomm. On Health of the H. Comm. on Ways and Means, 112th Cong. 38–47 (2011) (statement of Paul B. Ginsburg, President, Center for Studying Health System Change, documenting increasing provider market power and concluding that ineffective market competition may lead to government rate review or rate setting). *See also* Clark C. Havighurst & Barak Richman, *The Provider Monopoly Problem in Health Care*, 89 OR. L. REV. 847, 874 (2011) (citing rate regulation as a possible remedy to hospital market dominance)).

[432] Greaney, *supra* note 413, at 10–11 (citing Jeff Goldsmith, *Accountable Care Organizations: The Case for Flexible Partnerships Between Health Plans and Providers*, 30 HEALTH AFF. 32, 35 (2011)) (emphasis added).

[433] Coverdale, *supra* note 2, at 510–11 (citing John Paul II, Encyclical Letter Centesimus Annus P34–35 (1991)) (emphasis added).

Perhaps more directly to our current point, Professor Gawande has made the oft-quoted observation that "the most important decision we face in choosing how to control health care costs is not whether we create a single-payer system or a mixture of public and private insurance—*it is whether we choose to reward leaders who put the needs of patients first rather than profits first*."[434] Putting the needs of patients first, we suggest, would benefit greatly from an organizational form that embodies renewed commitments to mission primacy, fiduciary duty, and medical trust.

### *A. The Concept of Mission Primacy*

If, then, we accept the premise that institutional health care providers should always put the needs of patients before their organization's need to make a profit, why should we even permit for-profit, investor-owned hospitals (and similar institutional direct providers of care) to exist? Why indeed? Why not simply legislate that all such providers must operate as charitable nonprofits? *Simply put, why not ban all "profit-making" in the direct provision of health care services by corporate and other institutional entities*? After all, if health care is a right (or at least a "near-right"), why should corporations' passive investors be entitled to "profit" from its provision? Moreover, if the biggest problem in ensuring adequate health care for our entire population is the seemingly intractable problem of its ever-escalating expense, why should we not mandate that all such institutionally-delivered care be provided "at cost" without having to sustain the additional economic burden of a financial return to equity holders?

Needless to say, not everyone contributing to the production and provision of health care services across the entirety of the "Health Care Sector" could or should be limited to participation on a "nonprofit" basis. Individual health care professionals reasonably expect to make a living commensurate with their investments in education and training; the critical newly-developed inputs of pharmaceutical companies and the vast array of medical technology and equipment companies cannot reasonably be expected to continue without the impetus of a free-market profit motive. The same can be said of most of the other sub-sector participants in our massive health care "industry." However, *at the point of direct care delivery*—increasingly found at the level of the institutional rather than individual provider—what justification exists for corporate "margin" to

[434] David A. Gruenewald, *Can Health Care Rationing Ever Be Rational?*, 40 J. L. MED. & ETHICS 17, 20 (2012) (citing Atul Gawande, *The Cost Conundrum: What a Texas Town Can Teach Use About Health Care*, NEW YORKER (June 1, 2009)) (emphasis added).

predominate over "mission"? Nonetheless, the continuing (and probably inevitable) commercialization of health care has not only perpetuated, but in fact exacerbated, such predomination as we have discussed.

Professor Horwitz has pointed out that: "The basic commitment involved in being a hospital is a commitment to improve life through delivering medical care. . . . And, whatever responsibilities do or do not arise from being a provider of healthcare ought to apply to all hospitals equally."[435] She notes:

> The most important difference in moral obligation generated by the organizational choice between not-for-profit and for-profit hospitals is that for-profits have a privilege that does not accrue to not-for-profits: For-profits can make decisions in the pursuit of profits per se, while not-for-profit hospitals may not make decisions for this reason. . . .
>
> [D]oing so would contradict their constitutive pinciples. . . .[436]

Should today's ever-larger institutional direct providers of care—including ACOs—have any lesser commitment?

Further, Professor Horwitz quotes Professor Daniel Wikler for the proposition that "good healthcare, more than most other revenue-producing activity, requires behavior, which, at least in the short-to-medium run, is directly contrary to profit maximization."[437] She concludes that "[i]f this view is correct, for-profit hospitals are morally forbidden to pursue a strategy of profit maximization that would produce bad healthcare."[438] She also cites Professor Eric Orts, arguing "that the growth of institutional investors and the corresponding increase in pressure on investor-owned corporations to produce profits is making it more difficult for those corporations to meet social responsibilities."[439]

As to nonprofits, we refer back to the extensive discussion in our initial article of the growing proliferation of "bad acts" by charitable, tax-exempt

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[435] Horwitz, *supra* note 99, at 1400–01.
[436] *Id.* at 1401.
[437] *Id.* at 1402 (quoting DANIEL WIKLER, THE VIRTUOUS HOSPITAL: DO NONPROFIT INSTITUTIONS HAVE A DISTINCTIVE MORAL MISSION? 38 (J. David Seay & Bruce C. Vladeck eds., 1988)).
[438] *Id.*
[439] *Id.* (citing Eric W. Orts, *The Future of Enterprise Organization*, 96 MICH. L. REV. 1947, 1966 (1998)).

health care providers.[440] For her part, while Professor Horwitz acknowledges that nonprofit hospitals "need to earn enough profit to be going concerns," which they do through the accumulation of earnings known as "fund balances," she also notes the complete unacceptability of managers using "large fund balances as a proxy for profitmaking [just] to raise their status."[441] It would seem, then, that even if we were to outright ban the direct provision of health care by for-profit institutional providers,[442] a problem might well still remain.

Accordingly, as we noted in our initial article, "[s]ome have argued that the concept of '*mission primacy*'—a '*doctrinal recognition*' that a corporation's 'articulated mission' should be its *legally-enforceable primary objective* . . . —should be more strictly applied to tax-exempt, nonprofit health care corporations in order to better ensure director fidelity to the organizations' charitable missions."[443] Such an approach "appears warranted in view of the significant evidence that threatened loss of tax-exemption is, by itself, insufficient to ensure that nonprofits provide an appropriate and expected level of public benefit."[444]

To repeat several other additional points from our initial article:

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[440] *See* Corbett, *supra* note 3, at 131.

[441] Horwitz, *supra* note 99, at 1402–03.

[442] An unlikely step given the long-standing American tradition of free-market capitalism, the still-prevailing ethos of profit-maximization in all "business" undertakings, and our persistent (if not clearly substantiated) belief in the superior economic efficiency of the for-profit form in all circumstances.

[443] Corbett, *supra* note 3, at 166 (emphasis added) (internal citations omitted). Professors Greaney and Boozang explain the concept:

> As a general guiding principle, we suggest that "mission primacy" should be recognized as a central objective of the nonprofit enterprise . . . . This focus would incorporate mission-centered values into interpretations of the traditional fiduciary duties of care and loyalty. At the same time, like the model of "director primacy" advanced for proprietary corporations, it would preserve managerial discretion to balance the various constituents of the nonprofit firm including donors, consumers, and the community. Consequently, this standard would accommodate the relational imperatives of the modern business environment in health care. . . . Finally, mission primacy accounts for the particular circumstances of nonprofit governance because it preserves the central values of trust and volunteerism that are needed to reinforce legal duties.

*Id.* at 166–67 (citing Greaney & Boozang, *supra* note 72, at 83–84).

[444] *Id.* at 166.

> The recognition that mission objectives other than pursuit of profit are sufficiently important in health care to justify giving them more formalized legal status finds support in Robert G. Evans' concept of a "'*not-only-for-profit' sector*'"—a designation referring to "*firms 'in which a legal claimant to profits is well-defined, but profits represent only one among several competing objectives of the firm's ownership and management*."'[445]

Under such a construct, "[p]ursuit of 'profit'—in the sense of residual revenue over expenses necessary to meet ongoing capital needs for replacement and growth—would necessarily remain, but as a secondary rather than sole or even primary objective."[446] Such a construct "seems particularly apropos to ACOs, the acknowledged purpose of which is to improve the value, quality, and efficiency of health care services, as well as accountability for their delivery."[447] As we previously stated:

> Because accomplishing an ACO's purpose requires a significant degree of integration of, and collaboration among, different entities (nonprofit and for-profit alike), a new mission-centered form of health care organization specifically designed to serve the diverse objectives of multiple stakeholders makes sense, since the directors of such a new organization would have an explicit, legally-enforceable duty to take *all* mission considerations into full account in their business decision-making.[448]

In this regard, it is particularly worth noting that under CMS Rules for the MSSP ACO program, "[e]ach ACO participant and each ACO provider/supplier must demonstrate a *meaningful commitment to the mission* of the ACO to ensure the ACO's likely success."[449]

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[445] *Id.* at 167 (citing Theodore R. Marmor et al., *A New Look at Nonprofits: Health Care Policy in a Competitive Age*, 3 YALE J. ON REG. 313, 319 (1986) (quoting ROBERT EVANS, STRAINED MERCY: THE ECONOMICS OF CANADIAN HEALTH CARE 127 (1984)) (emphasis added).

[446] *Id.*

[447] *Id.*

[448] *Id.* (citing Greaney & Boozang, *supra* note 72, at 84) (emphasis added).

[449] 42 C.F.R. § 425.108(d) (2013) (emphasis added). The Code goes on to note:

> (1) Meaningful commitment may include, for example, a sufficient financial or human investment (for example, time and effort) in the ongoing operations of the ACO such that the potential loss or recoupment of the investment is likely to motivate the ACO participant

(*continued*)

In closing this discussion, unlike Professors Greaney and Boozang—who advocate only a "doctrinal recognition" of mission primacy[450]—*we advocate that mission primacy be made an explicit and fully-enforceable legal requirement under the constitutive structure of the HCBC's legal form itself*. Such requirement would limit wayward application of what has been called the "best judgment rule"—the "nonprofit equivalent of the business judgment rule that allows corporate directors space in which to exercise their discretion"[451]—that has too-often enabled inappropriate nonprofit emulation of for-profit conduct. As noted by Professor Henry B. Hansmann: "In the case of the nonprofit corporation, . . . the purpose of the

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> and ACO provider/supplier to achieve the ACO's mission under the Shared Savings Program.
> (2) A meaningful commitment can be shown when an ACO participant or ACO provider/supplier agrees to comply with and implement the ACO's processes required by § 425.112 and is held accountable for meeting the ACO's performance standards for each required process.

*Id.* § 425.108(d)(1)&(2).

[450] *See* Greaney & Boozang, *supra* note 72, at 5. Professor D. Jacobson and Soniya K. Mathur summarize the Greaney and Boozang "doctrinal" approach to mission primacy as follows:

> To address the reality that nonprofit health care provider board members have simultaneous duties to the organization's financial bottom line as well as the nonprofit mission, Professors Thomas L. Greaney and Katheleen M. Boozang suggest that mission primacy should be treated as the core purpose of nonprofit health care organizations with ample discretion left to directors to interpret the organization's mission. They recommend altering traditional fiduciary doctrine with respect to nonprofits by including mission-specific values into traditional corporate governance analyses, which tend to ignore mission values entirely. The concept of mission primacy would increase nonprofit directors' freedom to evaluate transactions while requiring that the directors constantly consider the organization's mission in their decision-making processes. This approach would circumvent the difficulty courts and legislatures have faced in clearly defining the legal applicability of organization mission to nonprofit board decision-making without curtailing board discretion to safeguard the organization's mission. The mission primacy approach could provide courts with a more sustainable doctrinal basis for assessing board conduct under the duty of loyalty.

Peter D. Jacobson & Soniya Keskar Mathur, *Health Law 2010: It's Not All About the Money*, 36 AM. J. L. & MED. 389, 396–97 (2010).

[451] Sugin, *supra* note 71, at 901.

charter is primarily to protect the interests of the organization's *patrons* from those who control the corporation."[452]

### *B. American Fiduciary Law*

> Many forms of conduct permissible in a workaday world for those acting at arm's length, are forbidden to those bound by fiduciary ties. A trustee is held to something stricter than the morals of the market place. Not honesty alone, but the punctilio of an honor the most sensitive, is then the standard of behavior. . . . Only thus has the level of conduct for fiduciaries been kept at a level higher than that trodden by the crowd. . . .[453]

We wish next to delve more deeply into a concept that has frequently been referred to throughout our review of both American corporate law and the American health care delivery system—the role of "fiduciary" responsibility. According to Professor Michelle M. Harner, "American fiduciary law has its roots in Roman and English law, which treated persons holding 'the character of a trustee, or character analogous thereto' as fiduciaries."[454] "The original purpose of fiduciary law was to prevent persons placed in positions of trust from abusing those positions for personal gain or otherwise."[455]

Professor Dana Brakman Reiser notes that all fiduciaries share certain characteristics: "the fiduciary performs some service for the individual or entity to whom he owes a fiduciary obligation (the 'entrustor'); the fiduciary must act in the best interests of the entrustor; and the fiduciary must avoid conflicts between his own interests and those of the entrustor."[456] In a general, but very real sense, "all fiduciary obligations are imposed to protect the entrustor from potential abuse at the hands of

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[452] Henry B. Hansmann, *The Role of Nonprofit Enterprise*, 89 YALE L.J. 835, 845 (1980) (emphasis added).

[453] Meinhard v. Salmon, 164 N.E. 545, 546 (N.Y. 1928) (Benjamin N. Cardozo, C.J.).

[454] Michelle M. Harner, *Corporate Control and the Need for Meaningful Board Accountability*, 94 MINN. L. REV. 541, 572 (2010) (citing ERNEST VINTER, A TREATISE ON THE HISTORY AND LAW OF FIDUCIARY RELATIONSHIP 1 (2d ed. 1955) (1932)).

[455] *Id.* "The doctrine of fiduciary relationship is a doctrine of equity, the rule being that a person must not take advantage of that relation to obtain a gift or other benefit to himself." *Id.* at 572 n.152.

