CHAPTER 8

EMPLOYMENT ISSUES

by

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Scope of Chapter:

This chapter covers the corporate practice of medicine; Stark, fraud and abuse and anti-kickback issues with respect to at-will employment contracts and compensation arrangements; anti-trust/competition considerations in physician hiring; and applicability of unions, NLRA and LMRA to physicians and physician groups.

Treated Elsewhere:

Medical staff peer review and credentialing, see Chapter 3

Labor and employment law, generally, see Illinois Juris, Labor and Employment

Research References:

Text References:

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Health Care Law Compliance Manual, Matthew Bender & Company, Inc.

Health Care Law: A Practical Guide, Matthew Bender & Company, Inc.

Fundamentals of Health Law, Douglas A. Hastings, J.D., Gregory M. Luce, J.D., and Nancy A. Wynstra, J.D.

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Annotation References:

Liability, Under Title VII Of Civil Rights Act Of 1964 (42 U.S.C.A. §§ 2000E Et Seq.), Of Hospital On Basis Of Refusal Or Revocation Of Hospital Staff Privileges To Physician Or Nurse, 174 ALR Fed 611.

Construction and application of sec. 8(g) of National Labor Relations Act (29 USCS sec. 158(g)), requiring labor organization to give notice of intention to engage in strike, picketing, or other concerted refusal to work at health care institution, 43 ALR Fed 449.

Effectiveness of employer's disclaimer of representations in personnel manual or employee handbook altering at-will employment relationship, 17 ALR5th 1

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For article, "Night Landings on an Aircraft Carrier: Hospital Mergers and Antitrust Law," see 23 Am J L and Med 191 (1997).

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Practice References:

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Federal Legislation:

Age Discrimination in Employment Act, 29 USCS §§ 621-634. Americans with Disabilities Act, 42 USCS §§ 12111-12213. Civil Rights Act of 1964, 42 USCS § 2000e et seq. Clayton Act, 15 USCS §1 et. seq. Family and Medical Leave Act, 29 USCS §§ 2611 et. seq. Labor Management Relations Act of 1947, 29 USCS § 141 et seq. Medicare Anti-Kickback Statute and Regulations, 42 USCS 1320a et. seq. and 42 CFR § 1001 et seq. National Labor Relations Act ("NLRA"), 29 USCS § 151 et seq. Stark Law and Regulations, 42 USCS § 1395 and 42 CFR § 411.350 et seq.

State Legislation:

Illinois Hospital Licensing Act, 210 ILCS 85/1 et. seq. Illinois Medical Practice Act of 1987, 225 ILCS 60/1 et seq. Illinois Professional Service Corporation Act, 805 ILCS 10/1 et. seq.

Auto-Cite®: Cases and annotations referred to in this chapter can be further researched through the Auto-Cite® computer-assisted research service. Use Auto-Cite® to check citations for form, parallel references, prior and later history, and annotation references.

§ 8:01. Corporate practice of medicine doctrine

One of the oldest laws affecting healthcare providers is the prohibition against the corporate practice of medicine. To understand this doctrine some historical perspective is useful.

During the early 19th century, physicians were struggling to create a general perception that medicine was a noble profession instead of one composed of a bunch of charlatans and frauds. The first step toward gaining legitimacy was to require licensure for physicians. Thus, by 1905 all but three states required completion of medical school and passing an independent state exam in order for an individual to practice medicine.[1] Such licensing requirements helped to garner medicine the professional status it desired, however, the industrial revolution threatened this achievement.

Specifically, railroads, mining companies and lumber mills began hiring physicians to provide health care services for their employees. Believing that such actions threatened the autonomy of physicians the American Medical Association ("AMA") challenged the practice of corporations hiring and employing physicians. Such arrangements, according to the AMA, would adversely affect health care services since the physician, rather than being an independent advocate for his patient, was instead beholden to the employer. By the early 1930's most states, heeding the AMA's warning, enacted statutes prohibiting the "corporate practice of medicine."

In Illinois, for example, the Illinois Medical Practice Act of 1986 (the "Illinois Medical Practice Act") declares that: "No person shall practice medicine, or any of its branches, or treat human ailments ... without a valid, existing license to do so.... "[2]

Although the Illinois Medical Practice Act does not specifically state that a corporation may not hire a physician, in 1936, in the case of People v. United Medical Service, Inc.,[3] the Illinois Supreme Court interpreted this act to prevent corporations from employing physicians. In this case, a corporation operated a low-cost health clinic

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1. Colloquy, Patient Care and Professional Responsibility: Impact of the Corporate Practice of Medicine Doctrine and Related Laws and Regulations, NHLA/AAHA (1997) at pg. 3.

2. 225 ILCS 60/3.

