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ABSTRACT: This Article provides an analytical framework for assessing state regulation regarding lay ownership of healthcare entities. The author suggests there are three categories of state regulation restraining lay ownership, each focused on a particular stakeholder in healthcare transactions: provider, patient, and payor. These regulatory paradigms are analyzed through a discussion of three state approaches (California, Illinois, and Florida), each exemplifying a particular stakeholder schema. The Article then highlights shortcomings of the three schemas, pointing out formal frustrations, application inequities, and doctrinal flaws. The author concludes that any successful state regulation of lay ownership in healthcare should incorporate aspects of all approaches in pursuit of accommodating the needs of all three stakeholders.

Our federalist system has produced a variety of state laws, rules, and regulations concerning ownership or control of entities that provide healthcare by persons who are not themselves licensed to provide such services. Some states prohibit lay-owned corporations from hiring physicians to provide medical services; some prohibit professionals from sharing their fees with lay persons; and some use variations and combinations of such strategies. Regulation of the ownership of physician practices and other healthcare entities by nonprofessionals is a subject of enduring concern, and particularly relevant in an era searching for new models for delivering quality healthcare on a cost-effective basis. If the search seems to have stalled since the spectacular rise and fall of the largest

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I lay ownership publicly-held practice management companies in 1999, the regulatory environment is at least partly responsible. Rules that purport to preserve professional integrity by restricting lay ownership also have the effect of restricting access to the capital and operational resources lay investors can provide. To a lay-owned entity developing a business plan subject to these laws on a multi-jurisdictional scale, the legal impediments are at best confusing. In many respects, such laws are as ineffectual as they are confusing, and at worst they unnecessarily impede progress towards solutions to the problems embedded in the national quest for access to high quality healthcare at a reasonable cost. Despite their failings, and despite repeated pronouncements of their demise, these laws persist, and courts continue to insist that they reflect public policy. This Article undertakes to explain why state restraints on lay ownership of healthcare enterprises endure, why they fail, and how they might better be conceived.

This Article advances an analytical framework for assessing regulatory restraints on lay ownership of healthcare provider entities. There are essentially three categories of state regulation of lay ownership of healthcare entities, focused respectively on the interests of the three parties typically involved in healthcare transactions: the provider, the patient, and the payor. This will become evident through analysis of the regulatory schema of three representative jurisdictions, California, Illinois, and Florida. Each regulatory program reflects a crucial policy need (hence the resilience of these rules), but each is, in and of itself, flawed. A regulatory program constructed from the singular perspective of the provider tends to overvalue professional autonomy and undervalue the needs of the payor, such as cost control and rational allocation of goods and services. Similarly, a regulatory program focused on the payor's need to constrain utilization, as through rules aimed at fee-splitting, kickbacks, and physician self-referrals, may undervalue provider autonomy and quality assurance; and a program aimed at promoting the patient's need for quality assurance, as through licensure, may undervalue both issues of resource allocation and those of provider autonomy. Taken alone, each such regulatory program fails because it does not harmonize with the reality of healthcare, which of necessity involves all three perspectives.

Put another way, any successful program seeking to regulate lay involvement with healthcare should accommodate the needs of
all three participants, the provider, the patient, and the payor.\(^1\) In a conceptually complete program, a healthcare provider should be required to take into account not only the need for quality assurance, but also the cost of healthcare, and the need to allocate healthcare goods and services rationally. The duty of the physician should be expressed not only in terms of the best interests of the patient, but also in terms of cost. The provider should be able to, indeed should be required to, consider allocation and access issues while evaluating her patient's need for quality care. The physician ultimately stands in a fiduciary relationship to the payor as well as the patient. For its part, the payor has a duty to consider the patient's needs, even while negotiating with the provider of healthcare services for coverage and cost. The patient, moreover, should accept a degree of responsibility for cost, particularly when circumstances (pure indemnity insurance, for example) put him in a position to conspire with the provider for coverage and access at the expense of the payor. Similarly, a regulator standing in the shoes of the patient to assure quality should be required to consider both the needs of the patient and the provider. Healthcare regulation should not create monopolies through licensure without considering as well the scope of services thereby made available to the public, and the patient's rights to healthcare self-determination. Nor should regulators insist on quality assurance at the expense of professional autonomy, the engine that drives innovation in healthcare. As they currently stand, state laws regulating lay participation in healthcare evidence the dangers of excessive protectionism. Regulators have an obligation to give healthcare professionals sufficient scope to evolve their profession. To the extent that all regulatory restrictions on lay ownership claim to serve public policy, these claims should be reviewed in the light of what is evident from the experiments that have historically been conducted throughout our federalist system, namely that any such policy—indeed, perhaps any healthcare policy—must accommodate the perspectives of all the participants in healthcare transactions: the provider, the patient, and the payor.

\(^1\) The payor is not always a third-party, of course; but even when the patient is the payor, the patient is acting in a separate capacity, which for purposes of the paradigm under consideration in this Article, may be envisioned as a third-party, such as an insurer.
I. Public Policy in the Managed Care Era

The enactment of health maintenance organization (HMO)-enabling legislation in the 1970s should have ushered many other successful models for lay ownership of healthcare delivery enterprises into the market. Before the passage of this legislation, before nearly every state followed suit with its own HMO legislation, and before the advent of profit, as well as nonprofit, multi-conglomerate hospital systems employing house physicians, it was relatively easy to articulate principled and reasoned objections to the employment of physicians by corporations. Commercialism was said to be essentially incompatible with professionalism. The profit motives of lay-owned organizations could corrupt the judgment of a healthcare provider and impair professional autonomy, and the loyalty a physician employee would owe to a commercial employer would conflict with her duty to her patient. Arrangements pursuant to which lay-owned commercial entities sold medical services to the public, or by which industry groups contracted with physicians for discount, and, it was argued, low-quality, medical services for employees had long been discredited by professional societies such as the American Medical Association ("AMA"). The protests of medical professionals against lay control found expression in a variety of state laws, regulations, and court decisions limiting the abil-
ity of lay-owned corporations to employ or control healthcare professionals or share in revenues from healthcare services. Such arrangements were generally and collectively known as the "corporate practice of medicine."

But of course everything has changed since then. State and federal statutes authorizing the formation of HMOs have made it evident that public policy is not offended by every manifestation of the corporate practice of medicine. Federal enabling legislation is explicit: federally-qualified HMOs are exempt from state laws prohibiting the corporate practice of medicine or similar arrangements. The Model Health Maintenance Organization Act propounded by the National Association of Insurance Commissioners provides for explicit preemption of state corporate practice laws. State HMO acts generally follow suit as required, which is generally the case because one of the organizational models contemplated for HMOs involves the

8 See Arnold J. Rosoff, *The Business of Medicine: Problems with the Corporate Practice Doctrine*, 17 CUMB. L. REV. 485, 500-01 (1987) ("A 'free market' approach and entrepreneurism in health care delivery are not merely tolerated these days; they are openly encouraged by governmental and private actions at many different levels.").

9 See Judith Parker, *Corporate Practice of Medicine: Last Stand or Final Downfall?*, 29 J. HEALTH & HOSP. L. 160, 161 (1996) (observing that "the prohibition against the corporate practice of medicine is not absolute . . . ", as evidenced by selective laws permitting the employment of physicians by HMOs, professional medical corporations, non-profit corporations, fraternal organizations, and hospitals).


11 Section 26(c) of the National Association of Insurance Commissioners (NAIC) Health Maintenance Organization Model Act of 1990 (Act) provides as follows: "Any health maintenance organization authorized under this Act shall not be deemed to be practicing medicine and shall be exempt from the provision of [citation] relating to the practice of medicine." NAIC, *HEALTH MAINTENANCE ORGANIZATION MODEL ACT § 26(c) (1991), reprinted in HEALTH CARE CORPORATE LAW: MANAGED CARE app. A at 1-172 (Mark A. Hall & William S. Brewbaker eds., vol. ed. 1996). In addition, Section 3(a) of the Act provides: "Notwithstanding any law of this state to the contrary, any person may apply to the commissioner [director, superintendent] for a certificate of authority to establish and operate a health maintenance organization in compliance with this Act." *Id.* at 1-132. The Act defines a "health maintenance organization" as "any person that undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments and/or deductibles," and further defines a "person" as "any natural or artificial person including but not limited to individuals, partnerships, associations, trusts or corporations." *Id.* at 1-131 to -132.

12 For a list of state HMO acts creating exceptions to corporate practice bars, see Parker, *supra* note 8, at 170 n.47. See, e.g., 40 PA. CONS. STAT. § 1554(a) (1999) ("Any law to the contrary notwithstanding, any corporation may establish, maintain and operate a health maintenance organization upon receipt of a certificate of authority to do so in accordance with this act."). But cf. Mo. Rev.
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direct employment of staff physicians, in contravention of the
corporate practice of medicine doctrine. Scholarly commentary
has generally urged reconsideration of the doctrine due to
its anachronism, its internal vagaries and inconsistencies, and
its history of erratic enforcement. Indeed, at one point in the
not-too-distant past, Congress contemplated legislation that
would have globally preempted state corporate practice bars,
whether or not in a managed care context.

HMO legislation is only one of the signs that state restrictions
on corporate practice and lay ownership should be fading. By
1971, all states had enacted statutes allowing physicians to
practice through professional corporations, although such
laws generally restrict share ownership to licensed professionals.
Courts in jurisdictions with corporate practice bars have long
taken judicial notice of the fact that hospitals and their affiliates
employ physicians, and enforcement of restrictive doctrines in

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models are (i) staff model HMOs, which directly employ physicians to provide
healthcare services; (ii) group model HMOs, which contract with an independent
multi-specialty physician group; (iii) network model HMOs, which
contract with multiple groups on a non-exclusive basis; and (iv) individual
practice association ("IPA") model HMOs, which contract with an IPA that in
turn contracts with individual healthcare providers. Id.

14 See Michael A. Dowell, The Corporate Practice of Medicine Doctrine Must Go,
HEALTHSPAN, Nov. 1994, at 7, 8; Chase-Lubit, supra note 5, at 475-87. See also
Parker, supra note 9, at 168 (noting that while the public policy reasons behind
the doctrine remain important, "[t]he doctrine's necessity may have passed.
The doctrine is riddled with exceptions; many states ignore the doctrine and
some outrightly have refused to enforce the doctrine. Changes in the health
care industry have also contributed to the demise of the corporate practice
prohibition, including the evolution of HMOs and the continuing rise in health
care costs.").

15 Health Care Fraud Prevention and Paperwork Reduction Act of 1995, H.R. 1912,
104th Cong. § 141 (1995) ("No provision of State or local law shall apply that
prohibits a corporation from practicing medicine.").

16 See Robert W. Hamilton, Professional Partnerships in the United States, 26 J. CORP.
L. 1045, 1048 (2001); Richard O. Jacobs & Elizabeth Goodman, Splitting Fees
or Splitting Hairs? Fee Splitting and Health Care—The Florida Experience, 8 ANNALS
HEALTH L. 239, 246 (1999); Patricia F. Jacobson, Prohibition Against Corporate
Practice of Medicine: Dinosaur or Dynamic Doctrine?, in 1993 HEALTH LAW HANDBOOK

17 See, e.g., Bing v. Thunig, 143 N.E.2d 3, 8 (N.Y. 1957) (Hospitals "regularly em-
ploy on a salary basis a large staff of physicians, nurses and interns, as well as
administrative and manual workers, and they charge patients for medical care
and treatment, collecting for such services, if necessary, by legal action.").
some of these jurisdictions is notoriously lax. In some jurisdictions, courts have gone out of their way to infer exceptions for specific practices, such as employment of physicians by teaching hospitals, private hospitals, federal military hospitals, and employers engaging "company doctors" for employees.

Under the circumstances, doctrinal restrictions on commercialism in medical practice should by now have become an historical footnote. And with the lowered legal and policy bars to lay equity participation in healthcare enterprises that should have resulted, there should now be a greater variety of arrangements than currently exist, under which healthcare providers could find employment, share enterprise ownership, access debt and equity financing, shift management responsibilities, create personal mobility and practice exit plans, and so forth. But the corporate practice doctrine and related impediments to lay ownership have proven remarkably resilient. As evidence, consider the following catalogue of concerns addressed in the Management Discussion and Analysis sections of Annual Reports filed by companies providing practice management services to physicians throughout the United States:

- State corporate practice laws, variously prohibiting the acquisition and ownership of healthcare provider entities and the employment of professionals by nonprofessionals or corporations;
- State laws prohibiting the practice of medicine without a license;

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18 Mark A. Hall & Justin G. Vaughn, The Corporate Practice of Medicine, in Health Care Corporate Law: Formation and Regulation § 3.4, at 3-13 to -14 (Mark A. Hall ed. 1999).
19 Id. at 3-14.
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- State licensure, registration, and minimum net worth requirements for insurance companies (a concern for risk-bearing PPMCs);
- State fee-splitting laws (whether aimed at kickbacks, improper practice development incentives, or quasi-ownership arrangements), especially where a management fee is based on a percentage of revenues or profits;
- State and federal antikickback regulations and self-referral prohibitions, especially when a management fee is based on a percentage of revenues or profits;
- Various payor restrictions on the assignment of professional receivables;
- Public policy restrictions on the enforcement of non-competition covenants against professionals;
- Federal and state antitrust regulations (especially price-fixing regulations and, if applicable, regulations triggered by market share);
- State certificate of need statutes and regulations controlling the development of new facilities and expansion of existing ones;
- Requirements of various payor programs for certification for reimbursement.

Why are the legal and policy barriers to lay ownership of healthcare enterprises so resilient? To the extent the answer is simply political expediency, legislative inertia, or the intransigence of

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22 Federal laws, and often state laws, carry civil and criminal penalties, together with the threat of expulsion from payment programs. Conduct raising the concern includes not only exclusivity and referral arrangements, but also physician practice acquisition, since physicians would remain under contract after the purchase and no "safe harbor" or Stark "exception" would exist. Amsurg, supra note 21, at 9–10; PhyCor, supra note 21, at 12–13.

23 E.g., Women's Med. Ctr. v. Finley, 469 A.2d 65 (N.J. Super. Ct. App. Div. 1983) (discussing physician-owned medical practices who contract with privately owned management companies, and whether these physician groups forfeited their private practice status and were therefore subject to New Jersey's certificate of need requirements).


professional interest groups, there is perhaps little of interest to be said on the subject. But to the extent that the legal barriers purport to stand on their merits and to serve public policy principles, other questions come to mind: Do the laws properly and effectively serve those principles? Why, as we shall see is the case, are the applicable laws so multiform, so porous, and so erratically enforced? Are they informed by a single coherent underlying principle, or several? Why are some entities (notably HMOs, stand-alone emergency care clinics, ambulatory surgical centers, and hospitals) treated differently from others in which nonprofessionals have equity interests? These are the questions that have prompted this Article, and that presumably have tormented many a business person, lawyer, physician, and investor contemplating a healthcare business plan affected by this doctrine. If there are to be changes in legislation and common law with respect to the issue of lay ownership, such changes should be informed by the answers to these questions.

This Article proposes an analytic approach to the body of law affecting lay ownership of healthcare enterprises. The history of the applicable doctrines is already well documented; More useful now is an understanding of their logic and the effect they are having on contemporary business planning. With an analytic framework with which to evaluate the various existing legal restraints, courts, agencies, and legislators should be more open to innovation that rationally protects the legitimate concerns and advances the legitimate interests of all groups involved. Progress toward that objective will involve discarding some venerable but unsound articulations of principle and creating new licensure authority for state or federal agencies.

II. The Physician Practice Management Company: An Experiment in Lay-Professional Partnering

The physician practice management company (PPMC) as it emerged and then declined in the 1990s was one such innova-

26 Rosoff, supra note 8, at 492 (noting the pressures brought to bear on legislatures by the AMA).
28 E.g., Chase-Lubitz, supra note 5.
tion. Once the darlings of Wall Street, the most ambitious of such companies have by now gone under or reconceived themselves. If their demise was in part due to the discovery that the exuberance with which they were initially greeted by investors was generally unjustified, the strain of complying with a multitude of state and federal regulations could not have helped. Regulation not only increased start-up and compliance costs, but provided disgruntled physicians with a ready store of legal claims and defenses when they sought to terminate their affiliations with PPMCs.

Very generally, PPMCs are lay-owned companies that provide management services to physicians. Such management services generally consist of billing, practice development, negotiating professional services and other contracts, providing non-professional personnel services, office space and equipment, insurance, accounting and legal services, and similar administrative support.


32 Id. at 500.

A. The Promise

The potential advantages of the PPMC arrangement to physicians were considerable. If the arrangement involved the sale and purchase of the physician's practice, the physician immediately realized full value for her practice. Purchase prices often included value for goodwill as well as assets and receivables, even when the selling physician remained in practice with the purchaser, which option was frequently not available in sales of practices to hospitals or other doctors. In any event, immediate realization of equity in a practice solved what many physicians had begun to appreciate could be a significant problem, the practice exit strategy. At a time when it had begun to appear that sales of practices by retiring physicians to younger physicians would become more rare, when state and federal regulations had begun to impact the form of such transactions adversely, when the flurry of acquisitions by hospitals and HMOs had begun to show signs of slowing, PPMCs were there to secure a selling physician's retirement in advance, often with a combination of cash and stock in companies then heralded by Wall Street.

In addition to the personal exit strategy, PPMCs provided selling physicians with other advantages. Doctors could be freed from administrative headaches to concentrate on providing medical care. Salaried doctors were promised income security.