[456] 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, 995–96 (2001).

the fiduciary."[457] Nonetheless, Professor Reiser also notes that the concept of fiduciary duty "resides on a continuum with differing content for trustees, corporate directors and simple agents."[458] She suggests that fiduciary obligations accordingly must be crafted with a specificity that fits the particular context and "the issues at hand."[459]

Professor Ethan J. Leib provides a somewhat different overview that resonates more specifically with our contentions regarding the obligations of direct providers of health care services:

> Generally speaking, a fiduciary relationship emerges in contexts in which one person (the fiduciary) has discretionary power over the legal or practical interests of another (the beneficiary). The law requires those who manage the affairs and assets of beneficiaries to operate within strict legal and ethical requirements that demand fidelity to beneficiary interests. *These requirements stem from the nature of the discretion afforded to the fiduciary, the trust reposed and presumed by the beneficiary, and the vulnerability to which beneficiaries are subject. Accordingly, three indicia identify fiduciary relationships: discretion, trust, and vulnerability*. Where these tripartite indicia exist, the private law imposes substantial obligations upon fiduciaries as a way of keeping them in line and incentivizing them to prioritize their beneficiaries' interests above the fiduciary's own.[460]

Similarly, Professor Marc A. Rodwin suggests that "[t]he fiduciary relationship is based on *dependence, reliance, and trust*" with fiduciaries held to "the highest standard of conduct."[461] He notes that fiduciaries' work "requires judgment and discretion," for which they usually have "specialized knowledge or expertise."[462] Significantly, he also notes that "[o]ften the party that the fiduciary serves cannot effectively monitor the fiduciary's performance."[463]

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[457] *Id.* at 996.
[458] *Id.* at 995.
[459] *Id.* at 996.
[460] Ethan J. Leib et al., *Fiduciary Principles and The Jury*, 55 WM. & MARY L. REV. 1109, 1117–18 (2014) (emphasis added).
[461] Rodwin, *supra* note 453, at 244 (emphasis added).
[462] *Id.*
[463] *Id.*

Hafemeister & Porter further round out the general contours of fiduciary responsibility:

> Generally speaking, the object of fiduciary law is to protect and maintain important societal relationships that the "morals of the market place" would place in jeopardy. . . .[464]
>
> Fiduciary law is routinely applied to relationships where one party is "charged with selflessly acting in the best interests of another," including relationships between directors and corporations, parents and children, and lawyers and their clients. Absent a fiduciary obligation, these relationships are ripe for exploitation by the fiduciary or others, potentially exposing the beneficiary to great harm and undercutting the purpose that the relationship was designed to serve. . . .[465]
>
> As a result, a fiduciary duty is generally construed to be "[a] duty of utmost good faith, trust, confidence, and candor[,] . . . a duty to act with the highest degree of honesty and loyalty toward another person and in the best interests of the other person . . . ."[466] In addition, "fiduciaries [generally] have a duty to disclose to competent beneficiaries any information relevant to fulfilling their fiduciary obligations."[467]

In brief summary, then, *"[a] fiduciary relationship may arise in a legal, moral, domestic, or personal context, where there appears on the one side an overmastering influence or, on the other, weakness, dependence, or trust, justifiably reposed."*[468]

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[464] Hafemeister and Porter, *supra* note 337, at 544 (citing Meinhard v. Saqlmon, 164 N.E. 545, 546 (N.Y. 1928) (explaining that fiduciary obligations require individuals to remain loyal in a way that morals alone cannot)).

[465] *Id.* at 546 (citing Tamar Frankel, *Fiduciary Law in the Twenty-First Century*, 91 B.U. L. REV. 1289, 1293–94 (2011) (cautioning that entrustment poses the serious and potentially harmful risks that fiduciaries will misuse entrusted property and power, not possess their claimed expertise, or not exercise their expertise well or at all)).

[466] *Id.* (quoting BLACK'S LAW DICTIONARY (9th ed. 2009)).

[467] *Id.* at 544–46 (quoting Thomas L. Hafemeister & Selina Spinos, *Lean on Me: A Physician's Fiduciary Duty to Disclose an Emergent Medical Risk to the Patient*, 86 WAS. U. L. REV. 1167, 1188 (2009)).

[468] Peoples Bank & Tr. Co. v. Cermack, 658 So.2d 1352, 1359 (Miss. 1995) (internal quotations omitted).

*1. The Particularized Fiduciary Obligations of Physicians*

> The notion of the physician as a fiduciary with obligations to protect vulnerable patients is the starting point for any ethical and legal discussion of health care providers' obligations. . . .
>
> A fiduciary obligation in medicine means that the physician focuses exclusively on the patient's health, the patient assumes the doctor's single-minded devotion to him, and the doctor-patient relationship is expected to be free of conflict. One ethicist defines a health care fiduciary as someone who commits to becoming and remaining scientifically and clinically competent, acts primarily to protect and promote the interests of the patient, keeps self-interest systematically secondary, and maintains and passes on medicine as a public trust for current and future physicians and patients. Medical ethicists frequently speak of the doctor's special duties in relation to the patient, often characterizing the doctor as a special friend to the patient, connected by bonds of loyalty normally subsumed within the meaning of friendship. It is a strong agency relationship in which we trust the physician as our agent to look out for our best interests because we are unable to do so effectively.[469]

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[469] Furrow, *supra* note 361, at 446–47. Professor Furrow goes on to note:

> Hans Jonas describes this duty owed by the physician to a patient as a "sacred trust," an intense obligation to ignore social and other concerns which interfere with the care of the specific patient:
>
> "In the course of treatment, the physician is obligated to the patient and to no one else. He is not the agent of society, nor of the interests of medical science, nor of the patient's family, nor of his co-sufferers, or future sufferers from the same disease. The patient alone counts when he is under the physician's care. . . . [T]he physician is bound not to let any other interest interfere with that of the patient in being cured. But, manifestly, more sublime norms than contractual ones are involved. We may speak of a sacred trust; strictly by its terms, the doctor is, as it were, alone with his patient and God."

*Id.* at 447 n.27 (quoting Hans Jonas, *Philosophical Reflections on Experimenting with Human Subjects*, PHILOSOPHICAL ESSAYS: FROM CURRENT CREED TO TECHNOLOGICAL MAN 105, 124 (1980)).

According to Professor Maxwell J. Mehlman, "the first time that a legal opinion used the term 'fiduciary' to describe a physician was an American case in 1848."[470] This was one year after "the AMA was formed and adopted its first Code of Ethics," giving rise to "a new conceptualization of the physician: as a professional."[471] Essentially, then, to be a professional came to mean acting at all times as a fiduciary for one's patients.[472]

Much later, in 1956, a California Court of Appeals directly "declared that '[t]he doctor-patient relationship is a fiduciary one.'"[473] Since then,

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[470] Maxwell J. Mehlman, *Why Physicians are Fiduciaries for Their Patients*, 12 IND. HEALTH L. REV. 1, 60 (2015).

[471] *Id*. at 59. Professor Mehlman goes on to explain:

> The Code sought to dispel the popular perception that physicians were interested primarily in their own welfare. "The central moral commitment of the Code," states Edmund Pellegrino, "was its dedication to something other than the physician's self-interest, that something being the primacy of the welfare of the patient. This was a necessary reaffirmation given the self-serving conduct of the physician at this time." Although the Code did not use the term "fiduciary" to describe the patient-physician relationship, there was no mistaking its emphasis: the first section states that "physicians should . . . minister to the sick with due impressions of the importance of their office; reflecting that the ease, the health, and the lives of those committed to their charge, depend on their skill, attention and fidelity." As a result of its embrace of professionalism, by the second decade of the twentieth century, the medical profession in the United States had become the most powerful profession in the country. The AMA controlled medical education and licensure. Physicians had become highly respected and their earnings began to increase.

*Id*. at 59–60.

[472] *See id*. at 61.

[473] Thomas L. Hafemeister & Richard M. Gulbrandsen, Jr., *The Fiduciary Obligation of Physicians to "Just Say No" if an "Informed" Patient Demands Services that are not Medically Indicated*, 39 SETON HALL L. REV. 335, 369 (2009) (quoting Wohlgemuth v. Meyer, 293 P.2d 816, 820 (Cal. Ct. App. 1956) ("[I]t is incumbent on the doctor to reveal all pertinent information to his patient.")). Further noting:

> The recognition of a fiduciary relationship between physicians and patients can be further traced back to at least 1931 when the Minnesota Supreme Court specifically noted that a fiduciary relationship exists between physicians and patients. Schmucking v. Mayo, 235 N.W. 633, 633 (Minn. 1931). In support of this proposition, the court cited Groendal—a ruling from 1912 by the Michigan Supreme Court. Groendal v. Westrate, 137 N.W. 87, 96 (Mich. 1912) ("[T]he relation of physician and patient, which, of itself, begets confidence and reliance on the part of the patient.").

(*continued*)

many other courts also have found that the "intrinsic nature of the physician-patient relationship" gives rise to fiduciary duties.[474] That relationship is acknowledged to generally include all three requirements for recognition of fiduciary duty: "(1) the vulnerability of patients and their dependence on physicians for their medical care, (2) the considerable and superior knowledge and related skills of physicians, and (3) the trust that patients and society imbue in physicians to protect and promote their patients' best interests."[475]

In recent years, however, an issue of growing concern is the stress that newer forms of health care delivery—and particularly the financing thereof—are putting on physicians' traditional fiduciary responsibilities. That is, as health care has increasingly moved away from fee-for-service reimbursement of independent physicians and toward ever-more "integrated" or "managed" types of delivery systems utilizing various

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*Id.* at 369 n.171.

[474] *Id.* (citing Lambert v. Park, 597 F.2d 236, 239 n.7 (10th Cir. 1979) ("The duty of the doctor to inform the patient is in the nature of a fiduciary duty."); Canterbury v. Spence, 464 F.2d 772, 782 (D.C. Cir. 1972) ("[W]e ourselves have found in the 'fiducial qualities of [the physician-patient] relationship the physician's duty to reveal to the patient that which in his best interests it is important that he should know.'") (internal citations omitted); Salis v. United States, 522 F.Supp. 989, 997 n.10 (M.D. Pa. 1981) (finding that the doctrine of informed consent is based partially on the fiduciary relationship between physician and patient); Hammonds v. Aetna Cas. & Sur. Co., 237 F.Supp. 96, 102 (N.D. Ohio 1965) ("It is axiomatic that the physician-patient relationship is a fiduciary one."); Mull v. String, 448 So.2d 952, 953 (Ala. 1984) ("Alabama recognizes [a] cause[] of action for breach of fiduciary duty . . . resulting from a physician's unauthorized disclosure of information acquired during the physician-patient relationship."); Cobbs v. Grant, 502 P.2d 1, 12 (Cal. 1972) ("Any defense . . . must be consistent with . . . the 'fiducial' qualities of the physician-patient relationship.") (internal citation omitted); Berkey v. Anderson, 1 Cal. App.3d 790, 804 (Cal. Ct. App. 1969) ("The relationship between a physician and his patient is fiduciary, which, like all such relationships, imposes a duty of full disclosure."); Wohlgemuth v. Meyer, 293 P.2d 816, 820 (Dist. Ct. App. 1956) ("The doctor-patient relationship is a fiduciary one . . . ."); Petrillo v. Syntex Laboratories, 499 N.E.2d 952, 960–61 (Ill. App. Ct. 1986) ("The fiducial nature of the physician-patient relationship flows not from the physician's ethical duties, but rather as a result of the physician's unique role in society. Like the confidentiality of the physician-patient relationship, we believe that our society has an established and beneficial interest in the fiduciary quality of the physician-patient relationship."); Woolley v. Henderson, 418 A.2d 1123, 1128 n.3 (Me. 1980) ("The historical underpinnings of the doctrine of informed consent are frequently attributed to the fiduciary character of the physician-patient relationship."); Borderlon v. Peck, 661 S.W.2d 907, 908 (Tex. 1983) ("[T]he physician-patient relationship is one of trust and confidence . . . ."); Nixdorf v. Hicken, 612 P.2d 348, 354 (Utah 1980) (noting the "fiduciary nature of the physician-patient relationship")).

[475] *Id.* at 370 (citing Marc A. Rodwin, *Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System*, 21 AM. J. L. & MED. 241, 245–46 (1995)).

forms of "global reimbursement," such innovations "have drastically changed the physician's role."[476] As commentator Gregory D. Jones observes:

> Traditionally, the conflict between health care consumption and cost has been between the patient and her insurer, with doctors generally acting as patient advocates. In contrast, managed health care has reversed the incentives, replacing the tendency for overutilization with economic incentives to physicians to provide less care to patients. Under managed care, physicians cannot escape the potential for conflicts of interest, financial arrangements, and incentives to limit the provision of medical services.[477]

### 2. *The Evolving Fiduciary Obligations of Institutional Healthcare Providers*

Among the most significant changes in health care delivery over the last several years is the shift from care being provided solely within the context of an isolated doctor-patient dyad—the "Marcus Welby" model—to care being provided systematically by and through an integrated team of

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[476] *See* Gregory D. Jones, *Primum Non Nocere: The Expanding "Honest Services" Mail Fraud Statute and the Physician-Patient Fiduciary Relationship*, 51 VAND. L. REV. 139, 166–69 (1998).

[477] *Id.* at 169 (noting that: "The change in health care delivery has produced an abundance of legal literature concerning the ethical and malpractice implications of cost containment and whether the existing legal and ethical duties of physicians can accommodate the new reimbursement systems." (citing *generally* Randall Bovbjerg, *The Medical Malpractice Standard of Care: HMOs and Customary Practice,* 1975 DUKE L.J. 1375 (discussing the application of malpractice law to HMO care))). *See also* Barry R. Furrow, *The Ethics of Cost Containment: Bureaucratic Medicine and the Doctor as Patient-Advocate,* 3 NOTRE DAME J. L. ETHICS & PUB. POL'Y 187 (1988) (suggesting that pressures to control costs are not always counter to the patient's best interests); Barry R. Furrow, *Medical Malpractice and Cost Containment: Tightening the Screws,* 36 CASE W. RES. L. REV. 985, 1032 (1986) (stating that ethicists look too narrowly at the dilemmas of choice confronting doctors); Mark A. Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment,* 137 U. PA. L. Rev. 431, 448–49 (1988) (discussing whether a strong degree of professional autonomy is necessary to ensure the quality of health care); Marshall B. Kapp, *Legal and Ethical Implications of Health Care Reimbursement by Diagnosis Related Groups,* 12 L. MED. & HEALTH CARE 245, 252 (1984) ("[L]egal and ethical principles must play a vital role in working out a balance with which we can all live."); Frank H. Marsh, *Health Care Cost Containment and the Duty to Treat,* 6 J. LEGAL MED. 157, 190 (1985) (stating that the changing health care scene will ultimately affect medicine as an institution).

medical and other health care professionals that is either institutionally-based or institutionally-coordinated.[478] In keeping with this change, hospitals increasingly have evolved from the traditional "physician workshop" model—with a quasi-independent, self-governing medical staff of individually-practicing physicians—into an "Integrated Delivery Network (IDN)" model that recognizes hospitals' "independent duties to patients and responsibility for the quality of care that occurs within their walls."[479] Professor Robert Gatter describes the evolution well:

> In the second half of the twentieth century, hospitals evolved from being merely the places where complex care took place to being the systems that managed that complexity. Modern hospitals maintain various kinds of facilities and services designed to centralize the care of acutely ill patients, including operating rooms, intensive care units, radiological services, laboratory services, and pharmacies. Likewise, they bring together highly skilled personnel at all levels of expertise (*e.g.*, physicians, nurses, and technicians) across a variety of generalized, specialized, and sub-specialized fields of medicine. Most importantly, hospitals implement systems to coordinate personnel and resources for the purposes of providing complete and high quality medical care to each of their patients. As one court put it, "[t]he corporate hospital of today has assumed the role of a comprehensive health

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[478] Susan M. Wolf, *Toward a Systemic Theory of Informed Consent in Managed Care*, 35 HOUS. L. REV. 1631, 1681 (1999).