3. People by Kerner v United Medical Service, Inc., 362 Ill 442, 200 NE 157, 103 ALR 1229 (1936) (superseded by statute as stated in Real v Kim, 112 Ill App 3d 427, 68 Ill Dec 139, 445 NE2d 783 (1st Dist)).

through the services of employed licensed physicians. Specifically, the Illinois Supreme Court noted that under the Illinois Medical Practice Act only an individual can become licensed to practice medicine. According to the court, a corporation, by its very nature, does not possess the qualities necessary to become licensed to practice medicine and a corporation can not alter this fact by employing physicians to do for the corporation indirectly, what the corporation could not do itself directly. The Illinois Supreme Court therefore held that a corporation could not employ a physician and the prohibition against the corporate practice of medicine was developed.

Other states developed similar prohibitions, either by statute or common law, such that by the early 1930's nearly all states had a prohibition against the corporate practice of medicine. Yet, although this prohibition existed in most states for over sixty years, in reality only a few states diligently enforced this prohibition. The advent of HMOs and other health care delivery systems, however, caused many states to re-examine their prohibitions against the corporate practice of medicine.

For instance, in 1994, in the case of Berlin v. Sarah Bush Lincoln Health Center, an Illinois physician who was employed by a hospital claimed that his employment agreement was void because it violated Illinois' corporate practice of medicine prohibition.[4] Specifically, the physician alleged that the corporate practice of medicine prohibition prevented the hospital from hiring him in the first place. Ultimately the case went to the Illinois Supreme Court, which held that Illinois' prohibition against the corporate practice of medicine, although rarely used, still existed and still prohibited corporations from employing physicians. Although the court upheld the prohibition, it did create an exemption to the prohibition to permit licensed not-for-profit hospitals to employ physicians citing that employment by licensed hospitals did

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4. Berlin v Sarah Bush Lincoln Health Ctr., 179 Ill 2d 1, 227 Ill Dec 769, 688 NE2d 106, 13 BNA IER Cas 727 (1997).

not pose the same potential harms to patients that employment by for-profit corporations did.[5]

More recently, in Carter-Shields v. Alton Health Institute,[6] the 5th District Appellate Court held that a medical provider which was not a licensed hospital and was partly controlled by a partnership with a non-physician member was barred by the corporate practice of medicine doctrine from hiring a physician as its employee. Moreover, since the provider and the physician could not enter into such a contract, the court held that the entire agreement, including a restrictive covenant, was void and unenforceable.

The Carter-Shields court narrowly construed the exception to the corporate practice of medicine doctrine created in the Berlin case. Specifically, the court noted that the exception was limited to licensed hospitals. The court also noted the public policy concerns about lay people controlling professional judgment.[7]

Thus, the current law in Illinois, similar to other states' laws, is that a business corporation may not employ a physician unless it is a licensed hospital. Nonetheless, in Illinois and in all other states, a professional corporation may employ a physician if all of the owners

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5. The court seemed to emphasize the fact that hospitals have an independent duty to care for patients' health and welfare. Berlin v Sarah Bush Lincoln Health Ctr., 179 Ill 2d 1, 227 Ill Dec 769, 688 NE2d 106, 13 BNA IER Cas 727 (1997).

6. Carter-Shields v Alton Health Inst., 317 Ill App 3d 260, 250 Ill Dec 806, 739 NE2d 569 (5th Dist 2000), app gr 194 Ill 2d 566, 254 Ill Dec 311, 747 NE2d 351 and (criticized in Prairie Eye Ctr., Ltd. v Butler, 329 Ill App 3d 293, 263 Ill Dec 654, 768 NE2d 414 (4th Dist)) and affd in part and vacated in part on other grounds, 201 Ill 2d 441, 268 Ill Dec 25, 777 NE2d 948, 19 BNA IER Cas 139, 147 CCH LC P 59660 and (ovrld in part on other grounds as stated in Mohanty v St. John Heart Clinic, S.C., 358 Ill App 3d 902, 295 Ill Dec 490, 832 NE2d 940 (1st Dist)).

7. Carter-Shields v Alton Health Inst., 317 Ill App 3d 260, 250 Ill Dec 806, 739 NE2d 569 (5th Dist 2000), app gr 194 Ill 2d 566, 254 Ill Dec 311, 747 NE2d 351 and (criticized in Prairie Eye Ctr., Ltd. v Butler, 329 Ill App 3d 293, 263 Ill Dec 654, 768 NE2d 414 (4th Dist)) and affd in part and vacated in part on other grounds 201 Ill 2d 441, 268 Ill Dec 25, 777 NE2d 948, 19 BNA IER Cas 139, 147 CCH LC P 59660 and (ovrld in part on other grounds as stated in Mohanty v St. John Heart Clinic, S.C., 358 Ill App 3d 902, 295 Ill Dec 490, 832 NE2d 940 (1st Dist)).

of the professional corporation are physicians.[8] The rationale, similar to the rationale in the Berlin case, is that unlike a business corporation which is motivated primarily by profits, a professional corporation has been established solely to provide professional health care services and therefore the dangers that the corporate practice of medicine prohibition are designed to protect against are not present.