34 Borsody, supra note 33, at 11.


36 Because no “exception” existed for such transactions under the Stark Law, 42 U.S.C. § 1395nn (2005), and no “safe harbor” under the Federal Fraud and Abuse Act § 1128B, commonly known as the Antikickback Statute, 42 U.S.C. § 1320a-7(b) (2005), such transactions risked civil and criminal prosecution. The risk related not only to the payment for goodwill (potentially a payment for a stream of referrals), but also to subsequent incentive compensation arrangements. See OIG, HHS, Advisory Op. No. 10 (Aug. 31, 1998), available at www.oig.hhs.gov/fraud/docs/advisoryopinions/1998/a098_10.htm (last visited Dec. 22, 2005).

37 See Cohen, supra note 31, at 496; McDowell & Brown, supra note 35. See also Rosoff, supra note 8, at 496 (noting the growing trend toward use of lay-owned management companies in the operation and financial support of physician practices in the late 1980s). See generally Respondents' Brief at 2-10, Moore v. Orthodontic Centers of America, Inc., No. D0358082002, WL 32351 (Cal. Dist. Ct. App., Jan. 11, 2002) (arguing that benefits provided to physician by PPMC included working capital loan, living allowance, office, equipment, staff, payroll, employee benefits, inventory management, accounting, billing, purchasing, marketing, insurance claim processing and enhanced practice mobility in relocating physician from a failing practice in Virginia to a successful one in California).
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PPMCs could offer revenue enhancement through ancillary medical services and access to clinical trials. PPMC doctors were afforded personal mobility and crisis support where the PPMC could help arrange professional or nonprofessional staff coverage. Where not prohibited by self-referral prohibitions, other PPMC-affiliated doctors constituted a pool of reliably-credentialed professionals to which to refer and from which they might receive referrals. Enhanced access to private and public capital markets often meant additional cash was available for practice development and capital projects, such as office and equipment upgrades or expansions. Overhead could be reduced through economies of scale and with the implementation of software solutions that had previously been out of the reach of individual practitioners. PPMC billing expertise could result in higher profits and fewer errors. PPMC clout could result in more favorable terms under managed care agreements or office and equipment leases. PPMC development resources could lead to new business. To the extent permitted by applicable employment or professional services contracts, doctors were sometimes afforded opportunities to relocate, which was mobility they often could not have hoped for as independent practitioners financially tied to a particular practice locale. Stock ownership in publicly traded PPMCs or options therefor seemed for a while to be excellent investments, and certainly offered more liquidity than did ownership of the assets of a typical medical practice.

Besides the advantages to physicians, the PPMC had potential benefits for consumers in terms of better facilities, more efficiently managed professional time, and even lower cost.

B. Form and Substance Struggles

In the earliest stage of their development, where permitted by law,38 many PPMCs experimented with business models involving direct purchase of physician practices and subsequent employment of the selling physician, since this format had the highest appeal to investors.39 The attractions for investors were (i) the value of the acquired practices could immediately be reflected on the companies' balance sheets, and (ii) as owner/employer, the PPMCs retained full ownership and control of all practice revenues. To the extent that practice acquisitions could be made with PPMC stock, more capital remained available for

38 Borsody, supra note 33, at 11–12.
39 Cohen, supra note 31, at 495.
operations and expansion. Publicly-traded PPMCs could pay physicians a price in the neighborhood of five to eight times the practice's annual management fee with the proceeds of stock that often traded at twenty to thirty times price-to-earnings ratios.  

As PPMCs moved across jurisdictions, they encountered a variety of state laws affecting lay ownership and were eventually forced to adjust their business models. For reasons that will become evident in a moment, most PPMCs eventually settled on a pure management model in which no equity interest in the physicians' practices was held directly by the PPMC. The relationship between the professional practice and the PPMC was that of independent contractors rather than employer/employee. This was necessary in states with law or other authority to the effect that corporations (other than professional corporations) could not employ physicians, and useful in any state to shield the PPMC from liability for professional negligence on a respondeat superior theory.

Viewed from the perspective of a hypothetical multi-state PPMC, the regulatory landscape is extremely challenging. Assuming the business plan was to acquire physician practices and subsequently employ those physicians, the PPMC could conceivably

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41 Cohen supra note 31, at 495.
42 Such restrictions exist in Arkansas, California, Colorado, Connecticut, Delaware, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Massachusetts, Minnesota, Montana, Nevada, New Jersey, New York, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Washington, West Virginia and Wisconsin. AM. ACAD. OF EMERGENCY MED. (AAEM), CORPORATE PRACTICE OF MEDICINE: STATE BY STATE LISTING OF RELEVANT STATUTES, CASES, AND OPINIONS (hereinafter AAEM), available at www.aaem.org/corporatepractice/states.shtml (last visited Dec. 22, 2005). For a shorter list of those states in which Appellate Courts have recently applied or reaffirmed the doctrine, see Andeel, supra note 29, at 275 (identifying Texas, California, Illinois, Iowa, Georgia, and Kansas).
43 But see, e.g., Wadsworth v. McRae Drug Co., 28 S.E.2d 417, 419 (S. Carolina 1943) (stating that a corporation may not avoid the professional negligence liability of its licensed employees even though corporations may not legally employ professionals to practice medicine).
44 For a survey of state corporate practice of medicine laws, see AAEM, supra note 42.
proceed to do so in Louisiana, Mississippi, New Mexico, and Virginia, but not in California, Colorado, or Illinois, and only at significant risk in Pennsylvania. Pennsylvania illustrates the ambivalence found in several states that may ultimately lead the PPMC decisionmaker to take an indirect approach to practice acquisition in order to avoid potential hazards. Pennsylvania repealed a regulation, based solely on common law, which stated that nonprofit corporations may not employ physicians to practice medicine, but the repeal left open whether the legislative intent was to overrule the common law corporate practice prohibition altogether and allow for-profit corporations to employ physicians, or merely to remove the codification of common law and allow the underlying case law precedent to continue, in which case presumably neither for-profit nor nonprofit corporations could employ physicians. Even in states

42 A Statement of Position by the Board of Medical Examiners dated August 20, 1992, provides that employment of a physician by a corporation is not *per se* unlawful under the Louisiana Medical Practice Act, as long as the physician is free to exercise "independent medical judgment in the diagnosing, treating, curing or relieving" of physical conditions. Id.

43 The Mississippi State Board of Medical Licensure does not concern itself with the form of business arrangements entered into by a physician, provided that the physician is licensed, has discretion over the method and manner of patient treatment and billing, and receives no inducement for referrals. Id.

44 1987 N.M. Op. Att'y Gen. 39, 1987 WL 270340 (concluding that a lay-controlled corporation may employ physicians to provide medical services if control of medical decisions is allocated to the physicians).


47 COLO. REV. STAT. ANN. § 12-36-117(1)(m) (West 2005) (Physicians may not practice medicine as the employee or in joint venture with any corporation other than a professional services corporation (§ 12-36-134), or any other entity, or as the partner, agent, employee or in joint venture with any lay person. Only a professional services corporation may practice medicine.); *id.* § 12-36-134(1) ("[C]orporations shall not practice medicine" except professional service corporations and except as provided in 25-3-103.2).


without an express prohibition against corporate employment of physicians, however, the PPMC could run afoul of prohibitions against excessive controls of physician conduct. As an added complication, state licensure statutes limit incorporated professionals to practicing in the state of incorporation, so a multi-state enterprise using a corporate format would have to link horizontally professional corporations licensed in separate states.

State laws that narrowly prohibit lay-owned corporations from employing physicians could be accommodated (circumvented) in various ways. One method was to employ what is called a "captive PC," or a professional corporation whose stock is owned entirely by one or more professionals contractually bound to the lay-owned entity in a manner assuring control by the lay-owned entity. The lay-owned entity, for instance, might have a professional services agreement or an employment agreement with the shareholder(s) of the professional corporation requiring the shareholder(s) to act within certain parameters with respect to the professional corporation (e.g., cause the professional corporation to enforce productivity standards for professional employees, to employ professionals on terms mandated by the PPMC, with compensation and incentive packages designed by the PPMC, and generally to comply with the provisions of the PPMC's management agreement). The "friendly" or "captive" PC could then in turn employ individual physicians. As a result, the PPMC would have indirectly what it could not achieve directly in an employer-employee relationship with the doctors. Control provisions could be inserted not only into employment agreements between the PC and the individual physicians, but also in the charter documents of the PC, in the management agreement between the PC and the PPMC, and in the employ-

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53 For example, a 1992 declaratory ruling by the Alabama Board of Medical Examiners effectively stated that "[p]hysicians are free to enter into contracts of employment for their professional services with professional corporations, nonprofit corporations, business corporations, partnerships, joint ventures or other entities, provided however, that the physician must exercise independent judgment in the matters related to the practice of medicine." AAEM, supra note 42 (emphasis in original). Similar agency positions were taken in Mississippi, Utah, and Virginia. Id. South Dakota permits corporate employment of physicians by statute, as long as the physician's independent judgment is preserved, the corporation does not mark up the physician's fees, and the arrangement is renewed every three years. S.D. CODIFIED LAWS § 36-4-8.1 (2005).
54 Hubbard, supra note 40, at III-12 to -14.
55 Id. at III-12 to -14.
56 Id. at III-14.
ment agreement (usually a medical director agreement) between the PC’s shareholder(s) and the PPMC. As added security, the “friendly” shareholder(s) of the PC were sometimes required to execute an option agreement, pursuant to which the PPMC could unilaterally require the shareholder(s) to sell their shares in the PC to a successor physician designated by the PPMC (since the PPMC could not own the shares itself). This would insure a management-friendly successor, and effectively placed into the hands of the PPMC another stick from the bundle of ownership rights.

The captive PC arrangement solved certain problems, but continued to face problems of revenue control, in that all revenue from professional services would belong to the PC rather than the management company. This weak link in the control of cash flow made lenders, investors, and underwriters nervous. In some jurisdictions, and with respect to some sources of revenue, this problem could be addressed by allocating to the management company a percentage of practice revenues equal to what would otherwise have been the lay entity’s share of equity in the PC as compensation for management services. That is, by having a right to a percentage of revenue net of expenses (profits), the management company would have the functional equivalent of an equity interest in practice revenues. In many cases, however, state statutory or common law doctrines, as well as principles of medical association ethics codes, prohibit such “fee splitting” with nonprofessionals. In such cases, a key attribute of ownership is effectively denied to the management company.

There are solutions even in jurisdictions with fee-splitting prohibitions, however. For one thing, as we shall see, some such j-

57 The Second District Court of Appeal in Florida, for instance, has held that a percentage-based management fee does not violate Florida’s fee-splitting prohibition as long as no inducement for referrals is implicated. Practice Mgmt. Assocs. v. Orman, 614 So. 2d 1135, 1138-39 (Fla. Dist. Ct. App. 1993). California allows percentage-based management fees when based on gross rather than net practice income. Cal. Bus. & Prof. Code § 650 (West 2005) (“The payment or receipt of consideration for services other than the referral of patients which is based on a percentage of gross revenue or similar type of contractual arrangement shall not be unlawful if the consideration is commensurate with the value of services furnished ...”).


risdictions frame fee-splitting rules to prohibit revenue-sharing only when the lay-owned entity is in a position to refer patients to the practice entity. For another, the management company can achieve something like the targeted percentage interest by contractually setting a flat fee in an amount estimated to equal or exceed the amount the percentage arrangement would have yielded. To protect the interest of the independent contractor physician in a negotiated minimum base income, such income could be guaranteed and would thereby come to resemble an employee's base salary more than an independent contractor's earnings. To assure that it would retain all but the revenues allocated to the physician income guarantee, the PPMC could supplement its fee with claims on practice revenue for performance bonuses, for debt repayment (from loans for start-up, upgrade, or operating costs), and for equipment and space leases. To achieve the maximum level of control over the revenue stream, the management company could undertake to bill and collect for the practitioner, then deduct fees and expenses from the proceeds. In addition, some PPMCs secured debt repayment obligations by factoring receivables. Such arrangements could in turn be further frustrated by regulatory provisions such as Medicare's anti-reassignment rule, which prohibits reassign-
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ment of Medicare receivables from the provider to a third-party except under certain circumstances.65

In the game of imbuing a (permissible) independent contractor arrangement with the control attributes of an (impermissible) employer-employee arrangement between a lay-owned PPMC and a professional, there are many stratagems in addition to the captive PC arrangement:66 To assure control a variety of mechanisms may be used: the PC or individual practitioner, as the case may be, agrees that the PPMC is the exclusive provider of management services, and the management agreement may have a very long term; the PPMC owns or controls all hard assets (equipment, space, nonprofessional staff), which it then leases to the practice; the practice may be obligated to buy the assets back from the PPMC, with physician guarantees secured by personal and practice assets; the PPMC may control managed care contracting, sometimes through a PPMC-owned provider group; where permitted, lay managers may hold offices in the PC, including directorships;67 the PPMC may control receivables, if not with a factoring arrangement, then through a billing services agreement under which practice receivables are applied to management services before being deposited to the practice’s account, or the account itself, if in the name of the practice, is subject to withdrawal restrictions protective of the PPMC; physician employment agreements, whether directly with the PPMC or with the friendly PC, contains restrictive covenants prohibiting the physician from competing with any practice controlled by the PPMC; any financing arrangements provided by the PPMC may be further secured by practice and personal physician assets; any practice acquisition consideration in the form of stock or options in the PPMC may be conditioned on continued physician compliance and performance goals; where

65 42 U.S.C. §§ 1395g(c), 1396a(a)(32) (2005); 42 C.F.R. §§ 424.73(a), 447.10(a) (2005). CTRS. FOR MEDICARE & MEDICAID SERVS., CARRIERS MANUAL PART III, ch. 3, § 3060 (July 1999), available at http://www.cms.hhs.gov/Manuals/PBM/list.asp (last visited Jan. 4, 2006). While direct payment of Medicare/Medicaid receivables can generally not be made to a third-party creditor, the provider may pledge them as long as payment is first made to the provider, who then pays the third-party. PPMCs typically use a “lockbox” arrangement to satisfy this requirement: receivables are deposited into the provider’s account and the PPMC “sweeps” the account on a daily basis. A lender’s security interest in Medicare/Medicaid receivables must be nonpossessory. See Michael M. Schmidt, Physician Management Service Agreements, at III(B)(7) (unpublished seminar outline), available at http://tinyurl.com/gpcb8 (last visited Mar. 5, 2006).
66 Hubbard, supra note 40, at III-4-7.
67 Connecticut permits three-fourths of the members of the board of directors of a healthcare center to be lay persons. CONN. GEN. STAT. § 38a-179(a) (2005).
the transaction began with a practice sale and purchase acquisition, subject to any applicable antikickback regulations, physicians may be further controlled by terms providing for deferred payment based on practice performance. As a further control device, some PPMCs established joint policy boards with practitioners to establish productivity goals and generally supervise actions taken to achieve them. The joint policy board could deadlock a PC in the event it sought to take a direction deemed by the PPMC to be inimical to business purposes.

With respect to the joint policy board and every other control mechanism used by PPMCs, it was always important to make it explicit that professionals would remain solely in charge of medical decisions. This was important not only, as previously noted, as a defense against any claims for professional negligence that might be brought against the PPMC itself, but also because no PPMC would wish to be deemed to be practicing medicine in violation of the medical practices or licensure act of any given state.

And so it goes, at virtually every point in the business plan of the PPMC, another regulatory hurdle, and with each such hurdle, another brilliant legal solution. Ultimately, rather than use one business model in some states and another in others (with the inevitable further state-to-state customization for still other reasons), most PPMCs chose a model that accommodated the largest number of regulatory circumstances with the least amount of state-to-state adjustment. For the most part, this meant a pure management model. But this choice was only the starting point on a path with many more choice points to follow involving control through captive PCs, management agreement terms, financing arrangements, joint policy boards, and so forth.

The example of the PPMC yields two observations of immediate relevance here. The first concerns the fact that the architects of PPMCs were forced to alter their business model to accommodate the vagaries of different state laws, and the second concerns the fact that the PPMC designers were able to do so. Let it first be acknowledged that the multitude of state laws in

68 Besides those contained in the Stark Law, 42 U.S.C. § 1395nn (2005), and the Federal Fraud and Abuse Act § 1128B, 42 U.S.C. § 1320a-7b (2005), various similar state antikickback regulations may be implicated by earn-out provisions.

69 Hubbard, supra note 40, at III-16.
our federalist system had the effect of forcing PPMC planners to ring changes on the initial model involving direct employment of physicians. Even the least obstructive of the state rules in question would have this effect, because lawyers knowing they would be required to give an enforceability opinion to a PPMC lender would not readily gamble on a direct employment arrangement that might be held to violate a corporate practice doctrine or a licensure statute when a management agreement would achieve the same result. The same lawyers opining as to the due organization and valid existence of a PPMC entity in a prospectus would have similar feelings where state rules on ownership of professional corporations by professionals are concerned.