> As Elliott Fisher and his colleagues observe, the U.S. health care system's focus on individual providers
> ". . . reflects the historical development, oversight mechanisms, and payment systems that prevail in the U.S. health care system and the interest of providers to be held accountable only for care that is within their direct control. The limitations of this approach are increasingly apparent. The provision of high quality care for any serious illness requires coordinated, longitudinal care and the engagement of multiple professionals across different institutional settings. Also, many of the most serious gaps in quality can be attributed to poor coordination and faulty transitions."

Laura D. Hermer, *Aligning Incentives in Accountable Care Organizations: The Role of Medical Malpractice Reform*, 17 J. HEALTH CARE L. & POL'Y 271, 285 (2014) (citing Fisher et al., *supra* note 397, at w44–45).

[479] Blumstein, *supra* note 264, at 212–13.

> center with responsibility for arranging and coordinating the total health care of its patients."[480]

Such growing complexity in the role of hospitals today also has resulted in their development of "independent institutional interests," such as managing "within economic parameters" and taking into account the need for "quality assurance, marketing and patient flow, and cost containment."[481] This new reality has further called "into question the tight regulatory vision of the hospital, with a separate medical staff with its own bylaws and, in some jurisdictions, independent legal status."[482] That said, "it is no longer desirable or probably even viable for medical practice within a hospital to remain outside the economics of the hospital or outside the authority structure of the management of the hospital."[483]

*With the "recognition that health care now is delivered in [such] large organizational contexts" comes the corresponding need to acknowledge that the same characteristics of trust, reliance, and dependence that have historically characterized and defined the fiduciary relationship between patients and their individual physicians now applies equally to the relationship between patients and hospitals as "institutional delivery-of-care providers*."[484] As Professor Gatter again observes:

> As hospitals have taken on responsibilities to organize the delivery of health care to their patients, they enter into fiduciary relationships with each of their patients as well, which are defined by the hospital's obligation to protect

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[480] Robert Gatter, *The Mysterious Survival of the Policy Against Informed Consent Liability for Hospitals*, 81 NOTRE DAME L. REV. 1203, 1253–54 (2006) (citing Thompson v. Nason Hosp., 591 A.2d 703, 706 (Pa. 1991) (hospital owes each patient a duty "to ensure the patient's safety and well-being while at the hospital.")). Professor Gatter notes:

> Rosemary Stevens, in her history of twentieth-century U.S. hospitals, traces this change to the 1930s when medical care became more technological and thus more hospital-based. Because of the growth in technological complexity of care, the hospital took on an independent institutional life, changing from the individual physician's "workshop" to "a technological system in its own right."

*Id.* at 1253 n.233 (citing ROSEMARY STEVENS, IN SICKNESS AND IN WEALTH 172–81 (John Hopkins Univ. Press, rev. ed. 1999) (1979)).

[481] Blumstein, *supra* note 264, at 213.

[482] *Id.*

[483] *Id.* at 224 (citing Mark A. Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431, 444 (1988)).

[484] *See* Wolf, *supra* note 478, at 1648–49 (emphasis added).

> the well-being of patients under their care.[485] In fact, given that hospital-based treatment for a particular patient is often provided by several physicians and many nurses and technicians, and that it is coordinated through various labs and departments, *it is best to conceive of the patient's having entered into one relationship with the hospital and attending physician as cofiduciaries, who together are responsible for the coordinated care of the patient*.[486]

To view hospitals (and other such institutional delivery-of-care providers) as having fiduciary obligations to their patients co-equal to those of physicians is further justified by contemporary patient expectations that

[485] Gatter, *supra* note 480, at 1268–69 (citing Cooper v. Curry, 589 P.2d 201, 207 (N.M. Ct. App. 1978) (Sutin, J., dissenting) ("A fiduciary relationship exists between hospital-patient and physician-patient.")).

[486] *Id.* at 1268–69 (citing Frank A. Chervenak & Laurence B. McCullough, *Physicians and Hospital Managers as Cofiduciaries of Patients: Rhetoric or Reality?*, 48 J. HEALTHCARE MGMT. 172, 176 (2003)) (emphasis added). This is hardly a new idea. As long ago as 1965, in the landmark decision of the Illinois Supreme Court in *Darling v. Charleston Community Memorial Hospital*, hospitals were recognized to owe a number of duties directly to patients. As the Court there said:

> "The conception that the hospital does not undertake to treat the patient, does not undertake to act through its doctors and nurses, but undertakes instead simply to procure them to act upon their own responsibility, no longer reflects the fact. Present-day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment . . . . Certainly, the person who avails himself of 'hospital facilities' expects that the hospital will attempt to cure him, not that its nurses or other employees will act on their own responsibility." The Standards for Hospital Accreditation, the state licensing regulations and the defendant's bylaws demonstrate that the medical profession and other responsible authorities regard it as both desirable and feasible that a hospital assume certain responsibilities for the care of the patient.

Hafemeister & Porter, *supra* note 336, at 541 (citing Darling v. Charleston Cmty. Mem'l Hosp., 211 N.E.2d 253, 257 (Ill. 1965)). Since that time,

> these non-delegable duties of the hospital have tended to coalesce into the following: "(1) a duty to use reasonable care in the maintenance of safe and adequate facilities and equipment;" "(2) a duty to select and retain only competent physicians;" "(3) a duty to oversee all persons who practice medicine within its walls as to patient care;" and "(4) a duty to formulate, adopt and enforce adequate rules and policies to ensure quality care for the patients."

*Id.* at 542–43 (internal citations omitted).

such organizations will "care for them"—an expectation that such organizations "do little to dispel."[487]

Professor Furrow summarizes the fiduciary obligations of modern institutional delivery-of-care providers this way:

> These three attributes—specialized knowledge, power, and loyalty—describe a large sphere we cede to the fiduciary over important beneficiary interests. *I want to expand this analysis of fiduciary duty into a tripartite perspective on fiduciary duty in the health care setting*. Power remains one of the core attributes, properly focused on the centrality of special knowledge and access to special tools, resources, and experience; loyalty is a second, focused on the importance of reducing disloyalty through minimizing conflicts of interest in the health care relationship; and the third is stewardship, by which I mean the commitment of a provider to good management of complex assets and services. *Stewardship captures the world of institutional practices and complex systems and moves fiduciary law into modern health care delivery.*
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> *This stewardship prong of a health care fiduciary duty recognizes the situational risks of the health care setting*, which poses a different problem from conflict of interest reduction. The fiduciary has to protect the beneficiary patient against external risks to her health, privacy interests, and safety. These risks might include hospital-based infections, medical errors during procedures, leakage of confidential patient information, physical harm from assaultive employees, and other third-party sources of injury. Patients as beneficiaries are especially vulnerable to these external risks of harm. *To what extent then can patients rely on the hospital to act as a fiduciary to protect them from these external risks*?[488]

He goes on to discuss the fact that ethicists, courts, and academics have all argued in favor of viewing modern hospitals as "*fiduciary*

[487] Hafemeister & Porter, *supra* note 336, at 568. "Direct advertising by hospitals to prospective patients emphasizing that they are a comprehensive service provider has increased in recent years. . . . Such advertisements frequently use language implying that the hospital is the treatment provider." *Id.* at 568 n.225.

[488] Furrow, *supra* note 361, at 443–44 (emphasis added).

*enterprises*."[489] He quotes medical ethicist Laurence B. McCullough for the proposition that *hospitals are co-fiduciaries*: "Healthcare organizations that deliver or influence the delivery of healthcare are co-fiduciaries with healthcare professionals of the population [of] patients for whom the organization is responsible, so that each receives an evidence-based standard of care."[490] Furrow then cites three excerpts from court cases that are illustrative of the same idea:

> • "The doctor-patient relationship is a fiduciary one and it is incumbent on the doctor to reveal all pertinent information to his patient. The same is true of the hospital-patient relationship."[491]
>
> • "[C]ourts should not be loathe to intervene when there has been a clear violation of the hospital's fiduciary duty to provide proper and adequate facilities for patient care . . . ."[492]
>
> • "[I]t seems axiomatic that the hospital has the duty not to institute policies or practices which interfere with the doctor's medical judgment."[493]

Lastly, Professor Furrow notes that "[a]cademic writing has also argued that such a fiduciary duty can be placed on hospitals."[494] From all

[489] *See id.* at 459–64 (emphasis added).

[490] *Id.* at 460 (quoting LAURENCE B. MCCULLOUGH, A PRIMER ON BIOTHEICS 4 (2d ed. 2006), *available at* http://net.acpe.org/InterAct/Ethics/BioethicsPrimer.pdf).

[491] *Id.* at 461 (quoting Wohlgemuth v. Meyer, 293 P.2d 816, 820 (Cal. Dist. Ct. App. 1956)).

[492] *Id.* at 462 (quoting Grodjesk v. Jersey City Med. Ctr., 343 A.2d 489, 500 (N.J. Super. Ct. 1975)).

[493] *Id.* at 463. In *Muse*, the Court ruled that "pursuant to the reasonable person standard, Charter Hospital had a duty not to institute a policy or practice which required that patients be discharged when their insurance expired and which interfered with the medical judgment of Dr. Barnhill." *Id.* (citing Muse v. Charter Hosp. of Winston-Salem, Inc., 452 S.E.2d 589, 594 (N.C. Ct. App. 1995), *aff'd* 464 S.E.2d 44 (N.C. 1995)). Professor Furrow explains that in this case, "the hospital [was] therefore positioned by the court as a co-fiduciary, in McCullough's sense, obligated to protect one of its patients by respecting its own staff physician's assessment of risk for a high-risk patient." *Id.*

[494] *Id.* at 461. Noting that:

> Academic commentators have also argued, or perhaps just assumed, that hospitals are fiduciaries, in special circumstances. *See, e.g.*, Robert Gatter, *The Mysterious Survival of the Policy Against Informed Consent Liability for Hospitals*, 81 NOTRE DAME L. REV. 1203, 1268–70 (2006) ("As hospitals have taken on responsibilities to organize the delivery of health care to their patients, they enter into fiduciary relationships with

(*continued*)

of this, he concludes that "[t]he recognition of institutional responsibility to better handle informed consent, disclosure of data, and revelation of errors turns the hospital finally into a recognizable legal fiduciary with an obligation to protect its patients from harm from third parties"—which, in turn, "properly imposes on hospital managers a higher duty to protect their patients, their beneficiaries, from harm to the greatest extent possible."[495]

In 2007, "a joint publication of the United States Department of Health and Human Services Office of Inspector General ('OIG') and the American Health Lawyers Association ('AHLA'), authored by, *inter alia*, Lewis Morris, Chief Counsel to the OIG," emphasized "governing body accountability for improving patient safety:"[496]

> With a new era of focus on quality and patient safety rapidly emerging, *oversight of quality also is becoming more clearly recognized as a core fiduciary responsibility of health care organization directors.* Health care organization boards have distinct responsibilities in this area because promoting quality of care and preserving patient safety are at the core of the health care industry and the reputation of each health care organization.[497]

Subsequently, the same Lewis Morris testified before a U.S. House Subcommittee on May 15, 2008 that "since at least 2003, the OIG has been working to raise awareness and provide educational resources for *hospital board members regarding their direct legal and fiduciary accountability for the quality and safety of the care delivered*."[498] Mr. Morris went on to note that "[w]ith a new focus on quality and patient safety, *oversight of*

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> each of their patients as well."); Maxwell Mehlman, *Fiduciary Contracting: Limitations on Bargaining Between Patients and Health Care Providers*, 51 U. PITT. L. REV. 365, 366 (1990) ("Hospitals, as health care providers, must also fulfill the obligations imposed by their fiduciary relationship with their patients."). Some commentators also characterize health insurers as fiduciaries for certain purposes. *See, e.g.*, Clifford A. Cantor, *Fiduciary Liability in Emerging Health Care*, 9 DEPAUL BUS. L.J. 189, 212 (1997); Peter D. Jacobson & Michael T. Cahill, *Applying Fiduciary Responsibilities in the Managed Care Context*, 26 AM. J.L. & MED. 155, 157 (2000).

*Id.* at 461 n.87.

[495] *Id.* at 483–84.

[496] *See* Brian M. Peters & Robin Locke Nagele, *Promoting Quality Care & Patient Safety: The Case for Abandoning the Joint Commission's "Self-Governing" Medical Staff Paradigm*, 14 MICH. ST. U. J. MED. & L. 313, 357 (2010) (emphasis in original).

[497] *Id.* (emphasis added) (emphasis in original).

[498] *Id.* at 358 (emphasis added).