Given the restrictions on the types of entities that can hire physicians, the remainder of this Chapter discusses various employment issues related to physicians in Illinois.

§ 8:02. Health care employers generally

The health care industry, which includes HMOs and health care plans, hospitals and nursing homes, medical practice management companies, and medical laboratories, is the largest employer in the United States.

Wage and salary employment in the health services industry is projected to increase 28 percent through 2012, compared with 16 percent for all industries combined.[9] Employment growth is expected to account for about 3.5 million new wage and salary jobs—16 percent of all wage and salary jobs added to the economy over the 2002-2012 period.[10] Projected rates of employment growth for the various segments of the industry range from 12.8 percent in hospitals, the largest and slowest-growing industry segment, to 55.8 percent in the much smaller home healthcare services.[11]

Many of the occupations projected to grow the fastest in the economy are concentrated in the health services industry.[12] For

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8. 805 ILCS 10/1 et seq.

9. "Health Services," Bureau of Labor and Statistics, www.bls.gov/oco/cg/cgs035.htm#emply.

10. "Health Services," Bureau of Labor and Statistics, www.bls.gov/oco/cg/cgs035.htm#emply.

11. "Health Services," Bureau of Labor and Statistics, www.bls.gov/oco/cg/cgs035.htm#emply.

12. "Health Services," Bureau of Labor and Statistics, www.bls.gov/oco/cg/cgs035.htm#emply.

example, over the 2002-2012 period, total employment of medical assistants—including the self-employed—is projected to increase by 59 percent, physician assistants by 49 percent, home health aides by 48 percent, and medical records and health information technicians by 47 percent.[13]

Employment in health services will continue to grow for several reasons. The number of people in older age groups, with much greater than average healthcare needs, will grow faster than the total population between 2002 and 2012, increasing the demand for health services, especially home healthcare and nursing and residential care.[14] Advances in medical technology will continue to improve the survival rate of severely ill and injured patients, who will then need extensive therapy and care.[15] New technologies will enable conditions not previously treatable to be identified and treated. Medical group practices and integrated health systems will become larger and more complex, increasing the need for office and administrative support workers. Also contributing to industry growth will be the shift from inpatient to less expensive outpatient care, made possible by technological improvements and consumers' increasing awareness of, and emphasis on, all aspects of health. All these factors will ensure robust growth in this massive, diverse industry.[16]

§ 8:03. The employment-at-will doctrine

As discussed above, in Illinois only professional corporations and not-for-profit hospitals are permitted to employ physicians. With the exception of the laws concerning this prohibition, the laws regarding physician employment are similar to those for other individuals.

For example, similar to other types of employers, when a healthcare

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13. "Health Services," Bureau of Labor and Statistics, www.bls.gov/oco/cg/cgs035.htm#emply.

14. "Health Services," Bureau of Labor and Statistics, www.bls.gov/oco/cg/cgs035.htm#emply.

15. "Health Services," Bureau of Labor and Statistics, www.bls.gov/oco/cg/cgs035.htm#emply.

16. "Health Services," Bureau of Labor and Statistics, www.bls.gov/oco/cg/cgs035.htm#emply.

employer hires an applicant, typically the legal presumption that governs their working relationship is that the employment is "at will." "At-will" employment generally means that the employment relationship is at the will of either party. The employer is, therefore, free to dismiss the employee at any time without explanation or legal penalty and the employee is also free to terminate his or her employment at any time and suffer no penalties. There are, however, a number of exceptions to the presumption of employment-at-will.

These exceptions can be either be: (i) statutory based (e.g., based on federal or state legislation), or (ii) evolved from common-law. The Civil Rights Act of 1964 which prohibits an employer from dismissing an employee for discriminatory reasons is an example of a statutory exception. Specifically, the Civil Rights Act makes it unlawful for an employer to refuse to hire or discharge an individual with respect to compensation or terms and conditions of employment.[17] An exception is made and discrimination is permitted, however, where religion, sex, or national origin is a bona fide occupational qualification ("BFOQ") reasonably necessary for operating a business.[18]

Other statutory exceptions to at-will employment are the Age Discrimination in Employment Act ("ADEA"),[19] the Americans with Disabilities Act[20] and the Family and Medical Leave Act.[21] These statutory exceptions protect employees for being terminated for age, disability, and for taking time off due to illness of the employee or a family member, respectively. For example, the ADEA prohibits discrimination in employment against persons forty (40) years of age and over, unless age is a BFOQ[22] that is "reasonably necessary to the normal operation of the particular business.

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17. 42 USCS § 2000e et seq.

For further discussion of employment discrimination, see Illinois Juris, Labor and Employment, Chapter 4. For discussion of civil rights actions in Illinois, see Illinois Juris, Personal Injury and Torts, Chapter 8.

