The following developments from the past month offer guidance on corporate and governance law as they may apply to health care organizations:

**INCREASING FOCUS ON CORPORATE PURPOSE**

There is a notable increase in governance discourse on the relationship of corporate purpose to sustainable revenue growth, in the context of changing social and political structures.

Prominent thought leaders such as Laurence Fink and Martin Lipton are emphasizing the “inextricable link” between corporate social purpose and profit. According to Mr. Fink, a company that truly understands and expresses its corporate purpose is more likely to function with the discipline that will produce long-term profitability. His 2019 letter to corporate CEOs continued his emphasis on the need for corporate leadership to focus more on the social and environmental needs of the regions and communities a company serves.

Mr. Lipton advises that concepts of social responsibility and environmental/social/governance criteria in investments “are becoming mainstream governance topics that encompass a wide range of issues,” including, for example, “climate change, systemic financial stability, human capital management, worker retirement, supply chain labor standards and consumer/product safety.”

Underscoring the timeliness of the social purpose discussion, Microsoft and Facebook recently contributed significant funding towards the development of affordable housing in Seattle and San Francisco, respectively.

These developments present a potential threat to the tax exempt status of nonprofit health systems. As for-profit corporations (especially those in the health care industry) commit to corporate social responsibility purposes, they narrow the distinction between their corporate purposes and those of nonprofit corporations as it relates to the justification of tax exempt status. The pressure for nonprofit health systems to demonstrate how their purposes are materially different from those of for profit systems will increase.
POST-SCANDAL GOVERNANCE CHANGES

The newly released Business Standards Report from Wells Fargo provides a comprehensive template for how boards (including those in health care) may implement governance and compliance based “lessons learned” from corporate scandals.

The report is premised on an acknowledgement of the root causes of the well-chronicled compliance scandal:

• Performance management and incentive programs that drove behaviors that were both inappropriate and inconsistent with corporate values

• A decentralized business model that granted too much autonomy to management and de-emphasized corporate oversight

• Certain control functions that adopted a narrow “transactional” approach to issues as they arose

The value in the Report is its description of the governance, structural, compensation and compliance based changes made in response to the scandal. These include the following:

• Eliminating product sales goals incentives for retail bankers and changing their incentive and performance management models to focus on customer experience and broader “team” incentives

• Centralizing functions such as corporate risk, human resources, finance, technology and data in order to ensure greater corporate oversight and consistency

• Adopting a more refined, comprehensive and better resourced risk management function

• Adopting a series of governance changes aimed at strengthening oversight and other board practices

Among the most significant governance changes were separating the chair and CEO roles; implementing compensation-based accountability actions against certain executives; changing the composition of the board to add members with experience in financial services, risk management and human capital management; changing the leadership and membership of several important board committees; amending committee charters to stress risk oversight factors; and improving the level of management reporting and analysis to the board.

THE 2019 ACC SURVEY

The latest edition in this important annual review provides relevant information to the board and executive leadership on the expanding role of, and the value provided by, the chief legal officer (CLO).

The survey articulates changes to the CLO’s role emerging from what the Association of Corporate Counsel (ACC) calls “the age of the chief legal officer.” These changes collectively indicate that CLOs are assuming more prominent roles within their respective organizations, which involve them in tasks beyond those of technical legal advisor. The CLO’s expanded role is attributed in part to such factors as rapid regulatory change, globalization, disruptive technology and the growing importance of corporate social responsibility issues—all of which, the survey correctly notes, have significant legal implications.

Several specific observations of the survey are of relevance to hospitals and health systems:

• The CLO’s role is that of an organizational leader on matters of ethics and culture, and on corporate sustainability efforts.

• 78 percent of surveyed CLOs report to their CEO (with an even higher percentage in Fortune 500 companies).

• 70 percent of those surveyed indicated that management regularly seeks their input on business decisions (i.e., when the CLO is not consulted in the business decision process, risk increases).

• A primary focus of CLO dialogue with the board focuses on risk-related issues.

• New regulations, brand and reputational issues, as well as disruptive technology, can be expected to significantly affect corporate decisions in 2019.

• The role of legal operations staff in the management of in-house legal departments is increasing.
Board and executive leadership should be made aware of these and other important conclusions of the ACC Survey as they relate to the proper organizational role of the CLO.

KAUFMAN HALL CFO OUTLOOK

The 2019 version of Kaufman Hall’s annual “CFO Outlook” makes an important observation about confidence in the health system’s ability to make critical decisions in the current transformational health industry environment.

One of the Outlook’s leading conclusions is that “CFO confidence” in organizational ability to manage the financial impact of evolving business conditions has dropped. Only 23 percent of the surveyed CFOs “are very confident in their team’s ability to quickly and easily make adjustments to strategies and plans,” which is a reduction from the 2018 survey. Kaufman Hall concludes that the data represents “red flags” that should be of “serious concern” to health systems, especially as it relates to the system’s ability to apply organizational agility to the twin challenges of changing payment and delivery models.