*quality is a core fiduciary responsibility of health care organization boards of directors*."[499]

*a. The "Fiduciary Medicine Model"*

As we noted in our initial article, "*[a]ccountability* is 'an obligation or willingness to accept responsibility or to account for one's actions.'"[500] Moreover, "*[f]iduciary law*, embodied in common law duties, statutory standards, and equitable principles, *is the primary legal mechanism for assuring accountability in American corporations*."[501] Inasmuch as institutional delivery-of-care providers—most of whom adopt the corporate form of organization—have come to be increasingly recognized as having fiduciary duties to the patients they serve, it should come as no surprise that *"accountability" has become a central tenet of health care reform*. In fact, the concept is "imbedded in one of the principal proposed reform mechanisms, the 'Accountable Care Organization.' Indeed, the very name suggests that this new, integrated, coordinated-care organization itself has a fiduciary obligation to the patients it serves . . . ."[502] To quote Professor Marc A. Rodwin: "Public policy and market forces are creating pressures for greater physician and provider accountability. And accountability is the core of the fiduciary ideal."[503] "This, then, is the essence of the '*Fiduciary Medicine Model*' proposed by Dayna B. Matthew, Vice Dean and Professor of Law at the University of Colorado Law School."[504]

In the Introduction to her seminal 2011 article,[505] Professor Matthew argues:

> *the legal and ethical foundations of fiduciary law—primarily of agency theory—provide an organizational model for describing this nation's emerging health care system and supply the legal framework for analyzing the inevitable challenges to the ACA's implementation*. Existing contract and tort law rules governing health care

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[499] *Id*. (emphasis added) (internal quotations omitted).

[500] Corbett, *supra* note 3, at 176 (citing MERRIAM-WEBSTER ONLINE DICTIONARY, *Accountability*, http://www.meriamwebster.com/dictionary/accountability?show=0&t=1385478126 [https://perma.cc/B7V4-2SK3]) (emphasis added).

[501] *Id.* (citing Freaney & Boozang, *supra* note 72, at 33) (emphasis in original).

[502] *Id*. at 177.

[503] Rodwin, *supra* note 453, at 255.

[504] Corbett, *supra* note 3, at 177 (emphasis added).

[505] *See* Dayna Bowen Matthew, *Implementing American Health Care Reform: The Fiduciary Imperative*, 59 BUFF. L. REV 715 (2011).

> entities will not suffice. For example, the laws that previously prohibited the corporate practice of medicine or required clinical integration to approve provider networks will have to be re-thought. *This Article argues that a refined look at the fiduciary law already governing some aspects of medical relationships provides an over-arching legal paradigm for analyzing, approving, or correcting steps taken to implement the ACA.* The contribution this Article makes is to present a body of legal principles that I call the "*fiduciary medicine model*." This model is the legal paradigm that can best guide legislators, regulators, courts, and the health care industry in implementing and achieving the goals of the ACA. The importance of this contribution is that without such a model, the implementation of America's health reform could fall far short of Congress's ambitious goal—to universalize access to health care, while simultaneously reshaping both the private and public markets that finance health care and the organizational entities that deliver and control the quality of health care in America.[506]

Matthew's basic idea "is to extend those fiduciary obligations (*i.e.*, good faith, loyalty, and due care) that are already well-established in the profession of medicine 'to all major participants in the health care industry' who are involved in the direct delivery of health care services to patients."[507] As we summarized in our initial article: "Such extension is justified by the changes in health care delivery brought about by the development of the 'medical industrial complex' and the reality of 'new, larger, and more interdependent actors in that medical complex,' increasingly engaged in 'group-based decision-making' under the new imperatives of the ACA."[508] Professor Matthew puts it this way:

> For at least twenty-five years, legal scholars have sought to expand the influence of fiduciary law to regulate health care relationships. Until now, the direction and reasons for that expansion have only been discussed in a piecemeal fashion, to address a discrete doctrinal deficiency in the individual physician-patient relationship. A systematic review of the legal scholarship on fiduciary

[506] *Id.* at 718 (emphasis added).
[507] Corbett, *supra* note 3, at 177 (citing Matthew, *supra* note 505, at 718, 761).
[508] *Id.* at 177–78 (citing Matthew *supra* note 505, at 742–43).

> law and its application to health care reveals an unexpected consensus. Legal scholars have collectively identified two significant defects in the current applications of the doctrine. *First, the current fiduciary law focuses too narrowly on selected obligations that flow between provider and patient, ignoring the larger systemic duties that are squarely within the influence and discretion of medical providers and vitally important to expanding access to health care*. *Second, the application of fiduciary law to medicine has not been updated to reflect the complexity of modern health care delivery systems that now exist in the United States, thus limiting the reach of the law's influence and excluding other actors in the network of relationships that comprise health care delivery today*. This second omission will be compounded as health care reform implementation adds new health care entities to the health care market.[509]

Professor Matthew's analysis

> acknowledges that all providers in American health care are not individual physicians. Indeed, the fiduciary model ably accommodates the variety of institutional providers, some of which deliver health care in the managed care setting. Managed care organizations, health plans, and even the new ACOs created by the ACA can deliver health

[509] Matthew, *supra* note 505, at 734–35 (emphasis added). Professor Matthew goes on to note:

> *[T]he authority to control costs, quality, and access to health care has shifted away from individual physicians and towards organizations*. . . .
>
> In order to serve these . . . radical changes in America's new health care landscape, the current fiduciary rules must first correctly identify the stakeholders who exercise fiduciary decisional discretion, then establish the most appropriate body of fiduciary law to apply to each stakeholder, and finally define an internally consistent paradigm for applying these fiduciary rules to the majority of health care relationships that will be appear under the ACA's implementation. . . .
>
> Simply put, any fiduciary law model that does not allow for divided loyalty by providers who care for patients, but are paid by their third party insurers, has no application whatsoever to modern health care delivery in America.

*Id*. at 743, 744, 752 (emphasis added).

> care through a single entity that delivers and finances medical care. *Especially in light of the new organizational landscape created by the ACA, the fiduciary care model must address the legal rules that govern providers well beyond the paradigmatic physician. The model must address provider organizations and networks that both deliver and finance health care services because these providers are fiduciaries* . . . .[510]

It should be said that the above discussion—while sufficient for our purposes—only highlights a few of the most relevant points from Professor Matthew's comprehensive exposition of the "fiduciary medicine model." In addition to a full and nuanced elaboration of the model's underlying concepts, she also puts forth a fully-developed proposal for a model statute she denominates "the Prudent Provider Rule," which "could be used by states to codify the fiduciary medicine model."[511]

### *C. The Singular Importance of "Trust" in Health Care*

Finally, and appropriately, we turn specifically to a discussion of the importance of "trust" in health care delivery. Much already has been said about trust as an essential, qualifying characteristic of the fiduciary relationship between patient and health care provider. As previously noted, Philosopher and Professor Hans Jonas has gone so far as to say: "We may speak of a sacred trust; strictly by its terms, the doctor is, as it were, alone with his patient and God."[512] Indeed, Professor Richard W. Bourne has opined:

> The primary reasons for extending fiduciary duties to healthcare providers are the inequality of power between doctor and patient and the need for such implicit trust that the patient need not spend her time examining whether her doctor is acting in her best interest. . . .
>
> [A] trust that goes to the heart of the therapeutic nature of the doctor-patient relationship.[513]

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[510] *Id.* at 758–59 (emphasis added).

[511] *See id*. at 800–05. We highly reccoment Professor Matthew's full article to the reader interested in further well-conceived detail.

[512] Furrow, *supra* note 358, at 447 n.27 (citing Jonas, *supra* note 469, at 124).

[513] Richard W. Bourne, *Medical Malpractice: Should Courts Force Doctors to Confess Their Own Negligence to Their Patients?*, 61 ARK. L. REV. 621, 643, 658 (2009).

Professor Gatter, who has maintained an ongoing academic colloquy with Professor Mark A. Hall on the subject, well summarizes the nature of medical trust:

> Trust is characterized by the vulnerability of one to the discretionary care of another; trust occurs when one believes that someone to whom she has consigned her interests will protect and serve those interests.[514] Trust in medicine, then, results when a patient, already vulnerable as a result of an illness or injury, chooses to make herself more vulnerable by placing her health interests *in the hands of health professionals and health care institutions* in the belief that they will help her achieve improved health.
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> Trust has long been recognized as playing an integral role in medicine, but a renewed interest in medical trust

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[514] Gatter, *supra* note 480, at 1260 (citing Robert Gatter, *Walking the Talk of Trust in Human Subjects Research: The Challenge of Regulating Financial Conflicts of Interest*, 52 EMORY L.J. 327, 358 (2003); Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463, 474 (2002) (describing trust as having "an optimistic attitude towards one's vulnerability" while in the care of another)).

For additional literature relating to trust in modern medicine, *see* Bradford H. Gray, *Trust and Trustworthy Care in the Managed Care Era*, HEALTH AFF. JAN.–FEB. 1997, *at* 37; Mark A. Hall, *Arrow on Trust*, 26 J. HEALTH POL. POL'Y & L. 1131 (2001); David Mechanic, *Changing Medical Organization and the Erosion of Trust*, 74 MILBANK Q. 171 (1996); David Mechanic, *The Functions and Limitations of Trust in the Provision of Medical Care,* 23 J. HEALTH POL. POL'Y & L. 661 (1998); David Mechanic & Mark Schlesinger, *The Impact of Managed Care on Patients' Trust in Medical Care and Their Physicians*, 275 JAMA 1693 (1996); David Mechanic, *Public Trust and Initiatives for New Health Care Partnerships*, 76 MILBANK Q. 281 (1998); Stephen D. Pearson & Lisa H. Raeke, *Patients Trust in Physicians: Many Theories, Few Measures, and Little Data*, 15 J. GEN. INTERNAL MED. 509 (2000).

For empirical studies relating to trust in medicine, *see* Lynda A. Anderson & Robert F. Dedrick, *Development of the Trust in Physician Scale: A Measure To Assess Interpersonal Trust in Patient-Physician Relationships*, 67 PSYCHOL. REP. 1091 (1990); Mark A. Hall et al., *Measuring Patients' Trust in Their Primary Care Providers*, 59 MED. CARE RES. & REV. 293 (2002); Mark A. Hall et al., *Trust in the Medical Profession: Conceptual and Measurement Issues*, 37 HEALTH SERV. RES. 1419 (2002); Audiey C. Kao et al., *Patients' Trust in Their Physicians: Effects of Choice, Continuity, and Payment Method*, 13 J. GEN. INTERNAL MED. 681 (1998); Audiey C. Kao et al., *The Relationship Between Method of Physician Payment and Patient Trust*, 280 JAMA 1708 (1998); David H. Thom et al., *Further Validation and Reliability Testing of the Trust in Physician Scale*, 37 MED. CARE 510 (1999); Beiyao Zheng et al., *Development of a Scale To Measure Patients' Trust in Health Insurers*, 37 HEALTH SERV. RES. 187 (2002)).

> has deepened our understanding of it.[515] Most important to the inquiry here is that trust in medicine includes different objects of trust. In other words, trust in medicine is not merely a function of trust in physicians. *Instead, there are several objects of trust in medicine, including hospitals*.[516] *Additionally, there are different kinds of trust: interpersonal trust, which generally is based on personal experience, and systemic trust, which is based on perceptions of institutions and structures designed to support those institutions*. . . .[517]

Studies confirm that medical trust correlates positively with a number of specific patient behaviors: seeking medical care when needed; compliance with treatment plans; positive clinical outcomes; less questioning of their physicians' judgments and seeking of second opinions; and, fewer disputes (and litigation) with providers over bad outcomes.[518]

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[515] Gatter*, supra* note 480, at 1261 (citing Robert Gatter, *Faith, Confidence, and Health Care: Fostering Trust in Medicine Through law*, 39 WAKE FOREST L. REV. 395, 398–405 (2004) (identifying and explaining an emerging medical trust movement and conclusions that have resulted from empirical study of trust in medicine)).

[516] *Id.* (citing Mark A. Hall et al., *Trust in Physicians and Medical Institutions: What is it, Can it be Measured, and Does it Matter?*, 79 MILBANK Q. 613, 619–20 (2001); Thomas A. LaVeist et al., *Attitudes About Racism, Medical Mistrust, and Satisfaction with Care Among African American and White Cardiac Patients*, 57 MED. CARE RES. & REV. 146 (2000)) (emphasis added).

[517] *Id.* at 1260–61 (citing Hall, *supra* note 516, at 619–20 (The interpersonal/systemic trust distinction commonly overlaps with distinctions among the objects of trust, with interpersonal trust directed at particular hospitals or physicians and systemic trust directed at broader categories such as the medical profession or hospitals in general)) (emphasis added).

[518] *See id.* at 1263. Professor Bourne has noted that there is:

> substantial evidence that distrust aroused by physicians' failure to communicate with patients is one of the major reasons patients bring malpractice litigation against their healthcare providers. Study after study has indicated that patients who choose to sue for medical malpractice do so because they believe doctors are hiding something from them. . . . This means that "there is a link between malpractice actions and patient trust, in that patients are more inclined to attempt to detect and remedy poor outcomes if they distrust their physicians, [and] the widely noted increase in the severity of malpractice actions . . . support[s] the proposition."

Bourne*, supra* note 513, at 633–34 (citing Maxwell J. Mehlman, *The Patient-Physician Relationship in an Era of Scarce Resources: Is There A Duty to Treat?*, 25 CONN. L. REV. 349, 375 (1993)).

"There is also speculation that medical trust triggers the placebo effect and other mechanisms of healing that cannot be explained scientifically."[519] Further, the AMA Code of Medical Ethics unequivocally states that: "the relationship between patient and physician is based on trust and gives rise to physicians' ethical obligations to place patients' welfare above their own self-interest and above obligations to other groups, and to advocate for their patients' welfare."[520] For all of these reasons, Professor Gatter suggests that "we may be witnessing the emergence of a new medical trust movement in health care management and health policy."[521] Nonetheless, he observes that "[c]orporatization in health care arguably threatens trust in medicine . . . because it pits the financial interests of providers against the medical interests of patients. . . . [This] causes individuals 'to question the motives and decisions of these [corporate] organizers and providers of care.'"[522]

We will end this entire discussion of the need for mission primacy, fiduciary duty, and trust in institutional health care delivery with the following observations of Professor Furrow:

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[519] Gatter, *supra* note 480, at 1263.

[520] Barbara J. Zabawa et al., *Adopting Accountable Care Through the Medicare Framework*, 42 SETON HALL L. REV. 1471, 1489 n.137 (2012).

[521] Gatter, *Faith, Confidence, and Healthcare*, *supra* note 515, at 404.