Without a doubt state laws had an adverse impact on transactional, compliance, and operations costs of PPMCs; but did the laws have the effect of protecting the interests for which they were intended? Admittedly this question cannot be answered until we can better understand the purpose(s) of those laws; but we can at least acknowledge here that the PPMCs went forward and became, at least for a time, darlings of Wall Street. The legal architects of PPMCs, that is, were successful enough to create something of value to the public financial markets, as well as to the participating physicians. Put in the most cynical terms, they circumvented state prohibitions, and did so well enough to satisfy the national equity markets and a number of physicians hoping, among other things, to rid themselves of administrative and financial distractions in order to concentrate more exclusively on the application of their professional skills. The PPMC could be structured as a relative of the HMO, the credentials of which had already passed the scrutiny of public policy, except

Commentators have occasionally observed that the corporate practice doctrine, for instance, is moribund, and that enforcement would be unlikely. Jacobson, supra note 16, at 67. Some reputable hospital systems, however, calculated and then took the enforcement risk when they initiated programs in the 1990s to acquire physician practices in states with common law corporate practice doctrines. The Hospital of the University of Pennsylvania, for instance, established a subsidiary nonprofit, Clinical Health Care Associates, through which to acquire practices and employ the selling physicians, as did Wilkes-Barre General Hospital in the same state, at a time when counsel for Pennsylvania’s Corporation Bureau generally took the position that nonprofit corporations could not employ physicians. See Letter from John T. Henderson, Jr., Assistant Counsel, to Melinda J. Roberts (May 3, 1994) (on file with the Secretary of the Commonwealth of Pennsylvania); 19 Pa. Code § 41.4(d) (repealed 1998).
that a PPMC is arguably less intrusive than the HMO where such principles as physician autonomy, quality assurance, and the physician-patient relationship are concerned. At any rate, the relative success of the adaptive strategies of PPMCs in circumventing state laws forces us to ask whether any of those laws served other than a temporarily obstructive purpose. Advocates of lay-owned healthcare enterprises may lament the compliance costs and the litigation risks necessitated by the applicable regulations, all of which inevitably add to the cost of capital. Anyone not inclined to cheer the advance of lay ownership of healthcare enterprises may applaud their demise, but nonetheless wish to reflect on the lost opportunities to physicians in terms of access to capital markets, mobility, retirement strategies, cost-effective administrative services, avoidance of management responsibilities, bargaining leverage with managed care and other payors, and so forth. But anyone, even someone not wishing well to lay-controlled healthcare, may feel discomfort at the picture of a regulatory environment whose objectives could apparently be fully circumvented, albeit at the costs detailed above.

III. State Law: Rules and Rationales

Did state laws succeed in protecting challenged values in the case of the PPMC? Was the underlying regulatory rationale served, for instance, by compelling the shift from a model in which a lay entity directly employed physicians to one in which the lay entity provided management services? If the purpose of the doctrine was to prevent unlicensed persons from practicing medicine, it could be said that at least there was no failure on the part of the doctrine. PPMCs, like HMOs, are scrupulous (at least on paper) in the observance of the principle that the physician is solely responsible and has sole authority with respect to medical conduct. After all, liability for professional negligence is at stake. But then again, this objective could have been met within a direct employment arrangement if all that is required is a straightforward stipulation to the effect that the physician is autonomous within the scope of her professional practice. If on the other hand the purpose of the doctrine is to assure that financial control of the practice is retained by the professional, or that the professional determines who may succeed to practice ownership, or where he may practice, or with what equipment,

71 On circumvention, see Rosoff, supra note 8, at 499.
or even how the line between professional and commercial conduct is to be drawn, the doctrine appears to have fallen short of its objective. As evidenced by the PPMC, these elements can be controlled by lay persons even when there is no direct employer-employee relationship.

A. Introduction

1. The Corporate Practice Doctrine

One of the principal mechanisms by which states restrain lay ownership of medical practices is a collection of rules and statutes generally known as the "corporate practice doctrine." This doctrine includes prohibitions against corporate employment of physicians and against the unlicensed corporate practice of medicine. To know definitively whether the doctrine has succeeded, we need a better understanding of its rationale. For its part, the corporate practice doctrine has been said to serve the following purposes (1) preventing lay control of physician practices; (2) preventing commercialization of the profession; (3) protecting the physician-patient relationship from interference by lay interests; and it has sometimes been added that (4) enforcement of the doctrine restrains impermissible fee-splitting. Items (1) and (3) are sometimes expressed in terms of the conflict of interest that may arise when a physician owes one duty of loyalty to an employer and another to his patient. This list is a good start at understanding the doctrine, with the admission that there is some overlap and some commingling of causes and results. In the last analysis, it is hard to say why there should be three or four such categories. The objection against lay control, for instance, presumably arises from the concern that a lay-owned enterprise would elevate profit motive above the best interests of the patient, and this is presumably also the concern underlying the commercialism objection, and to some extent the objection based on protecting the physician-patient relationship. Put another way, lay control of physician practices is the enabling and causal condition, commercialism the effect, and unjustified interference the means thereto; but it is hard to escape the feeling that with some effort the entire list of could have been expressed as one objection.

72 Chase-Lubitz, supra note 5, at 467.
73 Parker, supra note 9, at 161.
74 Hall & Vaughn, supra note 18, at 3-11.
2. Other Legal Restraints

It should be noted at the outset of this discussion that the corporate practice doctrine is but one subclass of the larger class of laws affecting lay ownership of the healthcare enterprise. Others include the various state medical practice acts, which universally prohibit anyone from practicing medicine without a license; laws against physician self-referrals; laws prohibiting fee-splitting; laws against restraints of trade or business; professional corporation statutes, generally requiring all owners to be licensed; and laws prohibiting the assignment of professional receivables to anyone other than the professional who performed the underlying services. The corporate practice doctrine itself consists of several variants from jurisdiction to jurisdiction, including those that admit exceptions for nonprofits, or for hospitals, whether or not organized as nonprofits, community health centers, and fraternal organizations; those that emphasize form (no employment of physicians, but control of independent contractors can be made acceptable); and those that emphasize substance (no control of physician practices, even in an independent contractor arrangement).

If the corporate practice doctrine is only a subclass of the larger body of laws that affect lay ownership, this Article is concerned with that larger body of laws. All belong to the same general class in that they impinge upon one or another aspect of ownership. The bundle of rights that would comprise lay ownership of a healthcare enterprise would include not only the rights of an employer that are directly implicated by the corporate practice doctrine, but also, and more particularly, rights to the revenue from the employee's services and command and control rights over the delivery of medical services. Some states prohibit corporations, other than professional corporations, from employing physicians to provide healthcare services, but do not separately restrict the sharing of fees, with the effect that lay interests may participate in healthcare revenue as long as they do so by means of an independent contractor rather than an employment arrangement. Other states prohibit fee-splitting,

75 E.g., Arkansas, Connecticut, Indiana, Iowa, Kansas, Massachusetts, Missouri, Montana, Pennsylvania, Washington, and West Virginia. See AAEM, supra note 42.
but arguably do not prohibit lay-owned corporations from employing physicians.\textsuperscript{76}

For purposes of analysis, the universe of laws affecting lay ownership can be grouped according to the interests they serve rather than the various aspects of objectionable results they seek to prevent (e.g., lay control, commercialism, conflicted conduct). A given law, that is, may be oriented towards one of the three component members of the healthcare triad of interests, the physician, the patient, or the payor. There is, for instance, a body of rules whose stated objective is to preserve physician autonomy; another aimed at quality assurance; and a third focused on cost control. In the first group, which includes certain types of corporate practice prohibitions, the implicit assumption is that to the extent practice control is left to the physician, quality of care will be best served and everything else will fall into place. The prime objective is to restrain commercialism or lay control. At the other extreme are rules arising from a concern with possible adverse results from excessive physician control, including runaway costs. From this perspective rules restraining overutilization of healthcare goods and services are necessary, and physician autonomy is a subordinate value. Rules in this group attempt to remove incentives for overutilization by regulating fee-splitting, kickbacks, and the like; or they attempt to remove restraints on competition, such as professional association advertising restrictions and antitrust laws; or they attempt to improve resource allocation, as with certificate of need laws requiring economic justification and regulatory approval for deployment of new facilities. And not fully accommodated by either the physician autonomy or the payor-oriented rules is the quality assurance perspective, which seeks to serve the interest of the patient by assuring that practice standards are met. Licensure laws are the preferred method of advancing this interest—both the autonomy of the physician and the interest of the payor are subordinate to objective practice qualifications and standards. Within jurisdictions that emphasize this rationale, the corporate practice doctrine may exist, but exceptions are made for licensed corporate healthcare providers such as hospitals.

The foregoing regulatory orientations may be represented schematically as follows:

\textsuperscript{76} Florida takes this approach. See Jacobs & Goodman, supra note 16, at 246.
This Article will ultimately urge that all such regulatory schemes, whether oriented towards provider autonomy, quality assurance, or utilization and cost control, are ultimately parts of a single whole, and that a fully articulated and integrated regulatory system needs to accommodate all three perspectives (as to a large extent HMO regulation has done). When all three perspectives are accommodated, a proper place can be found for lay involvement, even lay equity participation in the healthcare enterprise. On the other hand, when regulatory approaches to the issue of owning and controlling healthcare enterprises fail to acknowledge all three perspectives, we find regulatory schemes that seem to invite circumvention or dis-
regard. As a class, existing statutes, regulations and common law rules aimed at lay ownership of healthcare enterprises are too often reflexively prescriptive, formalistic, and fragmentary. As a result they have, ironically, proved to be relatively easy to circumvent. Faced with a ban against corporate employment of a physician, lawyers have not found it difficult to effectively duplicate an employment arrangement through a professional services agreement. Confronted with a ban on lay ownership, lawyers have responded with the near economic equivalent in the form of a management agreement.

If they are sieves on the one hand, these laws are traps for the unwary on the other; they are too frequently invoked collaterally, in contexts that do not even implicate the core rationale of the particular regulation in question. Prohibitions against corporate employment of physicians, for instance, are regularly employed as defenses by physicians seeking, for reasons unrelated to clinical autonomy, to avoid an employment agreement and, often, its restrictive covenant. They thus become, as one commentator has eloquently put it, “legal landmines,” remnants of an old and nearly forgotten war, half-buried on a field fast being built up with new forms of health care organizations.

That a regulatory relic of one jurisdiction resists integration with an orientation adopted by another is perhaps understandable when the inherent antagonisms among the various systems are considered. A system focused on preserving provider autonomy, for instance, naturally resists imperatives framed in terms of cost control or quality of care (particularly when administered by an administrative agency or other lay person). But it should

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77 For arguments against a breaching party defensively invoking the corporate practice doctrine, in dicta, see TLC The Laser Ctr., Inc. v. Midwest Eye Inst. II, Ltd., 714 N.E.2d 45, 55 (Ill. App. Ct. 1999) (“The contention could be made that the doctrine is intended to protect the public, not to allow medical professionals to avoid contractual obligations into which they have voluntarily entered.”).

78 A typical situation involves a court’s refusal to enforce a non-competition clause in an employment agreement with a corporation on the grounds that the agreement is void as against public policy. See, e.g., Carter-Shields, M.D. v. Alton Health Inst., 777 N.E.2d 1448, 960 (Ill. 2002); Early Detection Ctr. v. Wilson, 811 P.2d 860, 868 (Kan. 1991). See also HALL & VAUGHN, supra note 18, at 3-5 (citing Bartron v. Codington County, 2 N.W.2d 337 (S.D. 1942) (allowing county to refuse payment to a physician clinic under a contract it had negotiated for indigent care services, even though the services had already been rendered)).

79 Rosoff, supra note 8, at 499.
be obvious that any responsible regulatory system needs to accommodate such needs.

**B. Autonomy: The Provider Orientation**

The body of law principally aimed at preserving provider autonomy against interference by lay or commercial influences comes with a lot of history, most of which will not be recited here. The history of such law, however, helps explain its bias. These are laws, statutory and court-made, that emerged during the 1920s and 1930s in the context of the medical profession's struggle against "contract practice" medicine, healthcare purchased by industry for its employees. As Paul Starr describes the period, physicians had reason to resist the growth of contract practice:

> Employers had a practical interest in using medical services for recruiting and selecting workers, maintaining their capacity and motivation to work, keeping down liability and insurance costs, and gaining good will from their employees and the public. But they did not want to pay for medical services or the hidden costs of disease that their workers or the community would otherwise bear.⁸⁰

Some courts of the period envisioned the irresistible decline of the medical profession with the introduction of lay ownership. Witness the following fearful syllogism, offered by a court tracing the process by which lay ownership gives rise to a conflict of interest in the professional that ultimately leads to the commercialization and thus the corruption of the profession:

> Because of the rights with which the law invests a stockholder in a corporation for profit, recognition of such a means of conducting a professional business involves yielding the right of participation in control of its policies and in its earnings to lay persons. A share in the fees of professional men would come to the owners of capital stock as a matter of right in the form of dividends. The stockholder's right to vote his stock would provide him with an instrumentality to be used for shaping policy. Ownership of stock would ordinarily qualify him to serve as a director or officer

⁸⁰ *Starr, supra* note 7, at 200.
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of the company. Lay ownership of stock would be ultimately assured by the incidental rights of transfer and succession. The object of such a company would be to produce an earning on its fixed capital. Its trade commodity would be the professional services of its employees. Constant pressure would be exerted by the investor to promote such a volume of sales of that commodity as would produce an ever increasing return on his investment. To promote such sales it is to be presumed that the layman would apply the methods and practices in which he had been schooled in the market place. The end result seems inevitable to us, viz., undue emphasis on mere money making, and commercial exploitation of professional services. To universalize the use of this method of organizing the professions, or to permit such a use to become general, would ultimately wipe out or blight those characteristics which distinguish the business practices of the professions from those of the market place. Such an ethical, trustworthy and unselfish professionalism as the community needs and wants cannot survive in a purely commercial atmosphere. 81

That is stock ownership would be a corrupting economic interest and the power to do something about it, leading inevitably to the downfall of the medical profession. 82

Recognizing a divergence of the interests of the profession and those of the corporate purchasers of medical services, physicians resisted as “commercialism” the two most salient features

81 Bartron v. Codington County, 2 N.W.2d 337, 346 (S.D. 1942).
82 By way of contrast with this broadly conceived notion of professional autonomy, consider the position articulated by the U.S. Supreme Court in Liggett Co. v. Baldrige, 278 U.S. 105 (1928), in declaring unconstitutional on due process and equal protection grounds a Pennsylvania law providing that only licensed pharmacists may own pharmacies. With Justices Holmes and Brandeis dissenting, the Court noted legislative intent to the effect that a lay-owner might give more credit to the price than to the quality of drugs required to be stocked in the stores, but then observed that “mere stock ownership in a corporation, owning and operating a drug store, can have no real or substantial relation to the public health,” thereby rejecting the logic that compels the conclusion that lay-ownership would inevitably taint a professional enterprise. Id. at 113. Liggett was subsequently overruled, and the position of Justices Holmes and Brandeis adopted in an opinion by Justice Douglas in North Dakota State Bd. of Pharmacy v. Snyder’s Drug Stores, Inc., 414 U.S. 156, 167 (1973).
of contract practice: (i) employment of physicians by business concerns, and (ii) the advertising of professional services. If corporate employment of physicians threatened professional autonomy by subjecting the physician to a duty of loyalty to his employer that often conflicted with the physician's duty to his patient, advertising was equally a threat to autonomy because the resulting competition forced underbidding. Much of the applicable common law developed during the 1930s from cases like the "Painless Parker" cases. These were cases instituted by boards of medicine in states such as Colorado and California against a California business corporation owned by a dentist who had had his name legally changed to Painless Parker so that the word "painless," otherwise impermissible in the marketing of professional services, could be used on practice signage. Painless Parker, or rather Painless Parker Dentist, the California corporation controlled by him, attracted the prosecutorial attention not only by breaching advertising ethics, but also by employing dentists in various states.

The concept of professional autonomy as it emerged in California from the Painless Parker cases cut a wide path, in part due to court construction of statutory language defining the practice of dentistry. A person practices dentistry within the meaning of applicable California licensure statute if he "[m]anages or conducts as manager, proprietor, conductor, lessor, or otherwise, a place where dental operations are performed." This definition leaves little room for involvement by anyone but a licensed practitioner in a dental practice. There is no room for an ownership interest, even a minority one, even if the lay partner acts in a purely administrative capacity. The principle continues to apply in contemporary cases, and applies in the context of medical as well as dental practices. Thus, in a recent case in

83 Starr notes that physicians "had no more desire to be dominated by private corporations than by agencies of government, and consequently resisted the two forms in which business corporations threatened to move into medical services—the provision of treatment for their own employees through 'company doctors' and the marketing of services to the public." STARR, supra note 7, at 200.
84 HALL & VAUGHN, supra note 18, at 3-7.
85 Rosoff, supra note 8, at 491, n.14.
86 State Bd. of Dental Exam'rs v. Savelle, 8 P.2d 693 (Colo. 1932); People v. Painless Parker Dentist, 275 P. 928 (Colo. 1929).
87 Parker v. Bd. of Dental Exam'rs, 14 P.2d 67 (Cal. 1932).
88 There were as yet no professional corporation statutes, and therefore no format in which Painless Parker Dentist could legally employ professionals. See id.
89 CAL. BUS. & PROF. CODE § 1625(e) (West 2005).
California's First District, the Court of Appeal upheld a Medical Board disciplinary ruling against a physician on the grounds that a minority interest in the clinic that employed him was owned by two persons not licensed in California, even though the majority owner physician worked with what he deemed to be complete clinical autonomy.91

As it has evolved in California, the principle of professional autonomy amounts to an insistence that licensed professionals have authority over all aspects of their practices, including management. The alternative is seen as an incursion of commercialism offensive to both statutory law and public policy. The notion that clinical and administrative conduct cannot be separated becomes fundamental to the analysis of lay ownership cases in California, independent of any statutory justification. Thus in Marik v. Superior Court, to illustrate the impossibility of drawing a line between the "business" side of a professional medical corporation and the part that renders professional services, the court cited the example of a medical corporation's decision to purchase new equipment:

the prospective purchase of a piece of radiological equipment could be impacted by business considerations (cost, gross billings to be generated, space and employee needs), medical considerations (type of equipment needed, scope of practice, skill levels required by operators of the equipment, medical ethics), or by an amalgam of factors emanating from both business and medical areas. The interfacing of these variables may also require medical training, experience, and judgment.92

The physician must retain control over both clinical and administrative aspects of the practice, because the two cannot be divided. Moreover, the source of the physician's authority over his practice (both its clinical and administrative aspects) must be structural, not merely contractual. That is, licensed persons must hold all equity interests in the practice; it would not suffice for physicians to be employed by lay persons, even under contracts stipulating that all aspects of the practice remain within the control of licensed physicians. An employer-employee

relationship between laity and professionals would create an impermissible division of loyalties, as the professionals “would owe their first duty of loyalty to the corporation based on the employer-employee relationship and a ‘secondary and divided loyalty to the patient,’ jeopardizing the health and safety of the patients.”