18. 42 USCS § 2000e-2(e)(1).

19. 29 USCS §§ 621-634.

20. 42 USCS §§ 12111-12213.

21. 29 USCS §§ 2611 et seq.

22. 29 USCS §§ 621-634.

In addition to federal legislation, many state statutes also prohibit an employer from certain types of dismissals such as dismissing an employee for serving on a jury[23] or for filing a workers' compensation claim.[24]

Unlike statutory exceptions, which are based on legislation, common-law exceptions to the presumption of an employment at-will relationship are judicially created exceptions. In other words, the court finds either that the parties themselves, through their actions, created a contractual exception to the employment-at-will rule or that the employer's motive in dismissing an employee violates some tenet of public policy.

A common law exception to the presumption of an at-will relationship is often created when an implied contract of employment is created.[25] For example, in jobs where employment contracts are not routinely used, such as nurse aides or technicians, a court may, nevertheless, find that an employment contract has been created by implication by statements contained in personnel handbooks.[26]

In Duldulao v. St. Mary of Nazareth Hospital Center, for example, the Illinois Supreme Court held that provisions in an employee handbook may give rise to a binding contract with at-will employees who accept the terms of the contract by commencing or continuing their employment with the employer.[27]

Similarly, in Doyle v. Holy Cross Hospital,[28] the plaintiffs were nurses employed with the defendant, Holy Cross Hospital, for many years. In 1971, the defendant issued to existing employees and new

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23. 705 ILCS 305/4.1.

24. 820 ILCS 305/4(h).

25. Healthcare Facilities Law, Anne M. Dellinger, Critical Issues for Hospitals, HMOs, and Extended Care Facilities.

26. Doyle v Holy Cross Hosp., 186 Ill 2d 104, 237 Ill Dec 100, 708 NE2d 1140, 15 BNA IER Cas 164, 137 CCH LC P 58564 (1999).

27. Duldulao v St. Mary of Nazareth Hospital Center, 115 Ill 2d 482, 106 Ill Dec 8, 505 NE2d 314, 1 BNA IER Cas 1428 (1987).

28. Doyle v Holy Cross Hosp., 186 Ill 2d 104, 237 Ill Dec 100, 708 NE2d 1140, 15 BNA IER Cas 164, 137 CCH LC P 58564 (1999).

hires an employee handbook, which contained a number of policies and provisions regarding their employment. One of the policies regarding discharge contained an economic separation provision. In 1983, the defendant added disclaimers to the handbook, which stated that the defendant could terminate an employee at any time with or without notice.

In 1991, the plaintiffs were terminated. The appellate court and the Illinois Supreme Court held that the hospital's modification of the terms of the handbook were not enforceable against the plaintiffs because it was not supported by adequate consideration. In modifying the requirement for notice, the hospital provided nothing of value to the plaintiffs and did not itself incur any disadvantage. For those reasons, the court held that the hospital was contractually bound to the provisions of the original 1971 handbook.

§ 8:04. Physician employment contracts

As previously discussed, most employment relationships are considered at-will employment. A contractual arrangement, however, arises if the parties enter into an employment agreement.

Similar to most employment agreements, a physician-employment contract often addresses a number of issues, such as: (1) the physician's employment status and scope of work; (2) compensation; (3) on-call duty; (4) recruitment and retention bonuses; (5) restrictive covenants or "non-compete" clauses; (6) non-solicitation clauses; and (7) termination provisions.

§ 8:05. Employment status

One of the first sections in an employment agreement is typically one that defines the relationship between the parties. A physician's status vis-à-vis the health care employer is either (i) an independent contractor relationship, or (ii) an employee relationship. Defining a physician's employment status is important because it can affect both potential liability in the event of a malpractice suit and the tax burdens for the healthcare employer and the physician. Specifically, if a physician is an employee, the employer will be required to pay for and deduct FICA withholding taxes, benefits, etc. from the physician's

salary. On the other hand, if the physician is an independent contractor the physician is responsible for making his or her own tax payments and obtaining his or her own benefits. Additionally, there is a large difference between independent contractors and employees in that independent contractors do not necessarily receive the same protections as employees do under employment laws.

In addition to defining the relationship status, the contract should also state the scope of work to be performed. Although scope of work is difficult to predict due to workload and patient volume, the physician contract should stipulate the employer's basic expectations. A typical physician employment agreement will state whether the employee is full-time or part-time. If a physician is full-time, many physician employment agreements will state that the physician will devote his or her full-time to the employer and will not "moonlight." Alternatively, an employment agreement may permit "moonlighting" if it is either approved in advance or does not interfere with the physician's duties to the employer. If, on the other hand, the physician is only part-time, the number of hours to be worked should be stipulated.