[522] *Id*. at 410 (citing Mechanic, *supra* note 514, at 171–73 (stating trust is necessary to health care delivery and cannot be replaced by aggressive medical consumerism)). Professor Timothy S. Hall argues:

> Trust requires that the patient believe that "her health is the primary concern of the health care professional caring for her." However, managed care financial incentives threaten to raise issues of cost containment or limitation of care to a level equal to or higher than the health of the individual patient in an individual clinical encounter. Although traditional statements of physician ethics clearly place the patient at the center of the physician's ethical obligations, we cannot rely solely on aspirational ethical goals to regulate the physician-patient relationship in managed care. Although many commentators state that the physician's ethical duty is to avoid or reject unacceptable managed care contract terms, the vulnerability of individual physicians to the market power of managed care organizations makes it untenable to expect physicians to refuse to participate on less than ethical terms, at great personal loss to themselves. The recognition of the physician's duty to refuse unethical contract terms implies that consent is insufficient to cure certain conflicts; that there are conflicts that raise sufficient doubt about the physician-patient relationship, and that the better course of action is to avoid the conflict altogether, by prohibition if need be.

Hall, *supra* note 272, at 729 (internal citations omitted).

> *Is trust the core value of health care fiduciary law?* Preserving, justifying, and enhancing trust is the fundamental goal of much of medical ethics and a major objective in health care law and public policy. Mark Hall has argued that in the health care setting, trust must be a central goal. He constructs a patient driven instrumental view of trust as underpinning the stability of the health care system. We do not completely trust our doctors because of situational pressures that may at times corrupt or at least tempt them. Doctors work for economic and other gains, as we all do; they are weak at times, prey to needs and pressures not aligned with those of their patients; they are under tremendous pressures from patients, insurers, their own needs, other doctors, and drug companies; and they work in complex systems. Conflicts of interest run through the physician-patient relationship, and as a result physicians may not always be loyal solely to patients and patient interests.
>
> Is trust the key, however? *Is the law's goal to create trust, or to promote fair dealing and excellence in practice?* Trust by the beneficiary is an important aspect of fiduciary duty, but it focuses on the state of mind of the beneficiary, while *my interest is on the nature of the role and loyalty owed by the fiduciary*. *The key to fiduciary duty in my analysis is the use of legal norms and legal remedies to promote the higher level of conduct to which we hold fiduciaries*. To paraphrase Cromwell, "Put your trust in physicians, but keep your powder dry."[523]

## VIII. THE "HEALTH CARE BENEFIT CORPORATION" (HCBC): A NEW CORPORATE FORM FOR INSTITUTENTIAL HEALTH CARE DELIVERY

### *A. Overview*

Under the ACA approach, delivery system participants remain disparate—some will pursue profit-maximization, others will pursue the public good. Yet, as previously noted, the fundamental purpose of the ACA is to transform

[523] Furrow, *supra* note 361, at 448–49 (emphasis added) (internal citations omitted).

> the current fragmented delivery system into an integrated and coordinated care model that consistently produces improved quality, greater accessibility, and lower cost. ACOs are central to this effort by virtue of their specific intent to effect greater collaboration between and among these disparate system participants. *However, such collaboration will necessarily remain hindered by the conflicting organizational objectives inherent in the nonprofit versus for-profit dichotomy*. *What may be needed now is a new organizational paradigm.*[524]

In American business, "separation of ownership from control" in the traditional for-profit corporation gives rise to directors' fiduciary duties to protect the financial interests of the "shareholders" (traditionally viewed as the corporation's principal if not sole "stakeholders") through profit-maximizing behavior.[525] In an analogous way, the evolution of the "business" of American health care has come to "separate" patients from their ability to "control" their own health. The difference, of course, is that patients' interests reside not in their financial ownership of the health care enterprise, but rather in their beneficial receipt of high quality, cost-efficient, and readily-accessible health care services. In one very real sense, patients are not even the "customers" of the enterprise since they increasingly are not the parties paying (at least directly) for the services they receive. Nonetheless, compelling deontological justifications support the argument that patients are (or at least should be deemed) the principal "stakeholders" of the modern, corporate organizations in the "business" of providing health care. Does it not therefore follow that the directors of these unique corporate enterprises should also have legal fiduciary duties to protect those beneficial interests?

*This, we contend, is the fundamental contradiction and conflict inherent in the current American corporate business model for institutional health care delivery*. Moreover, as we have discussed, even use of the alternate "non-profit" corporate form (with its complete elimination of "shareholders" as principal stakeholders) has increasingly failed to resolve the problems created by this conflict. Far too often the cost-advantages theoretically made available to non-profit institutional health care

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[524] Corbett, *supra* note 3, at 165–66 (emphasis added).

[525] *See* Stephen G. Marks, *The Separation of Ownership and Control*, FINDLAW 692–93 (1999), https://reference.findlaw.com/lawandeconomics/5630-the-separation-of-ownership-and-control.pdf [https://perma.cc/2RWY-S88W].

providers by tax-exemption and the absence of any requirement for a "return to equity" have been more than offset by these organizations' tendencies to "empire-building" and unnecessarily indulgent executive compensation, as well as a seeming inability to moderate entrenched "profit-maximizing" operational mindsets. As the former dean of the Haas School of Business at the University of California Berkley observes:

> our society "does not have a strong philosophical foundation to explain collaborative behavior. That is, while we have libertarian philosophies rationalizing the positive effects of individual initiatives and collectivist philosophies positing the social gains of shared efforts and rewards, we do not have a clear-cut logical system laying out the costs and benefits of behavior motivated simultaneously by personal desires and an awareness of external obligations."[526]

If the United States is not ready to embrace the idea of health care as an unqualified right that should be provided "free" to all citizens through a regulated single-payer system financed out of general tax revenues—wishing instead to view health care as a no more than a "quasi-right" to competitively-offered commercialized health care services predicated on the individual's reciprocal obligation to pay for them—then we would argue that those who use the corporate form of organization to provide such health care must be held to legally-enforceable fiduciary duties to do so in furtherance of an explicitly-stated social mission that necessarily trumps any unlimited right by the enterprise to "profit" beyond certain specified constraints.[527] In our opinion, the characteristics, complexity, and overall importance of today's institutionally-delivered health care demand a new organizational attitude and structure predicated upon mission primacy, fiduciary duty, and trust. If health care in the United States is to continue to be provided as a private, commercialized "business," it must be recognized for what it is—*a business that is clearly differentiated from other forms of commerce by its unique requirements for quality, efficiency, and fairness befitting its deontological place in the lives of all Americans.*

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[526] Coverdale, *supra* note 2, at 492–93 (internal citations omitted).

[527] *Id.* at 511 (Professor Coverdale notes: "John Paul II's view of property and the market suggests that the law should require companies to be managed for goals broader than shareholder wealth maximization. This does not mean, however, that profit does not have a legitimate role to play in business.").

Professor Reiser summarizes well the constructive role that "special form legislation" could play in this regard:

> Specialized form legislation should impose a clear social-good prioritization standard on organizations themselves and on the actions of their leaders. To impose this standard on organizations, *statutes should state unambiguously that the social purposes of adopting entities must trump their business purposes*. To impose it on leaders and managers, *legislation should structure fiduciaries' duties* to require prioritization of social good. Unfortunately, current legislative efforts rarely do either.[528]

We wish here to make an additional point that we will later return to: as Professor Horwitz notes, *corporate form can be used* "*as a proxy for direct regulation*," providing—particularly in "some complex industries like healthcare"—possibly "one of the best" and most cost-effective "policy levers" available.[529]

### 1. *The Intersection of Health Care and Business in American Corporate Law*

> A *"binary" approach* to the intersection of *healthcare and business*—one which holds that the objectives of providing quality healthcare and of generating a reasonable profit are, of necessity, wholly incompatible with one another—can *inhibit* innovation in healthcare delivery models.
>
> The availability of new hybrid organizational structures may facilitate movement beyond the limitations of binary thinking, and allow an approach to potential transactions by and among licensed healthcare professionals and unlicensed individuals or entities from a fresh perspective. At a minimum, the potential application of the various hybrid forms raises interesting questions that deserve consideration. . . .[530]

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[528] Dana Brakman Reiser, *Theorizing Forms for Social Enterprise*, 62 EMORY L.J. 681, 694 (2013) (emphasis added).

[529] Horwitz, *supra* note 99, at 1411 (emphasis added).

[530] Lofft, *supra* note 275, at 14 (emphasis added).

So wrote Lofft *et al*. in a 2013 article previously cited herein, as well as in our initial article. At that time, it was difficult to see exactly how the newly-proposed benefit corporation might be applied to that "intersection"—hence the limited "conceptual" nature of the HCBC proposal in our initial article.[531] However, with the clarity now provided by the additional more-detailed and more current information here discussed, it appears clear that the "standard" form of benefit corporation as proposed by B Lab, and adopted outright by many states, *is not well suited to this purpose*.

To recap, benefit corporations "are dual purpose, blended entities, adhering to the mold of Dodd's social enterprise theory and the social entrepreneurship movement, with a legal structure that embraces both the pursuit of profit and the material enhancement of the public good."[532]

Strictly speaking, they are not social enterprises. According to Thornsberry:

> A social enterprise is defined as "(1) an organization that serves first and foremost a social mission, (2) through the use of sophisticated business models . . . (3) pursuing multiple financing options, and (4) facing novel governance challenges when balancing the interests of donors and investors." When using this definition, and examining a social enterprise's main purpose to "create social benefits from those whose lives it touches," *it appears that the benefit corporation movement has separated itself from being placed solely in the social enterprise box. Benefit corporations will sometimes fit within the social enterprise categorization; however, not all benefit corporations can be categorized as a social enterprise. While general social purpose is woven into its articles of incorporation, the ability to pursue profit is still strongly within a benefit corporation's focus*. While "[t]he general public understands traditional charity, as well as for-profit business . . . [it] does not yet fully understand companies that balance both financial and social gain." In explaining benefit corporations, it is important for them to be distinguished from social entrepreneurship, yet not

[531] *See* Corbett, *supra* note 3, at 180 ("While a complete explication of such a new conceptual entity is beyond this article's scope, its essential features and advantages can be described.").

[532] Corbett, *supra* note 3 (citing King, at 891–92).

> separated from the movement's energy to commit to best business practices that entail more than a singular focus on profit.[533]

According to Johnson, benefit corporations "closely resemble early American corporations that largely were formed to advance public-serving purposes, not private gain, and thus, historically, they represent a return to early practices as well as a seeming ultra-modern innovation in corporate form."[534] Today they embody a growing "institutional pluralism" that overcomes "longstanding and overly stark dichotomies that simplistically categorize activity (and actors) as either profit or nonprofit, and as either public or private."[535]

It is difficult at present to find detailed, objective information about the extent of adoption, growth, and performance of benefit corporations. Not surprisingly, one of the few current sources of information is B Lab itself––whose lobbying activities, and criticisms thereof, have already been discussed at some length.[536] According to B Lab:

> Many different types of businesses have become benefit corporations since the first law was passed in Maryland in 2010. The benefit corporations currently incorporated in the United States come from many different industries, including retail, manufacturing, tech, service, professional services, private education, and food and beverage production. Benefit corporations also come in all sizes, from small one-person service companies to large-scale international brands with many employees.[537]

According to B Lab's Website, at the time of this writing there are 2,026 B Corporations in fifty countries representing 130 industries.[538] B Lab also provides a "tracker" that attempts to maintain a current list of U.S. benefit corporations by state and company name.[539]

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[533] Thornsberry, *supra* note 166, at 164 (emphasis added).

[534] Johnson, *supra* note 180, at 272.

[535] *Id.*

[536] *See supra* Section IV.A.2.

[537] *What businesses have already become benefit corporations?*, BENEFIT CORP. FAQ, http://benefitcorp.net/faq [https://perma.cc/28SK-UNRD].

[538] *See A Global Community of Leaders*, CERTIFIED B CORP., https://bcorporation.net [https://perma.cc/R6BC-DEP2] (As of February 23, 2019, there are 2,778 B Corporations in sixty countries representing 150 industries).

[539] *See Find a Benefit Corp*, BENEFIT CORP., http://benefitcorp.net/businesses/find-a-benefit-corp [https://perma.cc/7FKQ-NH8B].

*Are institutional health care providers now availing themselves of this new organizational form?* As far as we have been able to determine, the answer is no! We attribute this apparent lack of interest to two basic issues: (1) Under the B Lab Model Act, *this new corporate entity remains a for-profit organization*. Thus, only for-profit health care providers can obtain the advantages of the "benefit corporation" form. Given the multitude of unique operational requirements already confronting for-profit (and indeed *all*) health care organizations, the burdens of an additional "general public purpose" requirement would seem to outweigh the putative advantages of the "benefit corporation" form. (2) *Nonprofit health care providers*—comprising the majority of the institutional health care delivery sector—would not only have to take on the additional "general public purpose" burden, but would also have to give up the many critical tax advantages that they presently enjoy as "pure" tax-exempt nonprofits.[540]

Moreover, Professor Johnson suggests that benefit corporations "usefully illuminate, but only partially meliorate, deep confusion within traditional corporate law over the relationship of three core concepts—*fiduciary duties, corporate purpose, and the corporation's best interests*."[541] In his opinion, while benefit corporations "move from a shareholder-centric toward a stakeholder-centric model of corporateness, they stop short of a truly new 'corporate,' mission-centric model and theory of corporateness."[542] He concludes:

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[540] It is for these reasons—we suggest—that we have only found a single instance where an institutional health care provider has so far opted for the "benefit corporation" form. As reported in an August 2014 blog, "Community First Healthcare of Illinois ('Community First'), an Illinois benefit corporation, recently announced plans to purchase [the financially-troubled] Our Lady of the Resurrection Medical Center (formerly Northwest Hospital [a nonprofit]) in Chicago from Presence Health[, the largest Catholic health care system in Illinois]." Christine C. Franklin, *A Benefit Corporation Steps Up to Purchase a Chicago Hospital*, HUFFINGTON POST: THE BLOG (Aug. 6, 2014), http://www.huffingtonpost.com/christine-c-franklin/a-benefit-corporation-ste_b_5648489.html [https://perma.cc/WE2X-WVVX]. Since the Illinois benefit corporation statute substantially follows the B Lab Model Act, this transaction is essentially little more than a nonprofit-to-for-profit conversion. *See* Christine Franklin, *The ABCs of Benefit Corporations in Health Care Innovation*, 19 HEALTH INS. REP. 32 (Aug. 14, 2013), *available at* http://franklinadvocacy.com/wp/2013/08/29/the-abcs-of-benefit-corporations-in-health-care-innovation/ [https://perma.cc/3XFV-4WZZ]. Whether adoption of the benefit corporation form will, in this instance, improve the entity's financial and/or clinical operations remains to be seen.

[541] Johnson, *supra* note 180, at 272 (emphasis added).