California’s commitment to a concept of physician autonomy that requires physician ownership and control of healthcare enterprises and refuses to indulge line-drawing between clinical and administrative conduct raises obvious difficulties for any business plan contemplating a division of labor between professionals and administrative participants. Consider Moore v. Orthodontic Centers of America, Inc., in which an orthodontist sought to avoid a Business Services Agreement (BSA) with a subsidiary of Orthodontic Centers of America, Inc. (OCA), a physician practice management company with practices in forty-two states, on the grounds that the BSA illegally gave OCA the right to manage and control the orthodontic practice. Dr. Moore, a Virginia orthodontist, had retained OCA to help him establish a new orthodontic practice in Southern California. Pursuant to the BSA, OCA established Dr. Moore in new offices in California, loaned him several hundred thousand dollars, provided him with a six-figure living allowance, assisted with equipping and staffing the new offices, provided administrative services (including marketing, patient scheduling, inventory, personnel, billing, accounting, and legal services), and provided financial assistance that allowed Dr. Moore to accept patients.

93 Moore, 2002 WL 32351, at *5 (quoting Parker v. Bd. of Dental Examiners, 14 P.2d 67, 72 (Cal. 1932)).
94 By way of comparison, a distinction between clinical and administrative conduct seems well within the limits of acceptability in other jurisdictions. See, e.g., Arizona, Arkansas, Colorado, Georgia, Indiana, Iowa, Louisiana, Maine, Michigan, Minnesota, Mississippi, Montana, North Dakota, Oklahoma, South Dakota, Utah and Virginia, all of which have statutory provisions erected on the assumption that clinical and administrative conduct can be segregated, or opinions of attorneys general to this effect. See AAEM, supra note 42.
95 Moore, 2002 WL 32351.
96 Dr. Moore relied on Sections 1625 and 1626 of California’s Business & Professions Code, the statute construed in the Painless Parker case. Parker, 14 P.2d at 67; Moore, 2002 WL 32351, at *4–5. Section 1626 provides “[i]t is unlawful for any person to engage in the practice of dentistry in the state…unless the person has a valid, unexpired license or special permit.” Cal. Bus. & Prof. Code § 1626 (West 2005). Section 1625 states “a person practices dentistry within the meaning of this chapter who does any one or more of the following: …[m]anages or conducts as manager, proprietor, conductor, lessor, or otherwise, a place where dental operations are performed.” Id. at § 1625 (emphasis added).
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with no down payment for services to be rendered. In return, besides repaying the loans, the BSA stipulated that Dr. Moore would practice exclusively with OCA-affiliated dental practices in California. Dr. Moore breached the exclusivity covenant within two years after relocating to California and allegedly diverted patients from OCA practices to his own.97 Dr. Moore, at all times an independent contractor with OCA, alleged that OCA had "lured" him into the BSA with an empty promise that he would eventually be located in San Diego, and then proceeded to pressure Dr. Moore into increasing his practice load to an unmanageable volume.98 When OCA proved unwilling or unable to relocate Dr. Moore to San Diego, he took the offensive in litigation (after allegedly breaching the BSA himself), suing for a declaration that the BSA was illegal and therefore unenforceable.99 The trial court held for OCA and awarded nearly $600,000 in damages, approximately $400,000 for loan repayment and $200,000 for lost profits and expenses.100 The Fourth District Court of Appeal reversed in part, holding that certain provisions of the BSA violated the corporate practice of medicine doctrine and were thus unenforceable.101

Although Dr. Moore was an independent contractor, not an employee of OCA or any affiliate, the Court of Appeal found objectionable those provisions of the BSA requiring Dr. Moore to practice exclusively at OCA-affiliated practice sites on a full-time basis. After struggling briefly with "the modern realities of medical/dental practices which often require a health care professional to obtain expert business assistance to exist in today's increasingly competitive medical environment,"102 the Court held that under the BSA, OCA, an unlicensed entity, was effectively practicing dentistry within the meaning of the Business & Professions Code, because OCA effectively controlled the orthodontist's hours and patient load.103 The Court acknowledged that the BSA was "carefully drafted . . . with the intent to comply with California's ban on an unlicensed entity managing a dental business":

The BSA's first operative paragraph states "it is expressly agreed that the Orthodontic Entity shall retain ultimate responsibility for the management of its orth-

100 Id. at *3.
101 Id. at *8.
102 Id. at *6.
103 Id. at *7-8.
I lay ownership of the orthodontic practice at the Center (including all business aspects of the practice), and nothing in the Agreement is intended to transfer such ultimate responsibility from the Orthodontic Entity to [OCA]." . . . Section 3.2 likewise provides "The Orthodontic Entity shall be solely responsible for the business management of the Center (including all business functions), and all business services provided by the Orthodontic Entity to [OCA] hereunder are at the discretion and subject to the control of the Orthodontic Entity." 104

Nonetheless, by requiring Dr. Moore to deal exclusively with OCA, and then requiring him to work at hours established by OCA at a particular location, the BSA effectively gave OCA impermissible control over a clinical issue, the amount of time Dr. Moore could spend with patients. 105 In singling out the exclusivity provisions of the BSA in finding it to have violated California’s licensure statute and corporate practice doctrine, and because the Court severed the loan provisions of the BSA and found them to be enforceable, the Court theoretically left open the possibility of a management services agreement that could comply with the Business and Professions Code. Presumably a dentist or physician in California can legally contract for administrative services. Decisions like Moore, however, must inevitably have an effect on the availability of the full range of benefits offered by OCA. It is hard to imagine a company willing to extend credit to the degree it had been extended by OCA in Moore without the security of a restrictive covenant. 106

At the very least, a decision like Moore increases the risk, and therefore the cost, of providing capital to professionals through a turnkey practice management format in California. Had Dr. Moore been fully successful with his claims, he would have been able to retain nearly $400,000 provided to him by OCA in loans and would have been able to walk away from over $200,000 in lost profits and expenses payable had the BSA been enforceable. As it was, only the loan portion of his obligation to OCA was affirmed by the Court of Appeal. From OCA’s vantage, Dr. Moore’s

104 Moore, 2002 WL 32351, at *6 (emphasis in original).
105 Id. at 7.
106 In exchange for the PPMC’s obligations to (i) exclusively contract with the PPMC in a defined area, (ii) commit to loan and fund capital expenditures, operating and working capital needs, and possibly to purchase practice assets and goodwill of the Physician Group . . . ., the PPMC will require several exclusivity covenants from the Physician Group.

Schmidt, supra note 65.
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Moore confirms the propositions that commercialism and the prospect of divided physician loyalty are perceived under California law to be the chief threats to professional autonomy, and that the protection of professional autonomy is the prime objective of California public policy. Given the historical origins of the state’s efforts in this area, this is not surprising, as an autonomous profession is well suited to restrain the harms that can be inflicted when industry controls medicine. Although things have changed since the days when railroad and lumber companies employed physicians for the limited purposes of making the labor force maximally productive and minimizing liability, the rationales forged to support those holdings continue in effect. From these historical origins derives the argument that the medical profession can best be protected using “a structural safeguard which prohibits economic or clinical control over a physician, to ensure that a physician’s medical decisions are not based on commercial interests, but rather on professional medical judgment.”

Left in control, the argument goes, physicians will do what is best for patients. If physician autonomy is assured, everything else will fall into place. The greatest threat to patient welfare arises from sources of interference with the physician’s primary obligation to the patient, such as a conflicting legal duty to a lay employer, or cost constraints imposed by payors (indeed, the cost-control perspective is sometimes identified in California jurisprudence as an adverse influence in the context of apologies for provider autonomy, as cost concerns may corrupt medical judgment).

108 Morelli v. Ehsan, 756 P.2d 129, 133 (Wash. 1988) (denying an accounting of an illegal partnership between a physician and a nonphysician to operate a medical clinic that had been funded in part by the nonphysician).
110 “In order to bring soaring health care costs under control, health coverage has [sic] shifted from traditional unmanaged, fee-for-service (‘indemnity’) insurance to prepaid managed care coverage. Under this managed costs sys-
The most vociferous proponents of this position, not surprisingly, have been professional associations—the AMA and various state medical associations. The position was recently articulated by the California Medical Association (CMA) in an appellate brief. The CMA described the rationale behind the corporate practice bar as protection against "(1) a division of the physician's loyalty between a lay entity and the patient; (2) the dangers of commercial exploitation of the medical profession; and (3) lay control over the physician's professional judgment." The CMA continued in language typical of proponents of professional autonomy:

All of these threats to a physician's professional autonomy undermine the profound public policy that physicians, who deal with the most intimate bodily functions, the most personal mental processes, and most profound life and death issues, will devote their entire professional judgment and training to the furtherance of their patients' best interests. Exceptions can be quite illuminating when it comes to understanding legal doctrines like the corporate practice of medicine bar. Illinois, as we shall see, allows licensed hospitals, whether profit or nonprofit, to employ physicians despite a general prohibition against corporate employment of professionals. California courts, on the other hand, may contemplate an exception for nonprofits, but not for-profit corporate entities, whether or not they are independently licensed hospitals, allowing the reasonable inference that it is the profit motive that California finds objectionable when it comes to lay ownership. In California Medical Association v. Regents ("CMA v. Regents"), the court referred to commercialism as one of the "principal evils attendant upon the corporate practice of medicine."

...
CMA v. Regents involved an attempt by an anesthesiology group to block the UCLA Medical School from establishing a closed anesthesia service, which would have precluded any anesthesiologist in the area unwilling to practice as an employee and member of the Medical School faculty from practicing in the UCLA hospital system. The case arose from UCLA's purchase of Santa Monica Hospital, where the plaintiff anesthesiologists had practiced. After the purchase, the Medical School offered the anesthesiologists an exclusive contract, but when they declined the Medical School staffed the anesthesiology department with Medical School employee physicians. The plaintiff anesthesiologists alleged not only breaches of California's corporate practice doctrine, but also that the arrangement would have entailed illegal fee-splitting and kickback arrangements. The anesthesiologists were joined in their suit against the Medical School by the CMA, eager to defend California's corporate practice bar. The Court of Appeals for the Second District, however, held that UCLA Medical School, as a publicly-funded nonprofit, was exempted from the corporate practice bar. The rationale for the corporate practice doctrine, the Court said, is to curb potential corruption of professional judgment by the profit motive: "Concerns about for-profit corporations have nothing to do with non-profit teaching hospitals." In addition, or perhaps as an alternative justification for its holding, the Court noted that the UCLA Medical School, as an instrumentality of the state, is exempted from the corporate practice doctrine because application of the corporate practice bar would effectively defeat the state's purpose in granting the University of California a charter to operate its medical center as a teaching and research institute.

It does not appear to be settled that nonprofits may be exempted from the corporate practice bar in California. When the Fifth District Court of Appeal addressed the issue in San Joaquin Community Hospital v. San Joaquin Valley Medical Group, the court determined that no such exemption exists and that the only

114 CMA, 79 Cal. App. 4th at 546. See CAL. BUS. & PROF. CODE §§ 650, 2400 (West 2005). Applicable California law would have permitted the Medical School to employ physician staff members in a teaching facility, but the plaintiffs contended that the clinic in question was not yet sufficiently integrated into the Medical School to qualify for such treatment. CMA, 79 Cal. App. 4th at 546-48.


116 Id. at 548.
valid basis for the CMA v. Regents decision was that application of the ban to the UCLA Medical School would infringe on the powers granted to it as an instrumentality of the state.\footnote{San Joaquin involved, among other things, a “friendly” or “captive” PC arrangement between San Joaquin Community Hospital, a charitable nonprofit (Hospital) and a professional corporation originally owned by Dr. Carlos Alvarez, a physician serving a poor Hispanic community the Hospital wished to support as part of its charitable mission. The Hospital initially supported Dr. Alvarez directly with loans, and then agreed to forgive a portion of the loans and to acquire the practice. Because the Hospital could not directly purchase the practice under California law,\footnote{California fee-splitting rules permit payment for management services based on a percentage of gross, but not net practice revenue. \textit{Id.} \S\ 650; \textit{see supra} note 57 and accompanying text.} the acquisition was to take place in stages, the first of which involved converting the loans to options for stock in Dr. Alvarez’s professional corporation, which would be held by licensed physicians designated by the Hospital, and the second of which involved the conversion of the practice entity into a management services organization (MSO), which could legally be owned by the Hospital. The MSO would then provide management services to Dr. Alvarez (or rather a new professional corporation established for his practice) in exchange for a percentage of practice revenues.\footnote{Cross-complainants include Heritage Provider Network, Inc., a healthcare service plan challenging the Hospital’s arrangement with Dr. Alvarez in connection with a dispute involving payments allegedly owed to the Hospital by the health plan. \textit{San Joaquin}, 2004 WL 1398551, at *4–5.} Cross-complainants in the dispute\footnote{See \textit{The Corporate Practice of Medicine Prohibition in the Modern Era of Health Care}, Health Law & Business Library (BNA) No. 2800, \S\ 2800.06.F (Dec. 2003) [hereinafter BNA Report].} alleged, and the court agreed, that the “friendly PC” arrangement constituted a violation of California’s corporate practice bar,}


\begin{quote}
The California Education Code grants the University of California the authority to engage in instruction . . . at its medical schools, but that does not include providing, and collecting fees for, direct medical care to patients. The argument [advanced by the Medical School] that every patient is “potentially” a teaching case is a real stretch. The court was determined to carve out an exception from the corporate practice prohibition for the university, and did so using a combination of the “state sovereignty” doctrine and a broad interpretation of California’s otherwise strict corporate practice prohibition to get that result.
\end{quote}
even when (i) holders of the stock in the professional corporation were licensed physicians, and (ii) the ultimate corporate entity in interest was a charitable nonprofit. Having determined that there is no exemption to the corporate practice bar for nonprofits, the court held that the Hospital could not do indirectly, through a professional corporation, what the law prohibited it to do directly, namely, exercise an owner’s control over a medical practice: "We cannot imagine any consideration of public policy that would cause us to impute to the Legislature the intent to, on the one hand, ban corporate ownership of medical practices and, on the other, permit such ownership through mere ‘straw men’ acting on behalf of the corporation."\textsuperscript{121} 

For the moment, then, California districts are arguably split as to whether there is an exemption from the corporate practice ban if sufficient absence of a profit motive can be established. Even if it is not clear whether California has settled the question of a corporate practice exemption for nonprofits, the fact that this is where California courts have considered the possibility of an exemption is diagnostic. It confirms the centrality of the profit motive to the analysis of questions of lay ownership of healthcare enterprises in California. If, as the court noted in \textit{CMA v. Regents}, the "principal evils attendant upon the corporate practice of medicine spring from the conflict between the professional standards and obligations of the doctors and the profit motive of the corporate employer,"\textsuperscript{122} then there is no need to apply the doctrine when a profit motive does not exist.

That there may be no \textit{per se} exemption for nonprofits does not mean there can be no lay equity interest in healthcare enterprises in California. The \textit{San Joaquin} court did not consider whether the proposed management agreement between the MSO and the new medical practice would have passed muster, but a management services agreement that could avoid the control pitfalls of that in \textit{Moore} could conceivably succeed. California’s fee-splitting statute, which expressly permits fee-sharing arrangements based on gross practice revenue, would seem to be conducive to management services arrangements. At last check, affiliates of Orthodontic Centers of America (the practice management entity involved in the \textit{Moore} case) were still operating in California. And with respect to corporate employer or “friendly PC” arrangements, perhaps it should be noted here that even if the exemption applies only for state, teaching, nonprofit hospitals,

\textsuperscript{121} \textit{Id.} at *18. 

as the San Joaquin court seems prepared to admit, that is a significant exception as both a theoretical and a practical matter. It is an exemption, even if so narrowed, that implicitly acknowledges that the California legislature does not perceive corporate practice to be an absolute evil, since it is willing to carve out the extremely large state medical school system.

Clearly, however, the corporate practice doctrine as established in California is quite restrictive. Neither CMA v. Regents nor San Joaquin involved any lay conduct of the sort the doctrine is intended to curtail, and yet the doctrine was successfully invoked to prohibit the business arrangements in question. But then a substantive finding of harm is not an element necessary to stating a claim for violation of the corporate practice doctrine in California. As the CMA has been consistent in arguing in its various amicus briefs filed on behalf of practitioners in California, the protections afforded by California’s corporate practice and fee-splitting prohibitions are “structural safeguards.” It is a point well taken. Under California law certain arrangements, such as employment agreements between for-profit entities and professionals, are structurally illegal, and “[a]ctual ‘medical’ control need not occur for a violation of these Californian laws to be shown.” California appears to proceed from the assumption that if a structure that assures physician autonomy is in place, the concerns of public policy for patient care will be served, and if this structure is not in place, the arrangement is inherently flawed no matter what conduct ensues. In California, taken here as an example of a jurisdiction whose regulation of lay ownership proceeds from the principle of physician autonomy, it is evidently sufficient to considerations of quality of care to address the structural issue, and it is evidently less than critical to address cost issues when considering lay ownership of the healthcare enterprise.