> ☛*Practice Guide:* Sample language: "Employee shall be employed as a radiologist by the Corporation and agrees to devote all of his or her professional time, knowledge and skill to his or her employment and perform such duties, render such services and occupy such positions as the Board of Directors may determine."

§ 8:06. On-call schedule

If the physician will be required to participate in an on-call schedule this should also be specified in the employment agreement. Since, however, most call-schedules are not determined more than a few months in advance, the agreement typically will only state that the employee must participate on the same basis as everyone else in the office.

> ☛*Practice Guide:* Sample language: "Physician shall participate in the on-call schedule developed by Employer; provided,

however, that Physician's participation in such on-call schedule shall be the same as other similarly situated employees."

§ 8:07. Compensation

Perhaps the most important section of any employment agreement is the compensation section. In a physician employment agreement, compensation is paid on one of the following bases: (1) a guaranteed annual sum or salary; (2) a variable amount based on "production" (usually calculated from billings or collections); or (3) a combination of both. Unlike other types of employee compensation, however, a physician's compensation arrangements are affected by certain legal requirements.

The Federal Medicare Anti-Kickback Statute (the "Anti-Kickback Statute"), for example, affects physicians' compensation arrangements in a number of ways. The Anti-Kickback Statute prohibits the knowing and willful payment or solicitation of remuneration to induce a referral of a patient for items or services for which payment may be made by the Medicare or Medicaid programs.[29] Violations of the Anti-Kickback Statutes are considered felonies and subject the individual to civil and criminal penalties, five years in jail, as well as exclusion from the Medicare and Medicaid programs.[30] From a physician's perspective, however, exclusion from the Medicare program is the more important threat since many physicians derive a significant amount of their revenues from Medicare.

Since the Anti-Kickback Statute's prohibitions are very broad, the Office of the Inspector General ("OIG") of the Department of Health and Human Services has promulgated certain "safe harbors" that protect certain activities and relationships from being deemed to violate the statute. Among these safe harbors are the:

1. Bona Fide Employee Safe Harbor; and
2. Personal Services Safe Harbor.

With respect to the Bona Fide Employee Safe Harbor, in order to

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29. 42 USCS §1320a et. seq.

30. 42 USCS § 1395nn et. seq.

qualify for this safe harbor, the requirements which must be met are that the employment agreement must be in writing, must have a term of at least one (1) year, and the compensation must be set in advance and not based on the volume or value of referrals generated between the parties.[31] Since compensation arrangements that reward "productivity" would violate the prohibition against basing compensation on the volume or value of referrals, productivity bonuses are usually not permitted unless certain conditions are met, as described later in this section.

The Bona Fide Employee Safe Harbor is used for employment relationships, the Personal Services Safe Harbor is used for independent contractor relationships. Similar to the Bona Fide Employee Safe Harbor, the Personal Services Safe Harbor requires that the independent contractor relationship be in writing, have a term of at least one (1) year, and that the compensation paid to the independent-contractor physician is set in advance and not based on the volume or value of referrals generated between the parties.[32] As with the Bona Fide Employee Safe Harbor, any form of productivity based compensation would not meet the prohibition against compensating based on the volume or value of referrals and are therefore generally prohibited unless they meet certain requirements as discussed in more detail later in this section.

In addition to the Anti-Kickback Statute, the prohibition against physician self-referrals contained in the Social Security Act ("Stark") also affects physician compensation. Stark prohibits a physician from making a referral for any "designated health services" ("DHS") payable under the Medicare or Medicaid programs, to any entity in which the physician has an ownership or compensation arrangement.[33] A financial relationship under Stark is defined as an ownership interest in or compensation arrangement with an entity.[34]

The DHS services which are subject to Stark are:

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31. 42 CFR 1001.952(i).

32. 42 CFR 1001.952(d).

33. 42 USCS 1395nn et. seq.

34. 42 CFR § 411.350 et. seq.

1. Clinical laboratory services;
2. Physical therapy services;
3. Occupational therapy services;
4. Radiology services;
5. Radiation therapy services;
6. Durable medical equipment;
7. Parenteral and enteral nutrients, equipment and supplies;
8. Home health services;
9. Outpatient prescription drugs; and
10. Inpatient and outpatient hospital services.

Similar to the Anti-Kickback Statute, Stark does provide certain exceptions to the prohibition against referrals. Specifically, under Stark there are various exceptions for physician compensation, depending upon whether the physicians are physicians in a group practice, employees, or independent contractors. Physicians in group practices are preferred under these exceptions. The Stark regulations make it clear that the Stark statute itself favors group practices by allowing group practices to divide revenues among their physicians in ways that are very different from the ways in which other DHS entities are allowed to share revenues with employed and independent contractor physicians.[35] For example, with regard to "incident to" services, Stark allows physician group practices to compensate physicians, regardless of their status as either an owner, employee, or independent contractor. Moreover, Stark allows group practices to compensate indirectly for other DHS referrals.[36]

In an attempt, however, to equalize physician compensation outside of the group practice context, the Stark regulations were recently modified to permit productivity based compensation under certain circumstances.