[542] *Id*. ("Instead, reflecting doctrinal and theory failures in corporate law generally, they embody an alloy of shareholder and stakeholder elements.").

> *The upshot is a missed opportunity to bring conceptual and doctrinal harmony to the interrelationship of corporate purpose, a corporation's best interests, and fiduciary duties that has long been missing in corporate law.* Instead, Benefit Corps. usefully equate the first two, but most do not then go on . . . to synchronize them with the third. Instead, *most seem to adopt a multi-stakeholder focus, not a truly "corporate" focus*. And this illuminates the root problem with those theoretical proposals (and now laws) that seek to displace a shareholder-centric view of fiduciary duties with a stakeholder-centric view. Doing so simply adds to the number of individual interests clamoring for the attention and duties of directors. Instead of attending solely to stockholder wellbeing, directors are required to consider the wellbeing of multiple interests, *whereas they should attend exclusively to the corporation's best interests and to advancing its avowed institutional purposes.*[543]

*We agree with Professor Johnson in the following regard: We believe that the B Lab Model Act approach to the benefit corporation—which inflexibly requires pursuit of a "general public purpose" in addition to or in lieu of a "specific public purpose"—fails to meet the need for a "new organizational paradigm" suitable for institutional health care providers.*[544] *The paradigm we envision instead focuses exclusively on a*

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[543] *Id.* at 290 (emphasis added).

[544] Professor Johnson goes on to argue:

> The point here is not simply . . . that to serve many interests directors really serve none, as many argue, a typical critique of stakeholder theories dating back to Adolf Berle. The point instead is that in renouncing shareholder primacy, and having invoked the "corporation" and its public benefits as the apparent organizational and legal focus, *Benefit Corp. statutes then seemingly abandon that larger institutional objective on the fiduciary duties issue. These statutes, in other words, renounced shareholder primacy as to corporate purpose but did not carry through on a fully corporate-centered, mission-oriented focus on fiduciary duties*. There is no necessary reason why a corporation cannot usefully advance a public benefit without also requiring the board to consider a range of individual stakeholders. They can be linked of course, but they are conceptual horses of a different color. *If certain stakeholder interests were truly deemed to be "corporately" important, they should be included in the definition of public benefit (general or specific), and thereby they would be an element of the corporate purpose*.

(*continued*)

*"specific public purpose" that is the corporation's legally-enforceable primary mission—a mission intended to better conform with such providers' proper objectives and fiduciary responsibilities, particularly under the new imperatives of the ACA.* As we suggested in our initial article, those new imperatives

> will further challenge the historical, limited "binary" choice between nonprofit and for-profit organizational forms. That is, the "integrated and coordinated care model" envisioned by the ACA necessarily will require additional industry consolidation, increased access to capital, closer collaboration between and among system participants, and greater accountability for quality and high-value outcomes. *It is for all of these reasons that a* ***new*** *organizational paradigm is here suggested—a* ***specific form*** *of Benefit Corporation (i.e., a "Health Care Benefit Corporation" (HCBC)) expressly designed for health care delivery and predicated upon the concept of mission primacy and the Fiduciary Medicine Model*. As a practical matter, the HCBC would be an adjunct to, rather than replacement for, existing nonprofit and for-profit organizations—arguably most appropriate for multi-stakeholder arrangements such as ACOs.[545]

*B. Greater Specificity—State "Adaptations" of the Model Act*

The B Lab Model Act's often-criticized lack of flexibility seems to make its form—with its inviolable "general public purpose" requirement—*unworkable for the HCBC*. More specifically, the principle features and drivers of the standard Model form appear fundamentally different from and counterproductive to those underlying our proposed HCBC. As previously noted:

> Benefit Corporations [under the Model] are required to have:
>
> a. *Purpose*: a corporate purpose to create a material positive impact on *society and the environment*;
>
> b. Accountability: expand fiduciary duty to require consideration of the interests of *workers, community and the environment*; and

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*Id.* at 290–91 (emphasis added).

[545] Corbett, *supra* note 3, at 179–80 (emphasis added).

> c. Transparency: publicly report annually on *overall social and environmental performance* against a comprehensive, credible, independent, and transparent third party standard.[546]

By contrast, our proposed HCBC is characterized and driven *by much more tailored and specific objectives*:

> First, like all Benefit Corporations, the HCBC would be a blended, dual-purpose entity having a legal structure that serves to pursue the public good together with profit seeking as the explicit and legally enforceable mission[s] of a single business enterprise. *The "public good" in this instance would be unequivocally identified in the corporation's articles of incorporation as the ongoing and consistent provision of affordable, high-quality, high-value, and readily accessible health care services. This would be the organization's primary mission*, which the governing directors and management would (for the first time) have a *legally enforceable fiduciary duty* to pursue. Second, *the HCBC would have a subordinate mission of targeted profit seeking and distribution*, intended to attract equity investors and management talent, as well as provide access to taxable capital markets. . . .[547]

Generally speaking, the principal motivations driving our proposed HCBC are the recognized needs for: improved cost efficiency and effectiveness in the delivery of high-quality, readily-accessible health care services; enhanced access to capital; enforced adherence to mission primacy; and, compelled professional and institutional accountability through acknowledged and formalized fiduciary duties—intended to restore patient trust in the institutional delivery system.

Our proposal—eliminating the B Lab Model's "general public purpose" requirement *for a variant form* of benefit corporation—is an idea supported by a recent 2014 article by Lofft and her colleagues, who have now considered and commented extensively on the health care implications of Delaware's recent entry into the benefit corporation arena:

> The legislation authorizing the formation of benefit corporations has, in many states, been inspired by the provisions of the Model Benefit Corporation Legislation

[546] Wexler, *supra* note 186, ¶7(a)-(c) (emphasis added).
[547] Corbett, *supra* note 3, at 180 (emphasis added).

> (the "Model Legislation"). However, Delaware has taken a different approach, and its public benefit corporation statute varies in some key respects from the Model Legislation. The authorization of benefit corporations in the form adopted by the First State is of significance, given Delaware's prime place in the world of corporate formation and governance. *Moreover, given the variations in the Delaware public benefit corporation model as compared to the form of benefit corporation under the Model Legislation, Delaware's public benefit corporation model is likely to be better suited to adoption by healthcare and life science companies than the benefit corporation models currently available in other states*.
>
> *Specifically . . . a Delaware public benefit corporation could focus on delivering healthcare to the underserved or improving public health without having an obligation to also deliver an environmental benefit.*
>
> All together, these developments could benefit not only healthcare providers and other healthcare companies directly, but also their investors, patients/consumers and the general public. [548]

We agree! To our view, only those state adaptations of the Model Act that allow for an *optional* general public purpose requirement—*or* that expressly provide for a variant form of benefit corporation that is permitted to pursue *only a specific public benefit*—would provide the essential structural form necessary for our proposed HCBC. At the moment, these would theoretically include the California Flexible Purpose Corporation, the new Delaware Public Benefit Corporation, the (unenacted) "Colorado Approach," or the most-recent Minnesota "Specific Benefit Corporation."[549] Of these, we submit that the Minnesota model currently presents the most simple and straightforward prototype for the HCBC.[550]

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[548] Katherine R. Lofft et al., *Delaware Authorizes Public Benefit Corporations: Will the First State Be the First to Benefit Healthcare Organizations?*, 23 HEALTH L. REP. (BNA) 1009–10, 1014 (July 31, 2014) (emphasis added).

[549] *See supra* Section IV.E.

[550] *See generally* Minnesota Public Benefit Corporation Act, MINN. STAT. § 304A (2014).

### *C. Premises Underlying the HCBC*

Let us now summarize, then, the most salient points and conclusions from our focused and more detailed review of both American corporations and the American health care delivery system. These points and conclusions serve, to varying degrees, as the premises underlying our proposal for a specific, variant form of benefit corporation that we call the "Health Care Benefit Corporation":

> • We need to address anew the foundational questions: why do corporations exist—why are corporations separate legal individuals—and for whose benefit do corporations exist?[551]
>
> • It is time to abandon the view that "shareholder primacy"—*i.e.,* that the corporation is the property of the shareholders, on whose behalf the directors are bound to act, through managerial powers held in trust for those shareholders as the *sole* beneficiaries of the corporate enterprise—is the *only* legal and proper construct through which "business" can be conducted through the corporate form.[552]
>
> • Further, it is time to acknowledge that every "business corporation" can and does, to a greater or lesser degree, have both public and private roles and obligations that require them to be managed in the interests of a broad range of stakeholders.[553]
>
> • We accept that "institutional morality" is a coherent and legitimate concept—the idea that the corporation functions as a "real person in society" with corresponding obligations to attend to the effects its presence and activities have upon a broad range of others.[554]
>
> • We endorse Pope Benedict XVI's concept of a "broad new composite reality embracing the public and private spheres, one which does not exclude profit, but instead

[551] *See supra* Section III.A.
[552] *See supra* Section II.A.1.
[553] *See id.*
[554] *See supra* Section III.

considers it a means for achieving human and social ends."[555]

• We agree with Professor Lyman Johnson that legally enabling benefit corporations to serve mixed purposes (*i.e.,* permitting corporations that are not nonprofit to seek profits without having to maximize those profits and/or to provide social services of a type the government might typically supply) arguably introduces a greater measure of desirable institutional pluralism into law and business that constructively blurs what otherwise might be considered an overly dichotomous understanding of the "public" and "private" spheres of action. *Further, we believe that variants of this new corporate form should be available for use whenever they facilitate a more effective and cost-efficient marshalling of the organizational resources, skills, and scale necessary to finance, produce, and broadly provide complex public goods and services*.[556]

• However, we also agree with the criticism of Professor Mark J. Loewenstein that: "The purpose of benefit corporation acts is not just to free up social entrepreneurs from the perceived constraints of profit-maximization, but to create a form that mandates non-profit maximizing behavior. The Model Legislation, which has been drafted to achieve that end, is at the same time too broad and too narrow."[557]

• Emphatically (and conclusively), we further agree with Professor J. Haskell Murray's criticism of the Model Act that: "Requiring social enterprise directors to consider an unprioritized group of stakeholders while also requiring a corporate purpose that looks at societal and environmental impact *as a whole* is not only unworkable, but could also exclude corporations with a more specific mission. *A corporation with a focused and specific public purpose at its core is more likely to pursue that purpose because the objective is more easily identified by directors. A more*

[555] *See supra* Section III.A; note 104 and accompanying text.
[556] *See supra* Section IV.B.
[557] *See supra* Section IV.D.1; note 204 and accompanying text.

*specific public purpose (or a prioritizing of certain stakeholders within a more general public purpose) would also provide a more workable system of board accountability.*"[558]

• As regards the current state of the American health care delivery system, the proliferation of third-party payment (which separates the payer for health care services from the "beneficiary" of those services) has resulted in the economic behavior of nonprofit institutional providers too often becoming unrestrained and lacking in accountability when proper adherence to corporate mission gives way to overly-commercial "business objectives."[559]

• However, from a deontological perspective, health care today is inherently both a social (public) good *and* a commercial service—notwithstanding continuing calls for it to be deemed a fundamental American right.[560]

• Moreover, our present health care delivery system necessarily is so dependent on a multitude of private technologies and other professional and commercial inputs that complete disengagement from markets is, as a practical matter, impossible. That said, it is becoming increasingly apparent that a strictly "commodified" view of health care that ignores its unique deontological character has led to outcomes that are neither practically viable nor just.[561]

• Yet, to fully understand the failures resulting from the continuing "commodification" of our existing system, it is necessary first to understand why competition policy is inexorably linked to the organizational structures of health care providers and payers and how the fragmentation and "unhelpful competition" that bedevils those arrangements has undermined its success.[562]

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[558] *See id*; note 203 and accompanying text (emphasis added).
[559] *See supra* Section V.B.
[560] *See supra* Section V.C.
[561] *See supra* Section V.C.1.
[562] See *supra* Section V.E.1.

• In this regard, current legal regulatory regimes (based on those structures) directly impede cost-restraining cooperation among existing health care providers. For example, the federal anti-kickback and Stark laws bar many forms of vertical and horizontal cooperation that could improve efficiency. As a result, the fragmented community of physicians and hospitals is prevented from responding to competitive market incentives to integrate via joint ventures and contractual arrangements. More than any other regulatory obstacle, the inability of hospitals to share efficiency and cost-effective improvements with physicians who order services impedes effective deployment of health resources.[563]

• Accordingly, a principal goal of the ACA has been to foster integration—as evidenced by provisions directly sponsoring development of new organizational arrangements such as accountable care organizations and patient-centered medical homes, and relaxation of laws and regulations that inhibit integration.[564]

• One of the most notable features of these new organizational arrangements is the enlarged and significant involvement of "multiple stakeholders," including both individual professionals and institutions. While the ACA requires "shared governance" of ACOs by these stakeholders, it has not (by design) required that such governance be accomplished through any specified functional or legal organizational form. That is to say, so long as all relevant statutory and regulatory requirements are met, the ACO itself can be a nonprofit corporation, a for-profit corporation, or some other type of legal business entity.[565]

• However, there may well be legitimate reasons for concern that ACOs will develop with a continued "margin over mission" mindset that fails to prioritize health care cost-containment, enhanced access, and quality

[563] *See supra* Section V.E.1.b.
[564] *See supra* Section V.E.2.d.
[565] *See supra* Section VI.B.2.

improvement over the continual growth of organizational profits.[566]

• In addition, current provisions of the Service providing the ways and means for tax-exempt nonprofits to participate in ACOs seem to comprise an unnecessarily complex and convoluted way to attempt reconciliation of the inherent tension between such entities' "mission and margin."[567]

• For these reasons, we suggest that the concept of "*mission primacy*," as articulated by Professors Greaney and Boozang, *should be adopted as the central organizational objective of institutional health care providers*—like ACOs—who choose to adopt our proposed HCBC form.[568]

• Further, we advocate that *such mission primacy—combined with explicit and expanded fiduciary duties—be made a fully-enforceable legal requirement under the constitutive structure of the HCBC's legal form itself* (in order to eliminate the "mission drift" into untoward emphasis on profit-seeking that currently seems to plague too many non-profit providers).[569]

• The fact is—since health care today is increasingly delivered by and through large, institutional organizations––it is time to acknowledge that the same relationship of trust, reliance, and dependence that has historically characterized and defined the fiduciary duties of physicians now appertains between patients and such delivery-of-care providers.[570]

• Finally, we note that "trust in medicine" is not merely a function of trust in physicians—instead, there are several objects of trust in medicine, including systemic trust,

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[566] See *id.*
[567] *See supra* Section VI.B.3.
[568] *See supra* Section VII.A.
[569] *See id.*
[570] *See supra* Section VII.B.2.