123 Regarding San Joaquin, “[t]here was no evidence in the present case that agents of Hospital actually interfered in Alvarez’s medical decisionmaking.” San Joaquin, 2004 WL 1398551, at *18. Regarding CMA, “[n]one of the abuses or practices that the prohibition was intended to prevent are [sic] present in the facts of this case (e.g., interference with the anesthesiologists’ professional medical judgment, etc.).” BNA Report, supra note 117.


125 Amici Curiae Brief, supra note 124, at Introduction.
C. Licensure/Quality Assurance: The Patient Orientation

Illinois, like California, regulates the lay ownership of healthcare practices with both a corporate practice doctrine and a fee-splitting prohibition, but each is conceived in a significantly different manner from its counterpart in California. The argument of the discussion to follow is that the differences between the two state regulatory schemes reveal fundamentally different orientations. Whereas California courts may entertain exceptions to the corporate practice doctrine where there is demonstrable absence of a profit motive, Illinois courts tend to base any exception on the issue of licensure, and in any event not solely on nonprofit status. Any Illinois exceptions to the corporate practice ban for hospitals are premised not the hospital being a nonprofit, but on its licensure as a healthcare provider. In the alternative to a licensure exception, an Illinois court may find no violation of the state's corporate practice bar where responsibility for clinical and administrative conduct are respectively delegated to licensed and lay personnel. California courts, by contrast, are generally unwilling to undertake to draw lines between clinical and administrative conduct. Whereas in California a "captive PC" arrangement has been categorically dismissed by one court as an effort to achieve indirectly what is impermissible if attempted directly, in Illinois such arrangements may be acceptable, as long as they properly delegate clinical responsibilities to duly licensed professionals. Ultimately

127 225 ILL. COMP. STAT. ANN. 60/22-(A)(14) (West 2005).
131 See supra note 93 and accompanying text.
133 See Cleveland Hair Clinic, Inc. v. Puig, 968 F. Supp. 1227 (N.D. Ill. 1996) (professional services corporation had exclusive contract to perform hair transplant procedures at lay-owned clinic, which had exclusive right to provide management services to professional corporation); TLC, 714 N.E.2d at 54 ("We see no basis to conclude that a company which solely provides administrative services to a physician or group of physicians is thereby engaging in the corporate practice of medicine.").
it is probably this willingness to entertain the possibility of segregating clinical and administrative conduct that distinguishes Illinois from California. Regulation in California proceeds from an expansive concept of physician autonomy, one that insists on the professional's ultimate control of all aspects of the practice, whether clinical or administrative. Illinois courts, on the other hand, proceeding from a narrower focus on clinical conduct alone, are willing to sanction arrangements in which physicians cede or delegate control over administrative aspects of the business of healthcare, as long as a licensed individual continues to be in charge of the delivery of healthcare. Depending on one's bias, Illinois could be said either to have a more restricted view of professional autonomy than California, or an inclination to focus more directly on the matters that fall within the purview of licensure and impact quality of care. This is not to say that Illinois is ultimately more concerned with quality assurance than California, but rather that the Illinois approach to preserving quality is more functional than structural. With respect to lay ownership, and solely with respect to the corporate practice doctrine, Illinois is, by virtue of its willingness to delineate and segregate licensure issues, more amenable to lay involvement with a healthcare enterprise. (The result with respect to fee-splitting regulations in the two jurisdictions is, as we shall see, somewhat different.)

At any rate, Illinois is among a group of states that infer a prohibition against the corporate practice of medicine from licensure statutes. Corporations cannot practice medicine, the reasoning goes, because they cannot be licensed to do so. Some such states, Illinois among them, go further and assert that the reason corporations cannot be licensed is that they cannot pass the exam, or satisfy certain of the other requirements for licensure, such as being twenty-one years old and of good moral character. For the limited purpose of medical licensure analysis, in other words, the legal fiction of personality otherwise generally attributed to corporations is withheld:

[The Medical Practice Act] prohibits the issuance of a license to any person unless he passes an examination of the qualifications therefor by satisfactory to the Department of Registration and Education. The next section declares that each applicant for such examination shall, among other
things, submit evidence under oath satisfactory to the department that he has attained the age of twenty-one years, that he is of good moral character, and that he has the preliminary and professional education required by the Medical Practice Act. . . The legislative intent manifest from a view of the entire law is that only individuals may obtain a license thereunder. No corporation can meet the requirements of the statute essential to the issuance of a license.\footnote{People ex rel. Kerner v. United Med. Serv., Inc., 200 N.E. 157, 162-63 (Ill. 1936), quoted in Berlin v. Sarah Bush Lincoln Health Ctr., 688 N.E.2d 106, 111 (Ill. 1997). The Kerner case suggests the reason Illinois goes to such lengths in claiming corporations cannot be licensed, as the respondent corporation accused of unlicensed practice of medicine in that case claimed that the applicable Medical Practice Act did not state what acts could be regarded as constituting the practice of medicine. 200 N.E. at 162. Accordingly, the court was forced to focus on the examination and other listed qualifications for licensure in order to uphold the doctrine.}

Taken at face value, this reasoning seems disingenuous. If this court's argument were applied universally, it would compel the prohibition of hiring of pilots by airline companies on the grounds that the corporation, physically unable to pass the exam to obtain a pilot's license, would be operating planes without a license. But clearly there is more behind the corporate practice doctrine than is explicit in this literalist argument. Illinois has centered its position regarding lay ownership of healthcare enterprises on the issue of licensure. The effect of this orientation can be seen by comparing the way the two jurisdictions deal with the issue of hospitals.

In the \textit{CMA v. Regents} case discussed above, a California Court of Appeals exempted a hospital-based arrangement from the application of the corporate practice doctrine on the grounds that the "principal evil" with which the doctrine is concerned derives from the profit motive of lay owners, and there was no profit motive where a nonprofit teaching hospital was concerned.\footnote{CMA v. Regents, 79 Cal. App. 4th 542, 550 (2000).} In \textit{Berlin v. Sarah Bush Lincoln Health Center}, the Illinois Supreme Court found the problem of lay control to have been alleviated where the lay entity in question was a licensed hospital that had taken steps to preserve physician control over medical services. The Illinois Supreme Court reviewed a decision by a county circuit court (subsequently affirmed by the appellate court) to grant summary judgment in favor of a plaintiff physician who sought to nullify his employment agreement with the medical
center, and thus its noncompetition covenant, on the grounds that the employment agreement violated the prohibition on the corporate practice of medicine.\textsuperscript{136} Dr. Berlin, a general surgeon, had been specifically recruited by the Health Center, at its expense, to relocate to its service area from New York. Initially Dr. Berlin operated as an independent contractor, but when he became dissatisfied with the development of his practice, he requested the employment arrangement that he later sued to nullify.\textsuperscript{137} His employment agreement with the Health Center specified a five-year term with a two-year restrictive covenant prohibiting him from practicing medicine within a fifty-mile radius of the Health Center. Under the terms of the agreement, the Health Center collected fees for Dr. Berlin's services and paid him a salary. Barely over a year into the agreement, Dr. Berlin gave his notice and accepted employment from the Carle Clinic, a competing hospital, at a facility located approximately one mile from the Health Center.\textsuperscript{138}

The \textit{Berlin} case was one of first impression in Illinois in deciding whether hospitals could employ physicians. Such employment practices were not novel, however, either in Illinois or in other jurisdictions throughout the United States, and accordingly the stakes were high. The court was called upon to determine whether the widespread practice of employing physicians and residents in hospital and clinic settings was legal. The case attracted significant attention from interested parties.\textsuperscript{139} Amicus briefs were filed in support of Dr. Berlin by the Illinois State Medical Society, the Illinois State Dental Society, numerous local and county medical societies, physician associations, and physician networks, and in support of the Health Center by the Illinois Hospital and Healthsystems Association, the Chicago Health Care Council, the American Hospital Association, and Cook County. In the end, the Illinois Supreme Court declined to follow the lower courts in declaring Dr. Berlin's employment agreement and restrictive covenant to be void for violating the corporate practice doctrine, choosing instead to carve an exception for licensed hospitals:

\begin{quote}
[We find the public policy concerns, which support the corporate practice doctrine,] inapplicable to a licensed hospital in the modern health care industry. The concern for lay control over
\end{quote}

\textsuperscript{136} \textit{Berlin}, 688 N.E.2d at 107.
\textsuperscript{137} Brief of Defendant-Appellant at *12-13, \textit{Berlin} (No. 81059), 1996 WL 33468391.
\textsuperscript{138} \textit{Berlin}, 688 N.E.2d at 107-08.
\textsuperscript{139} Including, one imagines, Dr. Berlin's new employer, the Carle Clinic.
professional judgment is alleviated in a licensed hospital, where generally a separate professional medical staff is responsible for the quality of medical service rendered in the facility.\textsuperscript{140}

The \textit{Berlin} court grounded its holding on the notice it took of the effectiveness of separations observed between professional and lay conduct. Evidence of the deliberate delineation of clinical and administrative authority was abundant. It was evident in the very structure of the hospital, the court noted, where there was a separate medical staff organization charged with quality assurance.\textsuperscript{141} There was also a provision in Dr. Berlin’s employment agreement stipulating that the medical center could exercise no control over Dr. Berlin’s medical judgment.\textsuperscript{142} The court further noted that that “Dr. Berlin . . . never contended that the Health Center’s lay management attempted to control his practice of medicine.”\textsuperscript{143} The implicit logic underpinning this analysis is that if there can be meaningful segregation of clinical and administrative conduct, the conduct with which licensure is concerned, and which has a direct impact on the quality of patient care, need not be compromised by lay influences. The \textit{Berlin} court expressly declined to follow precedent in other jurisdictions basing a hospital exception from the corporate practice doctrine on the theory that hospitals employing physicians are “not practicing medicine, but rather . . . merely making medical treatment available.”\textsuperscript{144} That is, in searching for the theoretical basis upon which to pin its justification for a new corporate practice exception for hospitals, the court reviewed theories prevalent in other jurisdictions and expressly declined to take the “not practicing medicine” approach. The court declined, moreover, to anchor its exception on the fact that the Sarah Bush Lincoln Health Center was a nonprofit entity, and in this the \textit{Berlin} court distinguishes itself from those in California that focus on commercialism as the “principal evil” to be guarded against: “We . . . see no justification,” the court observed, “for distinguishing between non-profit and for-profit hospitals in this regard. The authorities and duties of licensed hospitals are conferred equally upon both entities.”\textsuperscript{145} Given the court’s ra-
tionale for the corporate practice doctrine, the holding makes sense. An emphasis on the distinction between nonprofit and for-profit entities would perhaps have been more appropriate were the corporate practice doctrine logically grounded on concerns of commercialism, but in Berlin, the issue was licensure. For the same reason, in order to center on licensure, the court did not wish to dodge the issue by taking the “not practicing medicine” approach.146

Five years after Berlin, in Carter-Shields v. Alton Health Institute, the Illinois Supreme Court remained faithful to its focus on the state’s licensure statute when asked to decide whether the exception to the corporate practice bar could be extended to an unlicensed, nonprofit organization, itself controlled by a licensed healthcare facility and a partnership of physician groups.147 Dr. Carter-Shields had entered into an employment agreement containing a restrictive covenant with an unlicensed for-profit subsidiary of St. Anthony’s Health Systems, itself a nonprofit organization.148 Almost immediately, Dr. Carter-Shields expressed dissatisfaction with her employment arrangement, specifically with interference in the conduct of her professional practice from lay administrators.149 Eventually she sought a declaratory judgment to void the agreement and its restrictive covenant. The trial court denied her request and the Illinois Appellate Court for the Fifth District reversed. For its part, the Illinois Supreme Court refused to extend the exception created in the Berlin case for licensed entities to all nonprofit or charitable organizations and continued to apply the corporate practice prohibition to unlicensed corporations, whether profit or nonprofit.150 Noting that the dispute between the doctor and the corporate em-

146 See id. at 112. Illinois hospitals might well have wished the court had taken the “not practicing medicine” approach, given the liability problems attending a holding that they were in fact practicing medicine, but with a proper license.
147 777 N.E.2d 948 (Ill. 2002). The hospital’s partner in the Institute consisted of a partnership of medical groups—one of whom had a nonphysician therapist as a partner. Id. at 950.
148 The employment agreement was subsequently assigned by the employer to an Illinois medical services corporation whose sole shareholder was a doctor presumably having contractual ties to the hospital, as the doctor-shareholder appointed the hospital’s president as the executive director of the medical services corporation. The medical services corporation appears to have been what is commonly known in practice as a “captive PC.” Id. at 952.
149 “Plaintiff complained repeatedly about the lay persons who were directing her practice and interfering with the treatment of her patients.” Carter-Shields v. Alton Health Inst., 739 N.E.2d 569, 575 (Ill. App. Ct. 2000).
150 Carter-Shields, 777 N.E.2d at 958.
The agreement outlined plaintiff's duties as a physician in AHI's employ. For example, the agreement set forth AHI's expectations with respect to the productivity of plaintiff's practice, including the number of weekly patient appointments plaintiff was required to schedule, as well as guidelines plaintiff was expected to follow in requesting time off. The agreement also outlined the obligations of AHI as plaintiff's employer. For example, the agreement stated that AHI was to provide plaintiff with office space and was to furnish plaintiff with the equipment, services, supplies, and personnel that AHI "reasonably determines necessary" for the operation of plaintiff's medical practice.

... [And], (1) that, contrary to earlier assurances made by AHI that plaintiff would be able to fulfill her obligations to perform Army reserve duty without negative repercussions, she was subsequently informed that she would be forced to use vacation time or take unpaid leave; (2) that plaintiff's attendance at mandatory meetings set up by AHI reduced the amount of office time she could spend with patients; (3) that AHI failed to provide plaintiff with adequate staffing to set up and operate her medical practice; (4) that plaintiff had a dispute with AHI as to whether AHI had the right to compensation received by plaintiff as a result of her outside activity as a nursing home medical director; and (5) that although plaintiff had been assured by AHI that it would establish a retirement plan, she was concerned that AHI had taken no action to set up such a plan. In her letter, plaintiff stated that AHI's interpretation of her employment contract was "vastly different from the understanding I reached with AHI for the job of which I was recruited," and she requested that she be "involved in issues and decisions involving my office that relate to the practice."

Id. at 950-51.

Id. at 954.
and the concomitant willingness of Illinois courts to take into account the facts as to whether there is or could be actual lay interference with professional judgment, has meant that certain management services arrangements are permissible. In Cleveland Hair Clinic, Inc. v. Puig, for instance, the lay owner of a hair transplant clinic was permitted to proceed with a suit against independent contractor physicians for breaching their professional services contract and the exclusivity covenant therein. The agreement was typical of PPMC arrangements, a long term (ten year) contract with reciprocal exclusivity covenants (the physician group had the exclusive right to provide professional hair transplant services and the clinic had the exclusive right to manage the professional group). The lay-owned clinic provided space, equipment, marketing and advertising, nonprofessional staff (and even employed nurses, surgical assistants and professional consultants), and general management services. All scheduling of the procedures was carried out solely by the clinic. The physician would have little if any contact with the typical patient beyond designing the treatment plan (usually in tandem with the clinic’s employee consultant) and performing the actual surgery. Even then, of the three to eight hours a typical procedure would take, the doctor may have been present for only half an hour. Post-operative interviews, bandage changing and suture removals were performed by clinic employees.

The court found no licensure or corporate practice violations with this arrangement. Litigation was initiated in response to conduct of Dr. Puig, who had conceived what the court determined to be “an opportunistic plan to ambush Cleveland Hair and to leave it in a position in which it would have no viable alternative other than to turn over its . . . operations ‘lock, stock, and barrel’ to Puig Group.” Dr. Puig had solicited the clinic’s employees, secretly obtained financing for the project, and commenced devastating the clinic’s business. The U.S. District Court for the Northern District of Illinois found that the clinic had a protectable interest in its business sufficient to warrant injunctive relief.

The Cleveland Hair decision was followed in TLC The Laser Center, Inc. v. Midwest Eye Institute II, Ltd., which recognized the protectable interest of the lay purchaser of nonmedical assets of an ophthalmologic practice against corporate practice allegations.