Two other survey conclusions are particularly noteworthy for the health system board. One is the perceived leading priority areas for CFOs: identifying and managing cost-reduction initiatives, predicting and managing the impact of changing payment models, and improved performance management and reporting to operational and C-suite leaders (and presumably to the board). The other is the need for management to monitor the financial impact of capital projects after their completion. This is noted as critical to effect accountability and transparency, and to ensure that capital spending does not exceed capital capabilities.

The entirety of the Kaufman Hall Outlook is recommended reading for the board’s finance committee, and should also be considered by the governance committee as it evaluates opportunities for enhancements to the board’s existing approach to making informed decisions on important issues affecting the system’s business strategy.

DIRECTOR LIABILITY FOR CYBERBREACH

Boards that didn’t previously take their personal exposure for cybersecurity breach seriously may no longer need convincing, if the recent resolution of a prominent shareholder derivative action is any indication. The case arose from a series of security incidents that afflicted an internet content and service provider. The recent judicially approved settlement requires the provider’s former directors to personally contribute $29 million to the settlement. (The company had been sold in the period following the security incidents.) The derivative action contained a number of allegations, including but not limited to breach of fiduciary duty, unjust enrichment and waste of corporate assets. Plaintiffs claimed that company leadership improperly withheld information about the breaches and were more focused on covering up the incidents than on making proper disclosure.

As some observers have noted, it is one of the first instances in which a cyber-breach-based derivative action has been successful to any degree. While the settlement amount will be paid by the defendants’ insurance carriers, this case illustrates to corporate boards the personal costs associated with allegations that they failed to meet their cybersecurity oversight responsibilities. At a more practical level, the settlement is likely to motivate plaintiff’s attorneys whose primary goal may be to access the board’s D&O coverage, as opposed to litigating until verdict.

All of this is bad news for corporate boards already suffering from cybersecurity fatigue and lack of confidence in their cyber and digital literacy. The settlement’s direct implication may be higher expectations of director cybersecurity oversight.

DIRECTOR RETIREMENT POLICIES AND AGE DIVERSITY

Several recent developments are drawing attention to director refreshment concepts regarding age-based service limits and the impact of millennial directors. For example, the FedEx board recently announced that it approved changes to its corporate governance guidelines to apply its mandatory retirement age of 75 only to non-management directors. While the company’s press release didn’t specify the reason for the change, media speculation posits that it was to allow FedEx’s prominent and highly regarded founder, chairman and chief executive Frederick W. Smith to remain on the company’s board past his 75th birthday this year.
Also notable is a new academic survey that draws some controversial conclusions about the quality of board service by independent directors over the age of 65. Among these are that such directors are less able or have weaker incentives to fulfill board duties; that company performance suffers when it has a greater proportion of older directors on the board; and that such directors suffer from monitoring deficiencies that may limit board effectiveness in the exercise of its oversight of management.

There are no “best practices” with respect to director age limits. The Commonsense Principles of Governance 2.0 recommend that whatever the case, companies should clearly articulate their approach on term limits and retirement age. To the extent the board allows exceptions, the bases for particular exceptions (in the context of the board’s assessment of its performance and composition) should be clearly documented.

The “age diversity” of the board, appropriateness of age limitations, and the effectiveness of directors over a certain age are all likely to be a source of serious governance committee discussion over the next several years as boards of many leading companies become notably older in age. Contributing to the issue is the continuing demand for experienced independent directors, while companies limit the outside board service of their own directors. At the same time, there are slowly increasing amounts of data and other information on the perspectives and tendencies of director candidates from the “Generations X, Y and Z” eras.

All of this will increase expectations for the governance committee to make thoughtful, informed decisions with respect to age diversity on the board.

BUSINESS JUDGMENT RULE AND NON-DIRECTOR EXECUTIVE OFFICERS

Senior executive leaders should be counseled on conduct that could prompt fiduciary claims, given the ongoing uncertainty surrounding business judgment rule protection.

As executive leaders face continued pressure to translate sustainable business strategy into plans that can be effectively implemented, questions naturally arise with respect to their exposure to regulatory, derivative or other challenges to their conduct. In this context, the availability of business judgment rule protection becomes a concern for non-director executive officers.

A recent Delaware Court of Chancery decision provides an equivocal response to this concern. The case was a derivative action in which a shareholder alleged that the company CEO breached his fiduciary duty in the context of the sale of Xura, Inc. to a private equity firm. In a footnote to the decision (which addressed a motion to dismiss) the vice chancellor addressed the question of the standard concerning fiduciary breaches by non-director officers.

While expressing a presumption in favor of applying the business judgment rule to the CEO, the vice chancellor acknowledged the unsettled nature of the law on this point (i.e., whether the rule should apply, versus evaluating executive conduct under negligence standards based on agency principles). Given that uncertainty, he recommended that such officers be counseled to take certain steps to reduce exposure to fiduciary claims—for example, by ensuring that they act with due care, not in a conflicted state and in good faith.

Health system general counsel may wish to review the state of law on this point in their own jurisdiction(s), advise their executive leadership accordingly, and also confirm for those leaders the availability of insurance, indemnification and advancement protection.