> which is based on perceptions of institutions and structures designed to support those institutions.[571]

*D. Proposed Structure, Features, and Benefits of the HCBC*

We will not attempt here to present a fully-drafted proposed statute for our HCBC.[572] Because of the long-standing tradition that American law of

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[571] *See supra* Section VII.C.

[572] As will shortly become apparent, in order to operationalize what we are here proposing, additional expertise beyond our own likely will be required in such areas as accounting, finance, actuarial science, tax law, securities law, and others. Since each actually-formed HCBC entity necessarily will have its own unique operating characteristics and requirements, such further expertise will be needed to design a "model statute" that properly allows for such individuation.

That said, it should be noted that some authors have in fact suggested a model statute for a proposed "*Social Primacy Company*" that addresses some of the same issues driving our proposal for the HCBC. They propose "a new generation of hybrid designed to do the following":

> (1) require that *one or more designated and clearly defined social purpose(s)*, not necessarily limited by the narrow definition of "charitable" used in the Internal Revenue Code, have an innate and near permanent primacy within the managers' decision making and the owners' minds;
> (2) facilitate access to capital for social enterprises by allowing distribution of financial profits to investors to be an important purpose of the enterprises *so long as that purpose is subordinate to its designated social purpose(s)*;
> (3) *expressly provide for a fiduciary duty to maintain the primacy of the entity's social purpose(s)* and explicitly prevent its improper renunciation;
> (4) establish *meaningful remedies for breaches or deviations from that social primacy duty* that can be enforced in legal actions by owners (including "dissenter's rights") or by government to protect investors and the public; and
> (5) *promote* transparency and *accountability* through: (a) mandatory periodic reporting of activities to a regulatory oversight office that will be publicly available; and (b) public notice of entity conversion to another form akin to what in other contexts is called a "noisy withdrawal."

John Tyler et al., *Producing Better Mileage: Advancing the Design and Usefulness of Hybrid Vehicles for Social Business Ventures*, 33 QUINNIPIAC L. REV. 235, 284 (2015) (emphasis added). While similar to the HCBC in its focus on *only* one or more "specific" social purposes, and its emphasis on fiduciary duty and accountability, their construct obviously lacks the necessary "tailoring" of the HCBC to the specific needs of institutional health care providers.

corporations is a matter of state rather than federal jurisdiction,[573] the precise form of any such statute will necessarily differ from state to state. For example, the Minnesota Specific Benefit Corporation statute is drafted as a variant form under the broader Minnesota Public Benefit Corporation Act.[574] With the exception of the California Flexible Purpose Corporation (a "standalone entity"),[575] this is generally the approach taken by all states that have so far enacted some form of benefit corporation statute—that is, annexing some variation of B Lab's "Model Act" into the state's existing statutory framework of general corporation law.[576] Such annexation permits "each state's body of corporate governance law—most of which is useful to the operation of any business—to still apply" to the new form.[577] It also allows the new form's "body of corporate governance law to interact with and, to the extent that they are consistent, be updated by the cases and developments in other areas of the state's corporate governance law."[578] Accordingly, we propose that the same approach be taken with the HCBC—with the additional proviso that certain unique and essential features must be present if this new form is to receive the acceptance needed from federal health care regulators.

More specifically, in order for the HCBC to accomplish its intended health care purposes,[579] the federal government—including the Service, FTC, DOJ, CMS and OIG—will have to agree that certain changes and/or concessions in tax, antitrust, and fraud and abuse laws/enforcement will be made available to HCBCs that are structured with certain basic features. While at first blush this suggestion may appear unrealistic, what we propose is actually little different in kind or degree from the regulatory concessions currently being made to ACOs under the MSSP Program.

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[573] *See* Jill E. Fisch, *Leave It to Delaware: Why Congress Should Stay Out of Corporate Governance*, 37 DEL. J. CORP. L. 731, 732, 733 n.5 (2013) (citing Arthur Fleischer, Jr., *Federal Corporation Law: An Assessment*, 78 HARV. L. REV. 1146, 1153 (1965) ("The federal securities laws affect a wide range of corporate activities, but generally they do not preempt complementary state laws; they are pervasive but not exclusive.")).

[574] *See generally* Minnesota Public Benefit Corporation Act, MINN. STAT. § 304A (2014).

[575] *See* CAL. CORP. CODE § 2502 (West 2015).

[576] Westaway & Sampselle, *supra* note 143, at 1033.

[577] *Id.*

[578] *Id.*

[579] Again, those purposes being: achievement of greater cost efficiency and effectiveness in the delivery of high-quality, readily-accessible health care services; improvement in access to capital; enforced adherence to mission primacy; and, compelled professional and institutional accountability through acknowledged and formalized fiduciary duties—all intended to restore patient trust in the institutional delivery system.

That is, provisions are already being made for significant ACO Fraud and Abuse Waivers, as well as relaxed ACO antitrust enforcement, to support the MSSP ACO Program.[580] That said, there remain some thorny issues to be resolved regarding the tax treatment of the HCBC. As Lofft and her colleagues note in their 2014 article:

> *Benefit corporations are, fundamentally, for-profit entities*, although . . . they share certain limited attributes with non-profit or not-for-profit entities. However, neither the Model Legislation nor, to the authors' knowledge, any of the state benefit corporation statutes, confers any specific tax advantage or exemption on benefit corporations, *nor has the federal government or any authority(ies) in any state that has authorized the benefit corporation model elected to exempt benefit corporations from payment of income, real or personal property or other taxes. Moreover, there is no indication that monies "donated" to a benefit corporation would qualify for a tax deduction(s) to the donor under the law*. It remains to be seen whether some of the attributes of benefit corporations that are borrowed from the non-profit or not-for-profit model—including pursuit of a "public" benefit(s) or good, increased reporting requirements and enhanced transparency—if they bear out in practice, *will prompt changes in the tax code that would result in benefit corporations being treated more like non-profit or not-for-profit entities* for these purposes, and/or changes in the corporate code or other statutes that would allow non-profit or not-for-profit entities to reorganize as public benefit corporations.[581]

Throughout our exposition, we have discussed the problems inherent in institutional health care providers seeking to "make a profit" from the delivery of services. For the for-profit provider, the fundamental problem is the additional financial requirement of a "return to equity" that

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[580] *See* David L. Klatsky & Daniel H. Melvin, *ACOs Get Broad Waivers From The Fraud & Abuse Laws*, 17 J. HEALTH CARE FRAUD 2 (West) (Nov. 10, 2011), *available at http://www.mondaq.com/unitedstates/x/153324/Healthcare/ACOs+Get+Broad+Waivers+from+the+Fraud+Abuse+Laws* [https://perma.cc/U3GK-DRZ8]. *See also Tax-Exempt Organizations Participating in the Medicare Shared Savings Program through Accountable Care Organizations*, IRS FACT SHEET FS-2011-11 (Oct. 20, 2011).

[581] Lofft, *supra* note 548, at n.17 (emphasis added).

necessarily increases the cost of providing health care services; for the nonprofit provider, the problem is not only the competitive pressures of health care's increasing "commercialization," but nonprofit providers' tendency to "emulate" for-profit attitudes and conduct. As a result, unnecessary costs are added in both cases to a "product/service" that has a uniquely-important deontological status. This, in our opinion, is the essence of the "mission versus margin" conundrum found in both organizational forms and its particularly acute manifestation in modern health care delivery.

*The raison d'être for our HCBC, then, is to better calibrate the balance between mission and margin; specifically in this case, between the organization's mandate to provide high-quality health care services at the lowest possible cost, while still addressing the need for revenue in excess of expenses to meet the organization's legitimate needs for technological advancement, physical growth, retention of skilled management, and replacement of obsolescing property, plant, and equipment.* To our view, improvement in such calibration necessarily requires a new organizational form that permits the institutional provider to both: (1) continue to receive appropriate tax treatment that properly acknowledges the "public good" nature of its services (thereby reducing the overhead costs of providing such services), and (2) access additional sources of capital (including those heretofore only available to for-profits) as necessary to adequately fund the legitimate financial requirements of a commercial business enterprise as specialized, complex, and technology-dependent as today's health care delivery. Of course, it is the detail of designing such a new form and effecting such calibration that presents the challenge.[582]

Which brings us to the "dual mission" of the HCBC. We see no legal or other impediments to the HCBC being structured as a blended, dual-purpose entity designed to legally pursue *a singular specific public*

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[582] As Mayer and Ganahl opine:

> *The alternative to the existing [benefit corporation] structure would be to develop a much more specific public benefit requirement for hybrids to enjoy tax benefits similar to those enjoyed by charities, both in terms of what qualifies as a public benefit and what quantity of such public benefit would be required to obtain the desired tax benefits.* This arguably is what some states are already doing with respect to nonprofit hospitals that seek to maintain their exemption from property taxes. *As those state efforts demonstrate, however, developing such a requirement is no easy task under any conditions.*

Mayer & Ganahl, s*upra* note 103, at 427 (emphasis added).

*purpose (its primary mission, for which it would be treated as a tax-exempt nonprofit)*, while simultaneously pursuing the *additional purpose* of earning sufficient "profit" (*i.e.*, revenue over expenses) for the maintenance of adequate capital fund balances and the making of *limited* distributions to passive investors and/or other appropriate participating stakeholders *(its secondary mission, on which it would be taxed)*.[583]

*Significantly, this new paradigm essentially reverses the original benefit corporation approach of B Lab that has been adopted (with or without some modification) in most states thus far*. That is, the B Lab Model structures the benefit corporation as a taxable for-profit entity that is "enabled" through its new form to openly pursue *general* "social" purposes in addition to (and at the expense of) its mandate to maximize profit. *In direct contrast*, we propose that the HCBC be structured essentially as a charitable nonprofit that is "enabled" to openly pursue a prescribed amount of "profit" (limited to what is necessary to ensure its ongoing financial integrity) in addition to fulfilling its *specific* public purpose of providing the ongoing and consistent provision of affordable, high-quality, high-value, and readily accessible health care services. *While the structural distinction between the two approaches may appear to be more one of "degree" than of "kind," we submit that the difference in organizational orientation, conduct, and results will be significant*.

Obviously, to accomplish such a proposed "melding" of traditional nonprofit and for-profit forms will require "buy in" by the the Service. As discussed in our initial article,[584] in order to obtain federal tax-exemption, nonprofits historically (and still currently) have had to be *organized and operated exclusively* for *charitable* or other Code-specified purposes. In addition, *no part of the net earnings* of the organization could (or can) *inure to the benefit of any private shareholder or individual*. With

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[583] As Westaway and Sampselle argue in their discussion of benefit corporations:

> A fundamental assumption of positive economics is that rational individuals are exclusively self-interested, and while . . . this is a predictive tool that has served economists well in the past, old assumptions may not well serve this new governance model. Moreover, *it would be foolish to mire benefit corporation directors in a precedential dogma that thwarts the very purpose of the legislation—to allow individuals to act, not as economists assume them to act* in order to make predictive models about broad-scale human behavior, *but in the spirit of combined profit and public purpose for which they formed the benefit corporation*.

Westaway & Sampselle, *supra* note 143, at 1068 (emphasis added).

[584] *See* Corbett, *supra* note 3, at Section II.A.1.

adherence to these two principal requirements (and a few others), the *entire organization* then receives tax-exempt status. The only exception to these two requirements falls under the Code's provision for UBIT.[585] The UBIT approach, however, has been increasingly strained by the growing commercialization of health care services and the rise of large nonprofit system providers—a point repeatedly made. Because the large, commercial health care nonprofit is exactly the type of organization that the HCBC is intended to better serve, the problem becomes obvious:

> Active involvement in non-exempt activities will not threaten exemption so long as that activity "is in furtherance of the organization's exempt purpose . . . [and] the organization is not organized or operated for the primary purpose of carrying on" that non-exempt activity. *Courts have been willing to back up the IRS's denial of exempt status when there is evidence that any substantial purpose of an entity is non-exempt*, however, and they will not avoid parsing the difference between activity and animating spirit. *An examination of the manner in which the activity is carried out under the commerciality doctrine complicates matters, and the more an entity's activities and business methods approximate those of a standard for-profit, the less likely it will be able to sustain exempt status*.[586]

Clearly, then, what we have proposed with the HCBC—an overt secondary mission of limited profit-making—will jeopardize the organization's tax-exempt status under historic and still-current tax law unless an exception is granted by the the Service *To justify such an exception, we propose the following new structural approach for the HCBC*: Since, as a practical matter, the organization's dual missions cannot be readily differentiated (from an accounting standpoint) at the

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[585] *See* Mayer & Ganahl, s*upra* note 103, at 410 (citing I.R.C. § 511 (2012) (imposing UBIT on "unrelated business taxable income"); I.R.C. § 512 (2012) (defining UBTI as "income derived . . . from any unrelated trade or business . . . regularly carried on," less deductions "which are directly connected with the carrying on of such trade or business"); I.R.C. § 513(a) (2012) (explaining "unrelated trade or business" as "any trade or business the conduct of which is not substantially related [to the] purpose or function constituting the basis for . . . exemption") *Id.* at 410 n.106).

[586] *Id.* at 411 (citing Treas. Reg. § 1.501(c)(3)-1(e) (as amended in 2008)) (emphasis added).

granular level of individual activities and transactions,[587] *we propose instead "apportioning" the HCBC's total assets and net income according to "a priori-deduced percentages" that are best-estimated to reflect the desired calibration of balance between the primary and secondary missions*. To put it differently, we propose to "*bifurcate*" the organization's financial structure (*i.e*., assets, debts, equity, fund balances, and gross income) *into nonprofit and for-profit components* for purposes of assessing taxes—perhaps something on the order of 70% nonprofit to 30% for-profit.[588]

Traditional *tax-exempt financing* sources (such as tax-exempt bonds, tax-deductible donations, etc.) would still be available to the HCBC and could be used for supporting the corporation's primary (nonprofit) mission through application to operations or enlarging fund balances (but not for tax arbitrage).[589] *Financing from taxable sources* could be used *either* for the corporation's primary mission, *or* for either/both "return to equity holders" or incentive compensation for management (*i.e*., both instances of "private benefit"), so long as the amounts involved remain within the total *a priori* for-profit apportionment. Similarly, whatever unused annual *net income* remains within said total *for-profit apportionment* would be available for distribution to equity holders and/or management and would, as usual, be subject to taxation upon such distribution. Annual *net income*

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[587] As writer Emily Cohen observes:

> [T]he Code's view of an entity's status under the Code as non-profit or for-profit clouds the true color and correct nature of a for-profit's activities, and . . . the Code's failure to adjust its view of business purpose at the same pace as corporate theory, creates complications and contradictions within the Code. This Note will address how *having a state-incorporated purpose to create a social benefit in addition to a purpose of profit generation potentially affects the tax treatment of benefit corporations, because the Code determines its treatment of an entity's individual transactions and activities with consideration of the entity's purpose for those transactions*.