155 Id. at 1243.
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leveled by ophthalmologists: "We see no basis to conclude that a company which solely provides administrative services to a physician or group of physicians is thereby engaging in the corporate practice of medicine."156 TLC involved a (familiar) dispute between a lay-owned management company seeking to enforce an exclusive management services agreement and non-competition and confidentiality covenants against physicians from whom the management company had purchased assets. The management company had sought to preserve its interest in what it maintained were commercial assets, including its trade name, marketing and sales information, pricing formulae, contracts, and other business practices. The agreement provided that the physicians would maintain control over "all aspects of their practice of medicine and the delivery of medical service at the TLC Facilities," but also that they would work no fewer than twenty-five hours per week at TLC.157 TLC's complaint alleged that defendant surgeons conspired to "break away" from TLC, use TLC's trade name and confidential information, and divert patients to a new facility owned by the surgeons.158 The defendant physicians raised corporate practice and fee-splitting bars in their defense, and were unsuccessful with respect to the former.159 With respect to the corporate practice doctrine, the court held for the plaintiff management company, noting that applicable Illinois law was not simply the Berlin holding to the effect that only licensed entities could participate in medical enterprises, but rather that a lay entity could acquire a business interest in a medical enterprise cognizable at law, as long as the boundaries between lay and professional conduct are properly observed.160 In dicta the court noted, with detectable levels of sarcasm, that "[t]he contention could be made that the [corporate practice] doctrine is intended to protect the public, not to allow medical professionals to avoid contractual obligations."161

Thus far this Article has drawn a distinction between a regulatory orientation that asserts the preeminence of the principle of physician autonomy and one that proceeds to educe its principles from licensure regulations. Admittedly for convenience, and perhaps with some unfairness, the autonomy orientation has been attributed to California and the licensure orientation to Illinois. Both jurisdictions, of course, ultimately seek to ensure

157 Id. at 48.
158 Id.
159 Id. at 52. The fee-splitting issue, on which the defendants prevailed, will be considered below.
160 Id. at 54–55.
161 Id. at 55.
quality of care for patients by minimizing commercial interference with professional judgment; but there are nonetheless discernible differences in regulatory theory and application. The regulatory approach herein attributed to California has been termed “structural” by those intending to convey the fact that the court’s inquiry can begin and end with questions of ownership and contractual control;[162] “[a]ctual ‘medical’ control need not occur for a violation of these [Californian] laws to be shown.”[163] If California courts are reluctant to undertake line-drawing exercises to determine the boundaries between lay and professional conduct, Illinois courts have tended to venture there and consequently to inquire as to the existence of actual interference with professional conduct.[164] Structure can apparently be subordinated to function. From the vantage of the licensure orientation, autonomy is a principle that can be overvalued, with the effect that legitimate business interests may be sacrificed. From the vantage of the autonomy orientation, on the other hand, the licensure rationale may undervalue the threat of commercialism, the principal source of professional corruption.

The respective positions of California and Illinois on the corporate practice issue, however, are not sufficient as explanations of their respective positions on the lay ownership of healthcare enterprises. While the TLC court, for instance, exonerated the lay-owned management company on the corporate practice issue, it ultimately held that the arrangement with physicians in question violated Illinois rules on fee-splitting.[165] Among the bundles of rights comprising property or ownership interests in medical enterprises, the division of revenue is clearly one of the most important, and the methods of its regulation must therefore now be addressed.

D. Cost: The Payor Orientation

In TLC, the lay-owned management company prevailed on its argument that it did not violate the Illinois corporate practice doctrine, but lost on the issue of fee-splitting. The court found that its compensation arrangement, in which the management

[162] See Opposition Brief, supra note 124, at *1–2.
[163] Id. at *4.
[164] See People ex rel. Illinois Soc’y of Orthodontists v. U.S. Dental Inst., Inc., 373 N.E.2d 635 (Ill. App. Ct. 1978) (inquiring as to whether a training school charged with corporate practice of medicine was diagnosing patients or performing other services covered by the licensure statute).
[165] TLC, 714 N.E.2d at 55, 57.
company received a fee based on practice revenues in addition to its fee for services rendered, was illegal under Illinois law.\textsuperscript{166} 225 ILCS 60/22 makes the following illegal:

Dividing with anyone other than physicians with whom the licensee practices in a partnership, Professional Association, limited liability company or Medical or Professional Corporation any fee, commission, rebate or other form of compensation for any professional services not actually and personally rendered.\textsuperscript{167}

The management fee in question was not calculated as a percentage of revenue, but clearly increased as revenues increased, and this, the court held, was enough to violate not only the literal language of the statute but also the underlying public policy:

The policy reasons behind the prohibition are the danger that such an arrangement might motivate a non-professional to recommend a particular professional out of self-interest, rather than the professional’s competence. In addition, the judgment of the professional might be compromised, because the awareness that he would have to split fees might make him reluctant to provide proper (but unprofitable) services to a patient, or, conversely, to provide unneeded (but profitable) treatment.\textsuperscript{168}

The purpose of the Illinois statute, at least as recited by the \textit{TLC} court, is to prevent improper lay referrals and the ill effects of provider underpayment. Presumably the legislature had envisioned, and wished to prevent, medical “mills,” grinding out high-volume, low-quality medical services.

The teleology of Illinois’ fee-splitting statute matches that of its corporate practice doctrine fairly well. Both emphasize quality of care. Working together, these two regulatory principles permit some variations on lay involvement with healthcare: a lay-owned entity may employ physicians, provided the lay entity is independently and appropriate licensed (\textit{Berlin}); it may establish and enforce rights to a business plan involving

\textsuperscript{166} \textit{Id.} at 57.
\textsuperscript{167} 225 ILL. COMP. STAT. ANN. 60/22-(A)(14) (West 2005).
\textsuperscript{168} \textit{TLC}, 714 N.E.2d at 56.
the delivery of healthcare services, so long as the line between business and professional conduct is duly observed (Cleveland Hair, TLC); and it may simply provide management services to licensed healthcare providers, provided the compensation arrangement is neither a percentage of revenues nor an amount whose increases are too closely tied to increases in revenues (TLC). Given a situation for which a judicial consensus is relatively easy to reach, such as the medical "mill," these laws can be applied in confidence that public policy is being served. The corporate practice doctrine and fee-splitting statutes are simply complementary means of enforcing a licensure-based, quality-oriented public policy.

The problem is that it becomes increasingly difficult to discern the meaning, predict the effect, or articulate the rationale of fee-splitting rules the more one drifts from the consensus target situation like the medical "mill," and the target situation, it should be acknowledged, is often buried in history, like one of Professor Rosoff's legal landmines from a forgotten war.169 Consider, for instance, that with relatively manageable adjustments the medical "mill" of one era becomes the policy objective of another, a strategy for increasing access to healthcare while controlling cost. The AMA's stance against fee-splitting evolved in response to the late nineteenth century practice of surgeons paying family practice doctors for patient referrals, but eventually broadened to the point where the AMA opposed profit sharing plans that included lay employees.170 The expressions of policy that fee-splitting prohibitions are intended to serve tend to change at a much faster pace than the literal language of the rules can accommodate. A rule that may have originated to restrain surgeons from paying family practice physicians for referrals has more recently been pressed into the service of the corporate practice bar, prohibiting nonprofessionals from sharing in practice revenue.171

At their best, fee-splitting statutes may work together with corporate practice doctrines and other rules within a given jurisdiction to produce a harmonious regulatory effect. In California,

169 Rosoff, supra note 8, at 499.
170 Jacobs & Goodman, supra note 16, at 241; see Starr, supra note 7, at 136; Marc A. Rodwin, Medicine, Money & Morals: Physicians' Conflicts of Interest 23-31 (1993) (noting that historically fee-splitting rules were aimed at curbing the practice of dividing fees between professionals).
for instance, the fee-splitting rule, which permits the division of gross but not net practice revenue,\textsuperscript{172} is arguably consistent with the state's opposition to lay ownership generally, since the division of gross revenue would be consistent with payment of an expense to an independent contractor or employee, whereas division of net (profit) is the treatment a partner or co-shareholder could expect. In at least some jurisdictions in Florida, fee-splitting rules have been construed narrowly to apply only as a restraint on kickbacks and self-referrals, in part because it would be inconsistent with the fact that Florida has no corporate practice prohibition to apply the fee-splitting rules to prohibit lay ownership outright.\textsuperscript{173} But the fact is that fee-splitting rules and corporate practice rules regulate entirely different aspects of the healthcare business, its organization and its economy, its structure and its revenue, respectively. The two regulatory systems are not necessarily linked. Accordingly, one will sometimes operate at odds with the other. Thus the court in \textit{TLC}, after reproaching the professional who would invoke the corporate practice doctrine to avoid his contractual obligation,\textsuperscript{174} was forced to reach that very result in its analysis of the fee-splitting issue.

Few jurisdictions have joined the fee-splitting issue more hotly than Florida. In \textit{Orman}, Florida's Second District Court of Appeals applied Illinois law in a dispute between a practice management company and individual chiropractors who had defaulted under agreements to pay the company, Practice Management Associates, Inc. ("PMA"), a fee for practice development services.\textsuperscript{175} \textit{Orman} was a case of first impression for the appellate court, and will serve as a good introduction to the murky business of fee splitting rule construction. Faced with Illinois' simple proscription against "dividing" fees and lacking any statutory definition of the term,\textsuperscript{176} the court looked to dictionary definitions, all of which suggested that "fee-splitting" was objectionable only

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\item \textsuperscript{172} \textit{CAL. BUS. \\ & \textit{& PROF. CODE} § 650 (West 2005) ("The payment or receipt of consideration for services other than the referral of patients which is based on a percentage of gross revenue or similar type of contractual arrangement shall not be unlawful if the consideration is commensurate with the value of the services furnished ....").
\item \textsuperscript{173} \textit{See generally} Practice Mgmt. Assocs. v. Orman, 614 So. 2d 1135 (Fla. Dist. Ct. App. 1993).
\item \textsuperscript{174} \textit{See} \textit{TLC The Laser Ctr., Inc. v. Midwest Eye Inst. II, Ltd.}, 714 N.E.2d 45, 55 (Ill. App. Ct. 1999).
\item \textsuperscript{175} Practice Mgmt. Assocs. v. Orman, 614 So. 2d 1135, 1136 (Fla. Dist. Ct. App. 1993).
\item \textsuperscript{176} \textit{See} 225 ILL. COMP. STAT. ANN. 60/20-(A)(14) (West 2005).
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to the extent that it was a method of payment for referrals.\textsuperscript{177}

As the Second District Court of Appeals was later to assert, fee-splitting statutes have to be narrowed, because taken literally they have the potential of making it illegal for doctors to pay their utility bills:

The contrary interpretation, if carried to its logical conclusion, would lead to absurd results. Presumably[,] all of [the physician’s] gross income consists of “fees for services.” If he were not permitted to “divide” those fees to pay such necessary expenses as secretarial salaries, office rent, and telephone charges, his practice would not long survive.\textsuperscript{178}

To be sure no court has applied a fee-splitting rule to prohibit a professional from spending his income, but the Second District’s point may be taken to show the need for judicial clarification of exceedingly vague language. The Orman court thus applied its referral-based definition to uphold a Practice Starter Agreement, which provided for chiropractors to pay the greater of 10\% of weekly gross income or $75 per week to PMA for counseling services intended to promote the growth of the chiropractic practices. Although the services rendered by PMA related to practice development, there was no direct payment for referrals and therefore, in the view of the court, no offense to the Illinois statute.

For its part, Illinois has consistently rejected the interpretation of its fee-splitting law propounded by Florida’s Second District Court of Appeals.\textsuperscript{179} For Illinois courts, a fee division may be impermissible even where there is no question of patient solicitation; perhaps because to hold otherwise would open a back door by which lay management companies could pass through the state’s corporate practice bar and acquire the equivalent of an equity interest in professional practices. To permit lay manag-

\textsuperscript{177} Orman, 614 So. 2d at 1137.

\textsuperscript{178} Practice Mgmt. Assocs., Inc. v. Blickensderfer, 630 So. 2d 1147, 1148 (Fla. Dist. Ct. App. 1993) (construing New York’s law, which defines impermissible fee splitting in terms of “[p]ermitting any person to share in the fees for professional services.” N.Y. Educ. Law § 6530.19 (McKinney 2005)).

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...ers to take a percentage of practice income simply by avoiding the referral issue would be to allow unlicensed persons to enjoy an ownership interest otherwise prohibited by the corporate practice bar. But in Florida, where there is no corporate practice bar, the Orman decision has progeny, at least in the Second Appellate District. In Practice Management Associates, Inc. v. Gulley, the Second District Court of Appeals held that substantially the same agreement at issue in Orman did not violate Florida's fee-splitting law applicable to chiropractors. 180

There is much to be said for the relatively restrained approach taken by the Second District in the early 1990s, limiting the fee-splitting statute to referral situations. For one thing, it was consistent with Florida's statutory language, and arguably much more obviously applicable there than to Illinois law, which prohibited any "dividing" of fees, or New York law, which similarly prohibited fee "sharing." The applicable Florida statute, by contrast to Illinois and New York, embedded the operative term "split-fee arrangement" in a referral or antikickback context, prohibiting "(p)laying or receiving any unearned commission, bonus, kickback, or rebate or engaging in any split-fee arrangement in any form whatsoever with a physician, organization, agency, or person, either directly or indirectly, for patients referred to providers of healthcare goods and services." 181 Part of the attraction of limiting this law's application to referral situations is, as has already been mentioned, that this application is consistent with Florida's regulatory approach to the lay ownership issue generally. Florida law contained no express corporate practice bar, 182 and to the extent that this constituted a legislative policy to permit lay ownership, it would have appeared to some to be judicial overreaching to effectively bar lay ownership by prohibiting an arrangement where the lay owner could receive his share of the profits. 183 Put another way, a fee-splitting rule, in its narrowest configuration, regulates revenue, not organizational structure. It focuses on the revenue stream because its prime objective is to control cost, to restrain

181 Id. (quoting Fla. Stat. Ann. § 460.413 (1)(k) (West 1985)).
overutilization of medical goods and professional services, not to restrict the field of participants. The most direct effect of any restraint on improper referrals is to remove an incentive for revenue-generating conduct, to slow down the referral engine that otherwise drives the healthcare economy.

But fee-splitting regulation can be so much more, as Florida discovered along with the rest of the country in the early 1990s. In 1991, the Office of the Inspector General promulgated the first eleven of several “safe harbors” from the Medicare/ Medicaid antikickback rules, making it evident by inference that regulators might prosecute conduct that only indirectly stimulated referrals, such as below-market leases or practice acquisition transactions with payment provisions contingent on subsequent productivity. No longer would the federal government be bound to find a quid pro quo arrangement for compensating referrals before deeming conduct to violate Medicare’s fraud and abuse regulations. The effect of this approach, it was hoped, would be to magnify the effect of laws that restrained overutilization by restricting referrals. In this spirit, Florida enacted its Patient Self-Referral Act of 1992, and its patient brokering statute, which joined its antikickback and fee-splitting laws.

Additionally, Florida’s Board of Medicine initiated a series of rulings that departed from one of the fundamental assumptions of Orman and its progeny in the Second District. Whereas Orman had held that the inclusion of practice-enhancing services in a Practice Starter Agreement did not implicate antikickback regulations, the Board of Medicine initiated a series of rulings leading to another conclusion. The Orman court had distinguished

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185 The anti-kickback statute makes it a criminal offense knowingly and willfully to offer, pay, solicit, or receive any remuneration to induce referrals of items or services reimbursable by Federal health care programs. The statute has been interpreted to cover any arrangement where one purpose of the remuneration is to obtain money for referral of services or to induce further referrals.


187 Id. § 817.505.

188 Id. § 456.054.

189 Id. § 458.331(1)(i).
compensation paid for management services, acceptable even if calculated as a portion of professional fees, from compensation paid solely for referrals, which the court deemed improper and illegal. The court observed that payment for management services could be consistent with the “complexities of marketing and management of professional services in today’s competitive business environment without compromising the public policy behind legislation prohibiting or regulating the division of professional fees.”

Payment for certain services on a percentage-of-revenue basis, the court implicitly acknowledges, may be appropriate, as with billing services, where the management activity necessarily varies in accordance with revenue; and rewards commensurate with productivity, as in the case of compensation for marketing services based on practice growth, are reasonable in an era that had relaxed its earlier abhorrence of professional advertising.

In 1995, in holding an employment compensation arrangement to involve illegal fee-splitting, the Florida Board of Medicine (Board) began expanding the reach of Florida’s fee-splitting prohibition. The Board held a compensation arrangement to be illegal to the extent a physician was to receive, in addition to a base salary and a percentage of practice revenues generated by or under him, a percentage of all practice revenues in excess of a target level. This would have included revenues from ancillary services not performed by the physician (e.g., laboratory, radiology, diagnostic testing, and out-patient surgery fees) and to which the physician may have referred his patients. The Fifth District Court of Appeals affirmed over the objection of the physician that all ancillary services were performed “in house” within facilities owned or controlled by his employer and therefore did not constitute referrals subject to the fee-splitting prohibition.

The court noted that “the Board was concerned with the possibility that an employee physician’s medical judgment might be skewed where that physician benefits financially from overutilization of ancillary tests and services even if performed by [his employer].” Percentage-based productivity compensation was acceptable, but only to the extent of a division of the fees generated directly by or under the applicable physician.

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193 Id. at 1162.
This, in the view of at least one commentator, represented a materially new gloss on Florida's fee-splitting statute, which "does not define fee splitting, and particularly, does not distinguish between fees earned from ancillary services and personal services." The effect of the ruling, the commentator urges, is to make a new distinction between employee physicians, who may not share in the fees from ancillary services, from owners (whether or not they may be physicians), who may participate in revenues from ancillary goods and services by virtue of their equity interest in the provider. If Florida's fee-splitting statute had been conceived as a revenue-oriented regulatory scheme to curtail overutilization, with the Board's rulings it began to have an effect on the ownership of affected entities.

Consistent with its undertaking to expand the reach of Florida's fee-splitting sanctions, the Board scrutinized independent contractor compensation arrangements for evidence of fee-sharing based on referrals rather than services. As a general proposition, the Board accepted arrangements in which the professional's fees were paid directly to management corporations that retained a percentage for providing office space, advertising, billing, and administrative services. But where a clinic and an independent contractor physician divided on a percentage basis fees from the physician's services to clinic patients both within and outside the clinic, the Board found a fee-splitting violation, as some of the revenue thus retained by the clinic would not have related to services or overhead provided by it and would thus have been attributable to payment by the physician for referring the patient.