With respect to compensation under Stark, the Bona Fide Employee Exception requires that:

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35. 69 Fed. Reg. at 16066.

36. 42 USCS § 1877(h)(4)(B)(i).

1. The employment must be for identifiable services;

2. The amount of remuneration under the agreement must be: (a) Consistent with fair market value of the services, and (b) Not determined in any way that takes into account the volume or value of any referrals by the referring physician.

3. The remuneration is provided under an agreement that would be commercially reasonable even if no referrals were made to the employer; and

4. Any productivity bonuses must be based on services performed personally by the physician and not take into account the volume or value of DHS referrals.[37]

With respect to Stark's Personal Services Exception, this exception is used for independent contractor relationships. In order to meet this exception, the following criteria must be met:

1. The agreement must be in writing, signed by the parties and cover all of the services to be provided;

2. The agreement must cover all of the services to be furnished by the physician;

3. The services contracted for may not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement;

4. The term of the arrangement is for at least one (1) year;

5. The compensation to be paid is set in advance, does not exceed fair market value, and is not determined in any manner that takes into account the volume or value of any referrals; and

6. The services do not involve the counseling or promotion of a business arrangement or other activity that violates any state or Federal law.[38]

With respect to productivity bonuses, recent amendments to the Stark regulations make it clear that, under the Bona Fide Employment and Personal Services Exceptions, physician compensation may now

37. 42 CFR 411.357(c).

38. 42 CFR 411.357(d).

include productivity bonuses, if such productivity bonuses are based on the following:

(1) A percentage of revenues or collections for personally performed services;

(2) Productivity bonuses on any personally performed services; and

(3) Risk sharing payments made pursuant to participation in a physician incentive plan related to health plan enrollees.[39]

With respect to the Personal Services Exception, the main exception utilized by independent contractors, the compensation that the physician receives must be "set in advance."[40] Previously, the "set in advance" requirement prohibited most percentage compensation arrangements, thereby restricting compensation structures for physicians practicing as independent contractors relying upon these compensation exceptions. The Stark regulations were modified to permit some percentage compensation arrangements. As a result, like their group practice and employee counterparts, independent contractors can now receive limited forms of percentage compensation. Accordingly, the definition of "set in advance" has been tailored to allow certain percentage compensation payments and has been modified to clarify that the formula for calculating percentage compensation must be established with specificity prospectively, must be objectively verifiable, and may not be changed based on the volume or value of referrals or other business generated by the referring physician over the course of the agreement between the parties.[41]

The Personal Services Exception under Stark also contains an express provision allowing independent contractor physicians to be compensated under a physician incentive plan ("PIP") with respect to

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39. 66 Fed. Reg. at 16066-16067.

40. 42 CFR 411.357(d) and 42 CFR 411.357(l).

41. 42 CFR 411.354(d)(1).

As a result of the changes to the "set in advance" definition, academic physicians receiving payment pursuant to the academic medical center exception (which also contains the "set in advance" requirement), can also receive certain limited forms of percentage compensation.

services provided to individuals enrolled with the entity making the payments.[42]

Specifically, in the case of a PIP between a physician and an entity (or downsteam subcontractor) the compensation may be determined in a manner (through a withhold, capitation bonus, or otherwise) that takes into account, directly or indirectly, the volume or value of referrals if:

1. No specific payment is made directly or indirectly under the plan to a physician or a physician group as an inducement to reduce or limit medically necessary services furnished with respect to a specific individual enrolled with the entity;

2. The entity provides the Secretary with access to information regarding the plan in order to determine if the plan is in compliance; and

3. If the plan places a physician or physician group at substantial financial risk, itcomplies with certain requirements.[43]

Productivity bonuses under the Bona Fide Employee or Personal Service Exceptions are deemed not to relate to the volume or value of referrals if:

(1) The bonus is based on the physician's total patient encounters or relative value units;

(2) The bonus is based on the allocation of the physician's compensation attributable to services that are not DHS payable by any Federal health care program or private payer; or

(3) Revenue derived from DHS is less than 5% of the group practice's total revenues and the allocated portion of those revenues to each physician in the group practice constitutes 5% or less of his or her total compensation from the group practice.

> ☛*Practice Guide:* Regardless of whether the Anti-Kickback or the Stark Bona Fide Employee or the Personal Services Safe Harbors or Exceptions are used, it is wise to consult a healthcare attorney since the use of each of these require careful structuring.

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42. 42 CFR 411.357(d)(2).

43. 42 CFR 411.357(d)(2).

§ 8:08. Recruitment and retention bonuses

In many industries, recruitment and retention bonuses are common. This is true for physicians as well, however, there are certain restrictions on such recruitment and retention payments similar to the restrictions placed on physician compensation and productivity bonuses.