THE COMBINED CHAIR/CEO POSITION

Several recent developments commend continued discourse on the appropriateness, from a governance perspective, of the CEO also serving as the chair of the board.

Trends reflect a slight preference towards separating the position, reflecting the view that a stand-alone chair will be able to provide more effective oversight and balance to a stand-alone executive. There are also questions regarding CEO conflicts arising from votes on business proposals made by the CEO. But recent business media coverage has also reported on decisions by some major corporations’ boards to combine the position in a single individual in order to ensure continuity in a period of strong operational and financial performance.
This is another prominent governance topic for which there is no established “best practice.” For example, the Commonsense Principles of Governance 2.0 recognizes both approaches (without a specific preference) and recommends that the ultimate decision be the product of thoughtful board discussion. It also recommends that the board periodically review its leadership structure and explain clearly (in the appropriate form of public document) to interested third parties why it has separated or combined the roles, consistent with the board’s oversight responsibilities.

The expectation is that if a board combines the chair and CEO roles, it will apply a prominent designated lead independent director and governance structure. In such situations, it is important to clearly articulate the duties and responsibilities of the lead independent director in order to avoid confusion, conflict and misunderstanding.

**FAILED MERGER CONTROVERSY**

**Ongoing litigation** involving two nonprofit health systems highlights the types of legal claims that can be made by the parties to a proposed merger transaction that was terminated in the context of acrimonious circumstances.

According to news reports and litigation filings in state court, the two nonprofit systems pursued discussions in which Health System A would be substituted for Health System B as the sole corporate member of two hospitals. The parties executed a letter of intent (LOI) and commenced their respective due diligence reviews while simultaneously negotiating the transaction agreements. Unique terms of the LOI allegedly included a commitment by System A to cease negotiations with any other health system in the state during the term of the LOI, and to make a good faith deposit of $15 million in escrow in consideration for receiving an exclusivity commitment from System B. The LOI allegedly contained a due diligence “out” for System A under certain circumstances.

Subsequently, System A sought to exercise its “out” based on certain information provided to it by System B. System B refused System A’s request for return of its escrow payment, and System A filed a complaint seeking the escrow’s return as well as the cost of its due diligence. System B responded with a counterclaim alleging that System A improperly used confidential information obtained in its due diligence to attempt to recruit certain physicians away from System B.

The litigation is relevant in the context of the broader health care consolidation market. There is a notable increase in parties abandoning transactions post-LOI, for multiple meritorious reasons, such as possibility of regulatory challenge/legal feasibility issues, cultural concerns, due diligence issues and unresolvable disagreements on business issues. Depending upon the circumstances involved with a decision to terminate discussions, the allegations presented in this litigation could be relevant to the nature of disputes that could arise as a result of the termination decision, and the costs associated with the related dispute.

**LEADERSHIP ACCOUNTABILITY FOR QUALITY ISSUES**

Several recent health system developments suggest increasing board willingness to hold senior corporate management directly responsible for significant, high-profile quality of care incidents.

**In one incident involving a major medical center,** 23 employees (including members of management) were placed on administrative leave during the pendency of an internal investigation regarding allegations that a staff physician prescribed fatal doses of a particular pain medication for dozens of patients. The incident is also under local law enforcement investigation, and multiple civil suits have been filed against the involved physician and the hospital.

In another incident, essentially the entire senior leadership team of a prominent hospital resigned or otherwise left the organization in the wake of a local media investigation that identified what it described as dramatic increases in the hospital’s mortality rates. Among those leaving the organization were the hospital CEO, a vice president and the deputy director of the involved institute. The chair of the hospital’s department of surgery resigned his administrative position.

In both instances, the respective state departments of health and the Centers for Medicare and Medicaid Services (CMS) have threatened to terminate the hospitals’ CMS enrollment. CMS’s survey processes often include a review of the role
of the hospital governing body in identified areas of concern, including any evidence available to demonstrate appropriate monitoring and oversight of hospital operations, quality, practitioner privileging and credentialing, and other issues directly related to clinical care.

These developments highlight the increasingly closer nexus between quality of care incidents, board quality of care oversight responsibilities, and the reality of individual accountability under broad concepts of corporate compliance and patient stewardship. In particular, these developments suggest that traditional focus on medical-staff-based corrective actions alone may be an insufficient organizational response to the patient, financial, legal, regulatory enforcement and reputational costs associated with catastrophic quality of care incidents.

Going forward, quality, corporate compliance and financial protocols (at the least) may serve to establish an expectation of a broader, more comprehensive board-driven (or parent-organization-mandated) response to significant patient safety concerns that encompasses not only quality improvements and policy changes, but also individual accountability of corporate executives, as well as medical staff members and allied health personnel. It is certainly not inconceivable that board members may in the future be subject to related internal investigations and other scrutiny for their possible role in similar incidents.

FOR MORE INFORMATION
For additional information on any of the developments referenced above, please contact Michael at +1 312 984 6933 or at mperegrine@mwe.com or visit www.mwe.com/governinghealth.

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