195 Jacobs and Goodman argue that the Board's holding constitutes unauthorized rulemaking, and that in this respect the state agency borrows from federal agencies in their promulgation of Stark II regulations that effectively "preclude group practice physicians from being compensated for designated [ancillary] self-referred health services." Id. at 256–57.
196 But see In re: Petition for Declaratory Statement of George G. Levy, cited in Fla. Bar, supra note 182, at 37 (holding that the employer physician may not share in fees of employee radiologist where employer physician did not actually perform or supervise performance of radiologist services). Other commentators have noted that Board's rulings are inconsistent. Fla. Bar, supra note 182.
The Board rulings of perhaps the greatest consequence to practice management companies were those circumscribing the kinds of services that could be compensated on a percentage basis. Whereas the Orman court had held that payment for management services, even practice enhancement services such as marketing and advertising, could be structured as a percentage of revenues “without compromising the public policy behind legislation prohibiting or regulating the division of professional fees,” the Board, perhaps again following the lead of federal regulatory agencies, began to view practice enhancement services as a species of referral to which the fee-splitting prohibition might apply. Thus, in In re: Petition for Declaratory Statement of Joseph M. Zeterberg, M.D., the Board objected to a fee-share arrangement that included “‘the activities of the [management] company going out and marketing allergy care services.’” The Board’s approach culminated in In re: Petition for Declaratory Statement of Magan L. Bakarania, M.D., in which the Board rejected a proposed management agreement between Dr. Bakarania and a PPMC called PhyMatrix. Under the agreement PhyMatrix would have provided “practice expansion” services, such as access to a provider network, providing ancillary services and negotiating managed care contracts, and would have received, among other forms of compensation, a performance fee equal to thirty percent of practice net income. The Board concluded that the practice expansion services helped generate referrals upon which its compensation would ultimately be based, and was therefore illegal as a fee split tied to referrals. The Board’s decision was affirmed by the First District Court of Appeals in 1999 in a one-paragraph per curiam opinion to the effect that the Board’s interpretation of the law was not clearly erroneous.

Although the Bakarania decision may be limited to contracts in which the management company is obligated to generate refer-

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200 See OIG, HHS Advisory Op. No. 4 (1998), cited in Fla. Bar, supra note 182, at 44 (concluding that a PPMC agreement including passive marketing responsibilities for which the PPMC was paid on a percentage basis implicated the anti-kickback statute since the arrangement could encourage overutilization and upcoding).
201 Fla. Bar, supra note 182, at 41 (quoting Board of Medicine).
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tals,\textsuperscript{204} it had a chilling effect on PPMC operations in Florida,\textsuperscript{205} and was widely received as a ban on percentage-based management fees generally.\textsuperscript{206} Whatever the final position in Florida on percentage payment for practice enhancement services, \textit{Bakariana} evidences the potential of a fee-splitting statute to have a very broad effect. \textit{Bakariana} has been perceived in some quarters as a \textit{de facto} corporate practice bar, making it difficult for anyone but another licensed professional to hold an equity interest in a practice that in turn would constitute a claim against profits and thus violate the fee-splitting bar.

Florida has witnessed other applications of the fee-splitting rule to restrict lay ownership. In \textit{Medical Management Group of Orlando, Inc. v. State Farm Mut. Auto. Ins. Co.}, the court held the re-assignment of practice receivables from the provider to a manager constituted an improper fee-splitting arrangement. Here a lay-owned medical management entity took assignment of patients' rights to insurance reimbursement from an MRI facility. The management company did not, strictly speaking, share the professional fee, but the court noted the management company's role in attracting business to the MRI facility and accordingly held the practice a violation of Florida's antikickback fee-splitting prohibition.\textsuperscript{207} The resulting anti-reassignment rule has a counterpart in Medicare rules, which prohibit re-assignment of the patient's assignment to his physician of the patient's right to reimbursement under the Medicare program.\textsuperscript{208} The effect is to solidify the provider's control of a fundamental attribute of ownership, the revenue stream.

However close Florida courts may come to a position similar to the corporate practice bar in Illinois or California, Florida proceeds from a very different premise. Florida courts are consistent in viewing improper incentives for referrals as the principal evil to be guarded against, and the rationale underlying this is the concern that improperly motivated referrals lead to overutilization of medical goods and services. To the extent that this regulatory perspective focuses on restraining improper professional con-

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\item \textsuperscript{204} \textit{See Inre: Petition for Declaratory Statement of Rew, Rogers & Silver, M.D.s, P.A., cited in FLA. BAR, note 180, at 54 (providing that a percentage management fee did not necessarily violate the statute if the management company was not responsible for generating referrals).}
\item \textsuperscript{205} \textit{See Marshall R. Burack, \textit{Florida Board of Medicine Resists Change}, 7 U. MIAMI BUS. L. Rev. 485, 489 (1999).}
\item \textsuperscript{206} \textit{See Jacobs & Goodman, supra note 16, at 240.}
\item \textsuperscript{208} \textit{See supra note 65.}
\end{itemize}
duct and controlling healthcare costs, it is manifestly different from California's focus on provider autonomy or Illinois's focus on licensure. California appears tolerant of some exceptions to its rather broad fee-splitting prohibition, but in a manner that evidences its differences with Illinois and Florida on policy with respect to lay participation in healthcare enterprises. California, as mentioned above, permits fee-sharing as a division of gross but not net revenue, the net number being that which partners would presumably share, whereas a division of gross revenue would be consistent with the manner in which some businesses would pay for services (commissions, for example). California's position on fee-splitting is thus consistent with its approach to regulating lay ownership of healthcare enterprises generally, approaching the issue in structural and organizational terms. As in California (but unlike Florida), under Illinois law the policy against fee-splitting can be violated whether or not a physician referral is at issue, and regardless of whether the fee is split on a percentage or flat fee basis. Thus, in The Laser Center, Inc. v. Midwest Eye Institute II, Ltd., the management services contract in question was held to violate Illinois' fee-splitting rule because the management fee was based directly on professional revenues, although not on a percentage basis, and without the necessity of a showing that the arrangement might have influenced the professional's referral practices. The arrangement offended the same policy that stands behind the Illinois corporate practice rules, namely, that only licensed individuals should be in the business of providing professional services. This is a concern that Florida does not share.

IV. Shortcomings of State Regulatory Programs

This section provides a few general observations on the various state programs affecting lay ownership, starting with some relating to matters of form.

209 CAL. BUS. & PROF. CODE § 650 (West 2005) ("The payment or receipt of consideration for services other than the referral of patients which is based on a percentage of gross revenue or similar type of contractual arrangement shall not be unlawful if the consideration is commensurate with the value of the services furnished ... ").


A. Forma Characteristics

First, these laws are multifarious. They vary from state to state; they are susceptible to rapid transformation over time; and they are statutory, common law doctrine, and in at least one case codified common law. They may regulate organizational structure, as in the case of the corporate practice doctrine expressed as a prohibition against lay ownership of a healthcare entity; professional conduct, as with statutes and common law doctrines prohibiting the unlicensed practice of medicine; or receipts, as with fee-splitting and anti-assignment restrictions. Our federalist system is costly and risky for those seeking to do business with healthcare professionals on a national scale.

Second, these laws tend to be reflexively and excessively prescriptive, and, as a related observation, protectionist. Where commercial conduct has been perceived to have a potential to corrupt professional judgment, the regulatory response has historically been to prohibit, if not criminalize, everything that would make the conduct possible. Where the prospect of department stores providing medical services was offensive, the response has been to make it illegal, not just for retail commercial enterprises but for any corporation to employ healthcare professionals. The history of such regulation has often included a subsequent staged retreat from a radically prescriptive position as needed to make it accord with reality. Thus, while many states initially reacted to the perceived or real excesses of corporate medicine in the early part of the last century by prohibiting corporate practice altogether, by 1971 all states had created statutory exceptions to the ban on practicing medicine in a corporate format by authorizing the formation of professional corporations, generally with the stipulations that (i) no lay persons could own shares or hold offices and (ii) no professional could thereby limit liability for professional negligence. Likewise, where it has been perceived that the duty of loyalty of a physician to her patient would be divided if the physician simultaneously owed a duty of loyalty to an employer, the response has been to prohibit all business corporations from employing physicians. In jurisdictions where this extreme

\footnotesize{213 See supra notes 42, 52.  
216 See supra note 16; Rosoff, supra note 8, at 495 (noting the dual characteristics of professional corporations in most states).}
position was adopted, retreats have been ordered for various employment practices, including employment by professional corporations, by hospitals, by certain nonprofits, or by licensed entities. Where it has been perceived that physicians are more likely to refer their patients for MRI testing when the physician owns an interest in the MRI facility, the response has been to prohibit physicians from referring to facilities in which they have a financial interest, or from sharing fees, or from assigning receivables; and reasonable exceptions have been carved for referrals and fee divisions within a network, a partnership, or between employer and employee. From a regulatory viewpoint, the advantage of a radically proscriptive approach with extreme sanctions is that it can be effectively and efficiently administered on a wide scale. It is much easier to identify misconduct that has been defined structurally (Doctor X referred her patient to an MRI facility in which she held an ownership interest) than to evaluate individual conduct (did Doctor X's referral of her patient to her own MRI facility constitute overutilization of medical services?).

Such regulation is conceived with the virtuous intention of protecting all persons involved in transactions in which one or more participants are often disadvantaged. The physician, history had shown, could be disadvantaged by a corporate employer to whom a legal duty was owed;217 but the professional is not the only member of the triad of the healthcare economy that gets protection. Both the patient and the payor are also perceived as needing protection under one or another regulatory program. As professionals may need protection from the often rather vaguely conceived threat of commercialism, patients and payors need protection from professionals. Clearly a patient can be disadvantaged by the disequilibrium of knowledge and information existing between herself and her physician when it comes to medical matters.218 Where the patient is not the payor, and indeed may be insensitive to issues of cost because the payor is a third-party insurer, the payor is at a clear disadvantage when it comes time for the practitioner and the patient to agree upon course of action and price.219 Something in this perceived need for mutual protection, however, suggests a regrettable lack of faith in the integrity of persons otherwise engaged in a fiduciary relationship. Perhaps because of the mag-

217 See generally STARR, supra note 7, at 198-232.
219 See id. at 962.
nitude of the healthcare portion of the national economy, or the portion thereof sustained by public funds, or because of the difficulty in regulating such an economy without the use of in terrorem measures, relatively little is left to trust when it comes to regulating the business of healthcare. Thus to protect the autonomy of professionals, states have implemented various aspects of the corporate practice of medicine doctrine. To protect the interests of patients and payors, the federal and various state governments have implemented antikickback, self-referral, and fee-splitting rules to eliminate inducements for the overutilization of medical services.

Although regrettable, and although it may be fair to say that the protectionism of state healthcare regulation undervalues the integrity of the medical professional (notably to a degree the legal profession has not had to suffer), the impetus is nonetheless understandable. There is simply too much of what Kenneth Arrow termed “moral hazard” in the fabric of the healthcare profession to permit us to allow it to self-regulate, to find its own ethical level. Normal market forces cannot work unassisted to protect the interests of professionals, patients, and payors. To a large extent, the patient must rely upon the doctor not only to diagnose the condition and prescribe the treatment, but also to inform the patient of the extent to which the physician was successful in both undertakings. The payor, often absent at all relevant times, must trust both other parties, each with an interest adverse to its own, to negotiate cost. This is not a market that readily corrects itself. Information about the costs and benefits of services is not fully transmitted among the provider and consumer of and the payor for the services.

223 Arrow's point about what he calls “informational inequality” is not that the typical patient did not go to medical school, but that unlike the purchaser of a car, who can determine the effectiveness of what he has purchased, the typical patient does not know how to determine whether the service provided by the physician is optimal, or even effective.

To avoid misunderstanding, observe that the difference in information relevant here is a difference in information as to the consequence of a purchase of medical care. There is always an inequality of information.
It is also important to note in connection with this catalog of formalist characteristics of the subject body of laws, rules, and regulations that they are fragmentary. They tend to regulate fewer than all aspects of the conduct they seek to control, and as a result they have been relatively ineffective, taken individually. Thus a rule against the employment of professionals can be circumvented by replicating the terms of an employment agreement within the context of an independent contractor arrangement, and a rule against dividing fees on a percentage basis can be circumvented by dividing them on some other basis, or resorting to flat fees subject to adjustments, and so forth.

Put another way, each of the regulatory subclasses identified in the foregoing discussion—those respectively oriented towards the provider, the patient, and the payor—is deficient in its own way when viewed from a perspective that accommodates all three orientations. The provider orientation overvalues physician autonomy and undervalues cost issues. The payor perspective is the reverse; it overvalues economic incentives (the danger that a profit motivation will lead professionals to overutilize healthcare goods and services) and correspondingly undervalues professional integrity. For its part, the patient orientation arguably overvalues regulation itself in the pursuit of quality assurance through licensure.

One problem with such rulemaking is the problem of the baby and the bath water. Blanket restrictions on physician self-referrals may inhibit the commercial development of innovative technology. Doctors, who may be in the best position to evaluate the utility of new technology, could be a valuable source of financing, were it not for the moral hazard. So too, general structural prohibitions on lay ownership are not properly targeted to the "evils" at issue.

As a final and related observation about matters of form, the laws, rules, and regulations in question are Protean. They begin as one thing and rapidly become another. Thus fee-splitting statutes, as we have seen, can evolve to the point where they effectively achieve what corporate practice prohibitions are

as the production methods between the producer and the purchaser of any commodity, but in most cases the customer may well have as good or nearly as good an understanding of the utility of the product as the producer.

Arrow, supra note 218, at 951–52.
intended to do, prohibiting lay ownership of healthcare enterprises. Similarly, licensure statutes may be interpreted to prohibit corporations from practicing medicine. The rules in this class have a tendency to become unruly, to serve new masters, new rationales, as shifts in the perception of public policy from time to time require. Thus a rule that may have originated in response to pressures of medical societies to restrict professional advertising can become state versions of federal Medicare/Medicaid fraud and abuse regulations, restraining kickbacks and physician self-referrals.224

B. Application

Reflection on the application of state laws, rules, and regulations affecting lay ownership provokes another set of observations. First, as mentioned above, they have historically been less than effective, at least to the extent that they have been circumvented by sufficiently determined and resourceful parties. Secondly, they have too frequently been invoked disingenuously by practitioners seeking to unwind bargains voluntarily entered into, often from which the defaulting party has already disproportionately reaped the benefit.225

It may also be added in this connection that in their application these laws often appear to have an unequal impact on the parties. Witness the equal protection argument historically advanced to challenge state statutes restricting the practice of medicine to professional corporations.226 Whatever the merits of the assertion in that case, it seems clear that what may, as a practical matter, constitute a relatively immaterial formal difference can produce a materially different legal result. Thus where a hospital can employ a physician, a wholly-owned subsidiary of the same hospital may not; or where a hospital may not employ a physician, a captive professional corporation wholly owned by a physician controlled by the hospital may do so.

224 The point was made in the context of Florida's fee-splitting rules; but evidence of the federalization of state healthcare regulation is widespread. Pennsylvania's Workers' Compensation regulations, for instance, simply incorporate by reference the federal Stark exceptions to transactions that would otherwise constitute prohibited self-referrals. 34 Pa. Code § 127.301(c) (2005).
225 See TLC The Laser Ctr., Inc. v. Midwest Eye Inst. II, Ltd., 714 N.E.2d 45, 55 (Ill. App. Ct. 1999) (The applicable doctrine "is intended to protect the public, not to allow medical professionals to avoid contractual obligations.").
C. Doctrinal Shortcomings

It is not news that the various rationales traditionally invoked to support doctrines restraining lay ownership of healthcare enterprises are logically flawed.227 A more compelling question is, given their flaws, why have these rationales not been finally and definitively discarded? What is the source of their resilience?

1. The Autonomy Orientation

Those jurisdictions that, like California, tend to resist lay ownership on the theory it would damage professional autonomy generally point to the dangers of “commercialism,” lay control over professional judgment, and division of the physician’s loyalty between a lay employer and the patient.228 In the application of its protective doctrines, such a jurisdiction abhors lay employment of physicians, but may create an exception for nonprofits, and generally tolerates independent contractor arrangements between lay managers and physicians. Employment arrangements are suspect chiefly because the employed physician is thought thereby to have potentially conflicting duties of loyalty to the employer (presumably to maximize profits and minimize expenses) and the patient; but an exception may be contemplated for nonprofits, presumably because they lack the profit motive of a commercial enterprise. Independent contractor arrangements are presumably tolerated because the physician retains autonomy over professional matters, and in any event has no duty of loyalty corresponding to that owed to an employer. Where the same jurisdiction has a fee-splitting prohibition, it can be made consistent with the foregoing position on employment and independent contractor arrangements by permitting a division of fees on a basis that accommodates the latter but not the former. That is, the fee-splitting rule may permit a division of gross but not net revenue, since the former is consistent with payment for independent contractor services (such as billing or marketing services, which reasonably relate to revenue generated), while the latter implies a business partnership, a forbidden equity arrangement.