Emily Cohen, *Benefit Expenses: How The Benefit Corporation's Social Purpose Changes The Ordinary And Necessary*, 4 WM. & MARY BUS. L. REV. 269, 274–75 (2013) (emphasis added).

[588] Although, if the "repeal and replacement" of the ACA results in the number of uninsured again increasing significantly, a larger nonprofit apportionment may be required to provide the funds necessary for the organization to provide additional charity care.

[589] *See* Corbett, *supra* note 3, at 134 n.167 ("Tax arbitrage" is a practice in which tax-exempt nonprofit hospitals finance their capital projects "through tax-exempt bond debt instead of using their own available investment assets" (such as "unrestricted marketable securities that were earned through unrestricted gifts, investment income, retained earnings, and funded depreciation")).

within the *a priori nonprofit apportionment* would remain free of taxation and only available for supporting operations and/or additions to fund balances.

Mechanically, such apportionment could be accomplished through a combination of devices such as limitations on equity (stock) ownership (*e.g.,* asset locks),[590] limitations on secured debt, and/or caps on income distribution (including both dividends to investors and management compensation).[591] *Effectually, then, such an approach would define and*

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[590] *See What is an Asset lock*, MRASSOCIATES, https://www.mrassociates.org/knowledge-base/specified-accommodation/cat-1-exempt-accommodation/what-is-an-asset-lock [https://perma.cc/MTH2-KYSX] (An "asset lock" is a legal clause that ensures "that the assets of a company or society can never be cashed in by or transferred to private individuals or other companies for their own advantage."). Professor Murray suggests that

> benefit corporation statute drafters could consider a partial asset lock for benefit corporations. To prevent companies from raising capital for a benefit corporation by promoting themselves as a "good" company and then quickly selling to the highest bidder, the statutes could impose a lock on some percentage of the benefit corporation assets such that some percentage of the assets are guaranteed to be left behind even if the corporation is bought and has its benefit corporation status terminated. The statutes could require that some portion of the assets be given to a charity with a similar mission to the benefit corporation.

Murray, *supra* note 140, at 510. In our proposed case, 70% of the HCBC's total assets would be made subject to such a "lock," preventing any alienation or encumbrance that would or could result in private inurement.

[591] Precedent in the form of a similar approach can be found in the Community Interest Company (CIC), introduced in 2004 in the United Kingdom. As Mayer and Ganahl describe it:

> As with domestic hybrids, the goal was to blend attributes of for-profit and charitable forms. In order to qualify for registration as a CIC, an entity must be operated such that "a reasonable person considers that the activities being carried on are for the benefit of the community." The CIC enabling laws also include a number of features meant to protect against the improper use of assets that go well beyond what are found in any of the U.S. hybrids: *limits on the compensation that may be paid to managers and employees of CICs; a cap on the return that investors can earn, including a prohibition on the company repurchasing its shares at a higher price than that paid by the shareholder; a prohibition on the sale of assets for below market value during the life of the company or upon dissolution; a requirement that, upon dissolution, net earnings be dedicated to the same community purpose for which the CIC was operated*; and oversight by a "CIC regulator" with broad powers. The CIC regulator's authority includes the right to audit, to appoint and remove directors, and to appoint a

(*continued*)

*limit (for the purpose of taxation) the amount of "private inurement" that could occur as a consequence of the HCBC's dual mission*—thereby obviating (at least in large part) the historical and legitimate concerns of the Service as well as recent nonprofit critics like Senator Grassley.[592]

Further, by explicitly limiting and controlling the amount of private inurement permitted under the HCBC structure, much of the historical concern about fraud/abuse and antitrust also should be assuaged. That is to say, much if not most of today's current stringent regimen of fraud/abuse and antitrust controls on the health care sector is designed to prevent "profiteering" by the unscrupulous. While instances of "fraud" can and will happen in any structural context, "abuse" is most likely to occur only when "profit opportunities" are present; the same can be said of "anti-competitive" and "market-domination" activities. There is, we suggest, less incentive to "fix prices" or "restrain competition" if the "profit" from doing so cannot redound to private benefit.[593] Put differently, by limiting and controlling the amount of profit that can be "distributed" for the benefit of private parties, the motivation for engaging in such improper conduct in the first instance theoretically should be reduced. There is little reason, then, why the HCBC should not be afforded a similar degree of relief from such regulatory controls as are ACOs under the MSSP Program. To now repeat a previous point made by Professor Horwitz: *Corporate form can be used "as a proxy for direct regulation,"* providing–

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> receiver to take temporary control of a CIC's assets in the event that the directors are removed. . . .

Mayer and Ganahl, *supra* note 103, at 402–03 (emphasis added) (internal citations omitted). *See also* Reiser, *supra* note 528, at 721 n.152 ("*explaining that 'CICs are intended to use their assets, income and profits for the benefit of the community they are formed to serve' and describing their asset-lock and dividend-cap features.*") (emphasis added).

[592] *See* Corbett, *supra* note 3, at Section III.B.1.

[593] *See* Rowe, *supra* note 335, at 1885.

> It has been stated that the goal of antitrust law is to "change the incentives of business firms to ensure that the pursuit of private profit more fully promotes social welfare." If that is indeed the end goal, then it is hard to see how ACOs, in theory, based on their stated objectives, would be antagonistic to this goal. In fact, the concept of an ACO seems to parallel this goal by striving to make health care more affordable.

*Id.* (citing Joseph F. Brodley, *The Economic Goals of Antitrust: Efficiency, Consumer Welfare, and Technological Progress*, 62 N.Y.U. L. REV. 1020, 1024 (1987)). In this regard, what is true for the ACO is equally true for the HCBC.

–particularly in "some complex industries like healthcare"—possibly "one of the best" and most cost-effective "policy levers" available.[594]

Nevertheless, one might well ask at this point: why "bifurcate" the financial structure *within* a new, single corporate form in order to accomplish what already occurs in the current separation between the traditional for-profit and nonprofit corporate forms? The answer is the unique scale, operational requirements, and deontological character of modern institutional health care delivery organizations as they are evolving in this country. Whatever ultimately happens with the Affordable Care Act and the MSSP ACO Program, it is beyond dispute that the future financing, production, and delivery of health care services in the United States will continue to require "scaled operations" that can coordinate multiple complex and costly inputs necessary for both financial and clinical integration. Whether it be under the label of a Clinically Integrated Network, an ACO, or our proposed HCBC, the cost, complexity, and social importance of health care today will continue to increasingly require group-based decision making by multiple stakeholders engaged in systems-based care management.

That said, so long as the United States wishes to operate its health care delivery system on a predominantly private, commercial basis—foregoing the option of a universal, nationalized, single-payer governmental system comparable to the U.K.'s National Health Service (NHS)—institutional delivery-of-care providers will need to work collaboratively with both for-profit and nonprofit health care providers and other entities. Accordingly, the HCBC will need to be structured in a manner akin to a "membership nonprofit," where some participating stakeholders have equity participation and earning expectations that require them to be accounted for as part of the "for-profit apportionment." As a single, dual-purpose organizational and legal entity, however, the HCBC can address the "private inurement" issue directly, and legally avail itself more readily of the economic benefits of affiliations.

Nonetheless, the stakeholder coordination required of the HCBC will present its own challenges. Such coordination must be characterized by renewed organizational commitments to mission primacy, professional and institutional fiduciary responsibility, and restoration of patient trust—commitments that need to rise to the level of legally-enforceable duties. In our opinion, such a result can best be achieved by expressly imbedding such duties into the HCBC's primary mission statement, and delineating

[594] Horwitz, *supra* note 99, at 1411 (emphasis added).

within the HCBC's articles of incorporation who will have the legal right to bring action as necessary for the breach of these duties and under what circumstances—all of which can *only* be effectively monitored and enforced under the governance and management of a single stakeholder-oriented, mission-focused organizational entity that can develop the metrics necessary to realistically assess and adjust its own performance.

So, what will our HCBC look like from an operational standpoint? In sum, it will essentially:

> • be a "membership corporation" utilizing a "shared governance structure" that includes both organizational and individual members—likely consisting of individual medical professionals (*e.g.*, doctors, nurses, technicians), administrative professionals (*e.g.*, managers, accountants, lawyers), community representatives (*e.g.,* previous/prospective patients, business owners, government employees), and individual representatives of other relevant and related company and/or institutional interests (*e.g.*, medical group practices, medical suppliers, third-party payers, etc.)—who govern a "clinically (and/or financially) integrated health care delivery system" through a "self-electing board" of participating "stakeholders";
>
> • that has a "hybrid" corporate form—comprised of *both* nonprofit and for-profit components—reflecting a "bifurcated financial structure" (based on an *a priori* "apportionment" of nonprofit and for-profit activities) that effectually limits the amount of "private inurement" that can occur (and in turn be deemed taxable), thereby reinforcing a better "calibration" between organizational "mission and margin";
>
> • that is committed to the "primacy" of a "dual organizational mission"—*i.e., both* the ongoing and consistent provision of affordable, high-quality, high-value, and readily accessible health care services *and* targeted profit seeking and distribution (as necessary to attract equity investors and management talent, as well as provide access to taxable capital markets, to ensure the organization's financial integrity); and

• that formally recognizes and accepts its "institutional fiduciary responsibilities" (and corresponding liability) *both* for the professional provision of competent health care *and* for the general accomplishment of its organizationally-mandated dual missions.

Finally, we note again an earlier statement by Professor Greaney:

> *Proponents of the ACO strategy argue forcefully that the experiment is the last best hope for a market-driven rationalization of the health care system*. Jay Crosson, for example, contends that the ACO concept is "too vitally important to fail," predicting that the likely alternative if ACOs do not take root could be indiscriminate, across-the-board cuts to provider payment rates. *Optimistic observers suggest that ACOs will improve the dynamics of competition and may ultimately displace private insurance altogether*. . . .[595]

In view of what we might call the "affinity of purposes" between ACOs and the HCBC, it is foreseeable that those integrated delivery systems that wish to operate their own insurance plans might well avail themselves of the HCBC form—essentially operating such plans on either a limited-profit or totally nonprofit basis. *By the singular act of attenuating if not entirely removing third-party profit-maximization from the provision of health care insurance, significant cost-reduction could be effected in the entire health care delivery system*.

## IX. CONCLUSION

> The deontological status of health care in the United States today lies somewhere between a "public good" and a "right." It is clear that the ACA—by advancing a scheme to provide near-universal access to insurance coverage—is moving the delivery system closer to the "right" end of the continuum. It is equally clear that a significant percentage of the body politic will never subscribe to the idea of health care as a direct, government-provided entitlement. Clearly, it was recognition of this fact that led to the compromise position taken by the ACA—that Americans

[595] See *supra* Section VI.B.3. *See also* Greaney, *supra* note 413, at 10–11 (emphasis added) (internal citations omitted).

> do have a right to receive health care, but in a free, competitive marketplace with a corresponding obligation to pay for it.
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> This obligation to pay for health care departs significantly from the historical tradition of the charitable, nonprofit hospital—a tradition arising from a bygone era when the country's health care needs could be met wholly through charitable care-giving, institutional or otherwise. Such era ended when health care became commercialized as a result of knowledge and technology that exponentially expanded both the complexity and cost of health care services. Health care today constitutes a mature "industrial sector," consisting of a heterogeneous web of participants that includes nonprofit and for-profit service-providers, as well as innumerable sector-supporters. The web is diffuse and disparate, reflecting a high degree of specialization and comprising 17% of the nation's economy. It is also unwieldy and dysfunctional, and plagued with unintended consequences and counterproductive incentives. The often-sensationalized wayward behavior of some tax-exempt, nonprofit hospitals is but one example of this dysfunction.[596]

So we concluded in our initial article. These changes in the American health care delivery system and the public's reaction to them have drawn into question the continued viability of the traditional and limited binary choice of nonprofit and for-profit corporate forms for institutional healthcare delivery. The ACA's expected reduction in the need for charity care, and its new requirements for improving the value, quality, efficiency, and accountability of healthcare services with systems-based care management applied through integrated care models, signals the need for a new organizational paradigm. Such need will continue, regardless of the ACA's ultimate fate.

Borrowing from the "Social Responsibility Movement" in corporate law, the HCBC is proposed as a conceptually and structurally-new "dual mission" corporate form that will enable a better balancing of the two competing and often-conflicting imperatives that are inherent in the modern health care delivery system: providing the "public good" of

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[596] Corbett, *supra* note 3, at 178–79.

broadly-available, high-quality health care services at the lowest possible cost, while still meeting the financial "margin" requirements of increasingly complex, large-scale, and technology-dependent business operations. By "melding" these two heretofore-antagonistic imperatives within a single governance and management structure of a legal entity dedicated to "mission primacy," the HCBC is expected to create "a broad new composite reality" wherein the legitimate interests of multiple stakeholders can be acknowledged—and the professional culture and fiduciary responsibilities of health care delivery can be properly manifested—with an accompanying and necessary restoration of patient trust.

At the end of the day, development and use of "corporate forms" should not be limited to the strictly economic purposes of providing the ways and means for Adam Smith's "invisible hand" to allocate resources to provide the greatest financial return, or for providing "charity care" where markets fail. Rather, new forms should be developed and adopted that can accomplish such broader purposes as best marshaling, organizing, and controlling the multiple inputs and outputs necessary to produce and justly distribute something as technologically-demanding, complex, and essential to human well-being as professional, competent health care. As R. Buckminster Fuller said: "People should think things out fresh and not just accept conventional terms and the conventional way of doing things."[597]

[597] Blum, *supra* note 265, at 459 (citing R. BUCKMINSTER FULLER, SYNERGETICS (1975)).