For example, under Stark, a hospital is permitted to pay a physician to relocate to the hospital's geographic area in order for the physician to be a member of the hospital's medical staff. The recruitment arrangement must, however, meet the following requirements:

1. The arrangement must be set out in writing and signed by both parties;

2. The arrangement may not be conditioned on the physician's referrals;

3. The amount of remuneration under the agreement may not be determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the physician; and

4. The physician must be allowed to establish staff privileges at any other hospital and to refer business to other entities.[44]

Previously, the Centers for Medicare and Medicaid Services ("CMS") interpreted this recruitment rule to require that the recruited physician reside in an area outside the hospital's geographic area and actually relocate into the hospital area. Recent amendments to the Stark regulations changed this to focus solely on the recruited physician's medical practice, rather than the physician's residence. Thus, in order to meet the relocation requirement, the physician must:

1. Relocate his/her practice a minimum of twenty-five (25) miles; or

2. At least seventy-five percent (75%) of the physician's revenues must come from care provided to new patients.[45]

The amendments to the Stark regulations also modified recruitment bonuses paid to residents and new physicians (e.g., physicians who

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44. 42 CFR 411.357(e).

45. 69 Fed. Reg. at 16094; 42 CFR 411.357(e).

have been in practice less than one (1) year). Specifically, these physicians are now eligible for the physician recruitment exception regardless of whether they actually move their practices.[46]

Additionally, although recruitment payments were previously limited to individual physicians, the new Stark regulations now permit hospital payments to medical groups in connection with recruiting new physicians to join the group. Since many physicians prefer to join existing groups and encouraging a physician to join an existing group actually saves the hospital the cost and labor of setting up a new practice, Congress determined that any remuneration provided by a hospital (or Federally qualified health center ("FQHC")) to a physician indirectly, through payments to another physician or physician practice, are permitted if the following criteria are met:

1. The arrangement between the hospital and physician practice is in writing and signed by the parties;

2. The remuneration is passed directly through to, or remains with, the recruited physician;

3. In the case of an income guarantee made by the hospital to a physician who joins a local physician practice, costs allocated by the physician practice to the recruited physician may not exceed the actual additional incremental costs to the practice attributable to the recruited physician;

4. The new physician must establish a medical practice in the hospital's geographic area and join the hospital's medical staff;

5. The practice's arrangement with the recruited physician must be set out in writing and signed by the parties;

6. The new physician may not be required to refer patients to the hospital and is allowed to establish staff privileges at any other hospital and to refer business to other entities;

7. The remuneration from the hospital is not determined in any manner that takes into account (directly or indirectly) the volume or

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46. 42 CFR 411.357(e)(3).

The Stark amendments also revised the requirements such that federally qualified health centers may also offer recruitment payments under the same conditions. 42 CFR 411.357(e)(3).

value of any referrals (actual or anticipated) by the recruited physician or by the physician practice receiving the direct payments from the hospital (or any physician affiliated with that physician practice); and

8. The physician practice receiving the hospital payments may not impose additional practice restrictions on the recruited physician (e.g. a covenant not to compete), but may impose conditions related solely to quality considerations.[47]

Additionally, the arrangement may not violate the Anti-Kickback Statute and must comply with all relevant billing laws and regulations. Also, if the physician practice receiving the payments from the hospital is a DHS entity to which the recruited physician will refer (e.g., a practice that submits claims to Medicare for DHS), any separate or additional financial relationship it has with the recruited physician must fit within an applicable exception.[48]

With respect to retention payments, previously, no such payments were permitted since they would violate Stark. However, the new Stark regulations established a narrow retention exception for certain remuneration paid to physicians with practices in health professional shortage areas ("HPSAs").[49] This exception applies to retention payments made to a physician with a practice located in a HPSA who has a firm written recruitment offer from an unrelated hospital (or FQHC) that specifies the remuneration being offered and that would require the physician to move the location of his or her practice at least twenty-five (25) miles and outside of the geographic area served by the hospital (or FQHC). Additionally, the retention payment in this exception must be the lower of:

1. The difference between the physician's current income from physician and related services in the recruitment offer (over no more than a twenty-four (24) month period); or

2. The reasonable costs the hospital or FQHC would otherwise have to expend to recruit a new physician to the geographic area served by the hospital or FQHC.

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47. 42 CFR 411.357(e).

48. 69 Fed. Reg. at 16097.

49. 69 Fed. Reg. at 16097 and 42 CFR 411.357(t).

Notably, this new exception does not protect payments made indirectly to a retained physician via another person or entity, including a physician practice.[50]

§ 8:09. Restrictive covenants or "non-compete" clauses

A "non-compete" clause or "non-competition" clause prevents a physician from working for a competitor after the end of his or her employment. The contract might state, for example, that the physician shall not practice medicine within a ten (10)-mile radius of his or her prior employer's office location for a period of two (2) years.