Very little of the foregoing withstands scrutiny. First of all, with respect to “commercialism,” it should be acknowledged from

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227 See generally HALL & VAUGHN, supra note 18, at 3-19 to -23.
228 For a list of reasons for resisting lay-ownership of healthcare enterprises, including commercialism, lay control of professional judgment, and division of the physician’s loyalty, see Chase-Lubitz, supra note 5, at 467-70.
the outset that economic motivation exists regardless of the practice format, even where the physician's employer is not a business corporation—even, one might add, where the employer is a professional corporation, or, for that matter, where there is no employer. If the problem were simply that economic motives can divert the professional from acting in the best interests of the patient or the payor, it would have to be acknowledged that a doctor would be faced with that conflict whether she worked independently, for a nonprofit hospital, a for-profit hospital, or for a public company. Charitable institutions have revenue needs as palpable as those of commercial enterprises, and can as easily exert economic pressure on their professional employees. It would make little difference in an analysis focused wholly on the problem of economic coercion of professional conduct whether the coercive pressure were to come from shareholders, an employer, or creditors—or whether the employer were a lay entity, a professional corporation, or a nonprofit.

It seems hardly worth the effort to point out that what defines a nonprofit corporation is not a lack of interest in making a profit from operations; but having done so, we may also note the fallacy in the argument that nonprofits, as such, deserve an exemption from the corporate practice bar when “commercialism” is the “principal evil” to be guarded against.229

But in fairness to proponents of the “commercialism” rationale for the corporate practice and fee-splitting doctrines, the real objection must arise when the physician employee is subject not to conflicting economic temptations or coercions, but to conflicting legal duties. The physician employee, that is, has a legal duty to her employer and a professional duty to her patient, and the two duties could conceivably diverge. Those jurisdictions advocating the “commercialism” rationale are perhaps contemplating the situation in which the employer demands higher productivity at the expense of good medical practice.230

Yet the “divided loyalty” argument is also flawed. Legislative responses to the objection already exist both federally and in

229 See CMA v. Regents, 79 Cal. App. 4th 542, 550 (2000) (The profit motive is one of the “principal evils attendant upon the corporate practice of medicine.”).
many states, chiefly in the context of HMO legislation. HMO enabling legislation provides in one way or another that the business arrangement may not interfere with the independent professional judgment of the clinician. It may be fairly argued that this solution is in many ways inadequate, and that as a practical matter it is often impossible to distinguish clinical and administrative matters; but this argument is of necessity made in the face of legislation that, if nothing else, makes it clear that public policy does not prohibit an enterprise from proceeding under the promise of undertaking to observe the distinction.

There would seem to be no compelling public policy rationale, then, to preclude other healthcare delivery enterprises from attempting the same thing contractually. It is unlikely that the duty owed to an employer by a physician employee is nonwaivable in any jurisdiction, and if it were, there is no reason it could not be made waivable by legislative act within the context of healthcare contracts, so that the employer could agree to subordinate to clinical matters.

State laws permitting professionals to incorporate illustrate another flaw in the "division of loyalty" argument. The reasoning behind exempting professional corporations from the corporate practice bar is somewhat tenuous, as it would seem to depend on the dubious proposition that a physician, qua shareholder or employee of a professional corporation, does not have interests or duties that conflict with her duty of loyalty to patients. Nothing in the fact that only licensed professionals may own shares of a professional corporation compels the conclusion that as such they have a duty to patients. Certainly physician shareholders may not raise their duty to patients as a legal defense against corporate obligations to trade creditors, or even other shareholders. Why then should legislatures that otherwise seek to promote physician autonomy, exempt professional corporations from the corporate practice bar? One conclusion from the fact that they do so is that there may in fact be no logically compelling public policy against the corporate practice of medicine.

One further important, if somewhat provocative, argument against the "division of loyalty" justification for physician autonomy regulation is that in certain respects perhaps the

231 Witness the court's rejection of line-drawing solutions in Moore, 2002 WL 32351 at *5, (following Parker v. Bd. of Dental Exam'rs, 14 P.2d 67, 71-72 (Cal. 1932)).

232 See supra note 53.
physician’s loyalties should be divided. Perhaps at some point the physician should be required to respond to an obligation to the public at large to exercise reasonable restraint in the application of resources to a particular patient. Like managed care organizations, society may have a legitimate right to redirect the professional from the single-minded pursuit of the best interests of her patient.

Another fallacy among laws restricting lay ownership of health-care entities is the apparent assumption that, from the perspective of the patient, employment arrangements are necessarily worse than independent contractor arrangements. Is the duty a professional owes to her employer essentially more detrimental to the patient than a duty the same professional may incur through another form of contract? True, the extensive body of employment case law may help define the duty when nothing is expressed in an employment contract; but there is no reason that equally conflict-burdened stipulations could not be expressed in a carefully designed professional services agreement. It is unclear why the corporate practice of medicine doctrine should apply to employment of physicians, but not to provider contracts with physicians. By the same token, since any potential conflict of duty in an employment agreement is presumably waivable by the parties, an employment arrangement would seem as susceptible to redemption as an independent contractor arrangement with respect to establishing the priorities of the professional. From this perspective it is unclear why the corporate practice of medicine doctrine should apply to either an employment or an independent contractor arrangement. In any event, it is an evident weakness of the doctrine that under rules currently in effect it can be effectively circumvented with form over substance subterfuge, by substituting for an employment agreement a substantially equivalent independent contractor provider agreement.

2. Patient Orientation

The “licensure” rationale for the corporate practice doctrine has its own difficulties with logic. As developed in the Illinois line of cases following Berlin, the licensure rationale states that only individuals, not corporations, are capable of meeting the requirements established by licensure laws for the practice of medicine. This rationale involves construction of statutes and regulations, and in this activity it is generous with respect to hospital licensure regulations and stingy with respect to business corporations. The Berlin court, for instance, generously construes
the Illinois Hospital Licensing Act to infer legislative authorization to employ physicians from its definition of a "hospital" as: "any institution...devoted primarily to the maintenance and operation of facilities for the diagnosis and treatment or care of...persons admitted for overnight stay or longer in order to obtain medical...care."233 From this language and language in Illinois' Hospital Lien Act and Hospital Emergency Service Act referencing the provision of medical services by hospitals, the court concludes that the licensure statute implicitly authorized the employment of physicians, because how else could hospitals provide the services contemplated?234

One answer to this last question, conveniently overlooked by the court, is that hospitals could engage physicians on an independent contractor basis to provide the services, or admit them through the hospital's medical staff to do so without any professional services contract, thus avoiding the corporate practice prohibition on employment of physicians. Another answer involves recognizing that when the drafters of the Hospital Lien Act and the Hospital Emergency Service Act referred to the provision of medical services, it was not critical for them to distinguish between providing and arranging for the provision of the services. The most compelling objection to the court's construction of legislative and regulatory language was voiced by Justice Harrison in dissent, observing that in the sixty years since the Illinois Supreme Court had established its prohibition on corporate employment of healthcare professionals, the legislature had not taken action to change course, in whole or in part, even to clarify that hospitals may employ physicians. "To the contrary, it has continued to adhere to the requirement that

233 210 I.L.L. COMP. STAT. ANN. 85/3-(A) (West 1995).
234 The court reasoned as follows:

In addition, the Hospital Lien Act provides "[e]very hospital rendering service in the treatment, care and maintenance, of such injured person" a lien upon a patient's personal injury cause of action. Moreover, the Hospital Emergency Service Act requires "[e]very hospital...which provides general medical and surgical hospital services" to also provide emergency services.

The foregoing statutes clearly authorize, and at times mandate, licensed hospital corporations to provide medical services. We believe that the authority to employ duly-licensed physicians for that purpose is reasonably implied from these legislative enactments.

medicine can only be practiced by those who hold valid licenses from the state... The court-made licensure rationale is in the nearly untenable position of having to accomplish a legislative task in creating a licensing rule.

While the Illinois Supreme Court's construction of the license statute is generous to hospitals, its construction of corporate law is rather stingy. As mentioned above, this licensure rationale is essentially a selective refusal to extend to certain corporations (healthcare organizations, as opposed to, say, airline companies) the corporate attribute of legal personality. The application of this argument to healthcare is inconsistent with licensure principles as applied in other contexts in which corporations employ licensed individuals, such as airline companies.

Ultimately, the Berlin court justifies its conclusion not with regulatory parsing, but with its observation that the arrangement between Dr. Berlin and the medical center properly drew a line between professional and lay conduct and thereby maintained the requisite degree of professional autonomy, but in this, too, a trap awaits. As developed by the Berlin court, the licensure rationale may also be an indirect route to taking a position on corporate liability for professional negligence. The Berlin court expressly declined to follow the argument advanced in some jurisdictions to the effect that corporations do not themselves practice medicine so much as merely make medical practitioners available. The advantage of such an argument, from the point of view of the hospital, is that it creates a logical gap between providing and arranging for the provision of healthcare, in which a legal barrier to hospital tort liability can be erected. Indeed, it has historically been argued that the corporate practice doctrine protects not only physicians but also the hospitals that would employ them by establishing that hospitals do not practice medicine. It is the defense often erected for HMOs as they seek to avert tort liability by standing behind their function as mere insurers rather than providers. By declining to follow precedent that held hospitals could not employ physicians because they are not providers of services, the Berlin court arguably left the door open for hospital tort liability, and thus handed the Sarah

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235 Id. at 115 (Harrison, J., dissenting) (citations omitted).

236 The refusal is express in California law; Cal. Bus. & Prof. Code § 2400 provides: "Corporations and other artificial legal entities shall have no professional rights, privileges, or powers." See also Pediatric Neurosurgery v. Russell, 44 P.3d 1063 (Colo. 2002); State ex rel. Loser v. Nat'l Optical Stores Co., 225 S.W.2d 263 (Tenn. 1949).

237 Berlin, 688 N.E.2d at 112.
Bush Lincoln Health Center a victory on terms which may well have given the facility deep concern.

3. Payor Orientation

When fee-splitting laws fail to provide a coherent definition of the term “fee-splitting,” the task is left to courts, at which point it becomes apparent that the possibilities and their implications are endless. A court starting with the observation that the rule cannot mean professionals may not pay their bills may proceed, as in the TLC case, to draw upon historical expressions of public policy to help narrow the range of possible meanings. It is no mean feat to select an expression of public policy that does not pertain to a bygone business practice or a dated issue; but assuming the court avoids this pitfall, it faces the danger of articulating a policy position that may stifle a development the healthcare community would have accepted at the next opportunity. Thus, the TLC court, as noted above, focused on a policy against medical “mills”, or high-volume, low-paying service delivery arrangements, inevitably forging a rule that could clash with contemporary endeavors to lower medical costs and increase access.

To continue with the TLC decision as further evidence of the difficulties of statutory construction in this area, recall the court’s rationale for holding that a management fee violated the applicable fee-splitting statute: “The policy reasons behind the prohibition are the danger that such an arrangement might motivate a non-professional to recommend a particular professional out of self-interest, rather than the professional’s competence.” Perhaps the first question this statement provokes is why should a statute whose policy purpose is to discourage specified lay conduct, a recommendation made by a non-professional, appear in a licensure statute, with sanctions against only the professional? This question may quickly be followed by asking whether there is any rational purpose in seeking to preserve the integrity of a lay recommendation for professional services. Does anyone justifiably rely on such a thing?

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The Illinois statute, like several other state fee-splitting statutes, states its prohibition in terms of "dividing" professional fees. This language raises another definitional issue characteristic of states with fee-splitting rules. Illinois courts have drawn the reasonable conclusion that the legislative intent in using the word "dividing" was to prohibit percentage allocations of fees (thereby avoiding the interpretation that would have prohibited any use of a portion of fees to pay practice bills). But many subsequent decision points remain. Unless, as in California, the statute specifies that its target is net revenue, or profit, there is the possibility that an arrangement whereby a billing company would receive a percentage of billings as its fee would be illegal. The problem with this conclusion, as the California legislature has evidently recognized, is that such an arrangement, common in other areas of the economy, makes perfect sense with respect to matters such as billing, where the work involved increases proportionally with revenue generated. And where the legislative purpose is to preserve physician autonomy from lay persons who would become their partners, that purpose is served as long as any division of fees relates to gross and not net revenue. But in Illinois, where the legislative purpose is less tightly focused on the preservation of physician autonomy through the avoidance of equity-sharing arrangements, it is harder to direct the application of the statutory bar against dividing fees. If it simply meant that there can be no division based strictly on percentages, the statute could be circumvented with a modified percentage arrangement, such as one where a management fee is based on a percentage of revenue but subject to a cap. At some point, however, there must be a recognition that the process will lead to the equally untenable conclusion that a fixed, flat management fee cannot be related to the results achieved for the practice, or even the amount of effort expended by the management company, and at that point the purpose of the statute has to be revisited. In many jurisdictions, business persons and professionals alike are already facing the illogical effect of laws which apparently require that the management company agree in advance to a flat fee, which may or may not properly relate to either the results to be achieved or the efforts to be expended by the manager.

241 225 ILL. COMP. STAT. ANN. 60/22-(A)(14).
242 See CAL. BUS. & PROF. CODE § 650 (West 2005).
V. Conclusion

Given the logical, pragmatic, and other deficiencies of laws restricting lay ownership of healthcare enterprises, why do they endure? Because each is a manifestation of an abiding concern, if only partially conceived and partially expressed. It is the fragmentary nature of each of the regulatory perspectives that gives rise to problems. There is nothing wrong in and of itself with a public policy to protect the autonomy of professionals, or to guard against the unlicensed practice of medicine, as long as the policy finds room reasonably to recognize the interests of those with whom professionals interact, the patient and the payor; just as there is nothing wrong with a policy against overutilization of professional goods and services as long it properly observes professional autonomy and quality assurance concerns. What the various regulatory approaches throughout our federalist system clearly reveal is that there are ultimately three interdependent components to any fully-realized healthcare policy on lay ownership. The professional, the patient, and the payor each deserves protection, but not at the expense of the others.

What would a regulatory program that accommodated all three perspectives look like? To begin with, it should not be excessively formalistic or reflexively proscriptive. Simple prohibitions of selected behavior, as we have seen, invite circumvention, and as the rules evolve to thwart circumvention, they become unruly; they obstruct more conduct than originally intended. Narrowly conceived proscriptive regulation tends to leave underserved the interest of one of the members of the healthcare triad, professional, patient, and payor, and often it is the interest of the party the rule seeks to protect. Thus, rules against lay participation in healthcare enterprises have the effect of unnecessarily limiting professionals’ access to capital and administrative services.

Any regulatory program should be coherent, and in this regard the provider-patient-payor matrix should prove a useful assessment tool. It is a reminder that regulatory systems should not overvalue one perceived virtue, such as provider autonomy, at the expense of another, such as utilization control. By viewing the various methods of restraining lay ownership as interrelated, the matrix should promote consistency within a given regulatory system. Thus, a jurisdiction that gives with one hand by permitting lay corporate ownership of healthcare enterprises should not then take away with the other by prohibiting fee-sharing so broadly as to deprive the concept of ownership of a fundamental attribute. A jurisdiction that seeks to restrain lay control should rationalize its rules with respect to both owner-
ship and fee-sharing through independent contracting to be sure it has not barred the unwelcome conduct at the front door and invited it in through the back door.

A coherent regulatory system can take many forms. A minimally invasive program might accommodate (i) the need for provider autonomy simply by mandating that any lay-professional venture observe the authority of the professional with regard to clinical matters, (ii) the quality assurance objective by establishing and enforcing practice standards, and (iii) the payor perspective by simply recognizing a fiduciary obligation of professionals to payors to the extent they are not, in a given circumstance, in a position to negotiate and police utilization and other cost matters. Alternatively, a state could follow the HMO economic model by determining that the interests of the payor are properly accommodated when the provider has accepted sufficient risk.

While regulatory systems could continue to vary from state to state (and some jurisdictions could of course elect to continue as now without regulation), it is to be hoped that the regulatory landscape would ultimately be less Balkanized than is currently the case. It would be good if regulatory programs were sufficiently similar that multistate organizations with useful business solutions for healthcare providers and patients were not unnecessarily impeded. Our federalist system has performed its initial task in identifying the universe of regulatory concerns where lay and professional healthcare providers are involved. The time is ripe for the lawmakers of all jurisdictions to compare notes and share the best of their solutions to common problems. At a minimum, regulatory programs should consider licensing arrangements having certain qualifications in order to remove the uncertainty that currently plagues many enterprises and stultifies the development of others. Licensure would remove some of the "legal landmines" that are too often used simply as defenses by the breaching party against contractual obligations. A licensed PPMC, operating under state-sanctioned management agreements, would not have to worry that a disputing physician could bring down the whole operation by prevailing in a claim that the management contract is void as against public policy.

What would a regulatory program look like if it were to take into account all three components of the provider, patient, payor triad? HMO enabling legislation is an example. It authorizes a variety of legal relationships between laymen and professionals, including both employment and independent contractor
arrangements. The legislation contemplates different ways of allocating income from services, as long as the professionals and lay administrators stipulate that the professionals will have ultimate authority with respect to clinical matters, that certain minimal contract and statutory rights of patients will be observed, and that certain quality of care and level of service obligations are met. A PPMC licensure law could be another example, and other examples would undoubtedly follow, given the evidence of mutual lay and professional interest provided by PPMCs. To be sure, there would be litigation as to where the line between clinical and administrative conduct should be drawn and what should be the respective obligations of the lay and the professional parties, just as there is now in the managed care context; but the existence of such litigation cannot be taken as evidence of a public policy objection to lay ownership of all healthcare enterprises. Public policy has moved beyond the strictures sometimes attributed to it in the context of state doctrines restricting lay ownership of healthcare enterprises.

244 E.g., Whether the term "medically necessary" is a medical term or an insurance contract coverage term. See generally Pegram v. Herdrich, 530 U.S. 211 (2000).