There are, however, many different iterations of these types of covenants. For instance, a covenant might state that the covenant applies to all of the employer's office locations, and not just the location where the employee provided services to patients. Alternatively, there could be a statement that the provision will not apply if the physician is employed for longer than a certain period of time (i.e., to prevent new, young physicians from joining a practice and then taking all of the practice's patients after a short period of time). Or the provision could specify that the prohibition will not apply if the physician buys out of the restrictive covenant (e.g., if the physician has only been practicing for one (1) year he or she must pay $100,000.00 to opt-out of the covenant, if employed for two (2) years he or she must pay $75,000.00 etc.). Regardless of the exact wording and despite widespread physician opposition, these clauses continue to appear in most physician employment contracts.

Although non-compete clauses are illegal in some states as an unreasonable restraint on trade, Illinois enforces non-compete agreements in the medical profession as long as they are deemed "reasonable"[51] and there is a legitimate business interest to be protected by the arrangement. There are two legitimate business interests: (1) an

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50. 69. Fed. Reg. at 16097.

51. Canfield v Spear, 44 Ill 2d 49, 254 NE2d 433 (1969); Bauer v Sawyer, 8 Ill 2d 351, 134 NE2d 329 (1956); Gillespie v Carbondale & Marion Eye Ctrs., 251 Ill App 3d 625, 190 Ill Dec 950, 622 NE2d 1267 (5th Dist 1993); Retina Services, Ltd. v Garoon, 182 Ill App 3d 851, 131 Ill Dec 276, 538 NE2d 651 (1st Dist 1989).

employee learning confidential information through the job which would be used after employment terminated; and (2) an employer's relationship with the customers is nearly permanent and the employee would not have had contact with the customer absent the association with the employer.

Generally, reasonableness of a non-compete agreement is determined by the hardship imposed on the employee, the covenant's effect upon the general public, and the duration, geographic scope, and activity restrictions contained within the covenant.[52] Thus, for example, Illinois courts have upheld two (2) year covenants not to compete within a fifty (50) mile radius of a former employer's offices in Carbondale, Marion, Harrisburg, Fairfield and Carmi, as reasonable.[53] Similarly, courts have upheld a three (3) year restrictive covenant prohibiting a physician from competing in any of the counties where the employer was operating. Recently, however, in the case of Carter-Shields v. Alton Health Institute, an Illinois court has held that a twenty (20) mile radius restriction on the practice of medicine by a physician was an unreasonable restraint of trade and unenforceable on public policy grounds.[54]

In Carter-Shields, the court noted that a restrictive covenant will not be enforced unless there is a legitimate business interest to be protected by such an agreement. Yet, the provider in this case did not have such an interest because it did not show that the provider had a near permanent relationship with any of the plaintiff's patients.[55] In this case, the plaintiff had started a new office for the provider in 1995,

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52. Lawrence & Allen v Cambridge Human Resource Group, 292 Ill App 3d 131, 226 Ill Dec 331, 685 NE2d 434 (2d Dist 1997).

53. Gillespie v Carbondale & Marion Eye Ctrs., 251 Ill App 3d 625, 190 Ill Dec 950, 622 NE2d 1267 (5th Dist 1993).

54. Carter-Shields v Alton Health Inst., 201 Ill 2d 441, 268 Ill Dec 25, 777 NE2d 948, 19 BNA IER Cas 139, 147 CCH LC P 59660 (2002).

55. Carter-Shields v Alton Health Inst., 317 Ill App 3d 260, 250 Ill Dec 806, 739 NE2d 569 (5th Dist 2000), app gr 194 Ill 2d 566, 254 Ill Dec 311, 747 NE2d 351 and (criticized in Prairie Eye Ctr., Ltd. v Butler, 329 Ill App 3d 293, 263 Ill Dec 654, 768 NE2d 414 (4th Dist)) and affd in part and vacated in part on other grounds 201 Ill 2d 441, 268 Ill Dec 25, 777 NE2d 948, 19 BNA IER Cas 139, 147 CCH LC P

instead of a situation wherein a physician with an established practice had hired a newcomer who then usurped the physician's clientele.[56]

More importantly, the Carter-Shields' court cited the ethical rules of the American Medical Association's Council on Ethical and Judicial Affairs, which disfavors agreements between physicians that restrict the right of a physician to practice medicine for a specific period of time or in a specified area upon termination of employment.[57] The case was appealed to the Illinois Supreme Court.

In the meantime, shortly after the Carter-Shields' decision, the Illinois Appellate Court for the 4th District disagreed with the Carter-Shields decision. In Prairie Eye Center, Ltd. v. Butler,[58] the court distinguished the Illinois Supreme Court Rule prohibiting lawyer non-competition agreements from the AMA rule relating to physician competition. In the Prairie court's opinion, the AMA rule was merely advisory whereas the Illinois Supreme Court's rule is

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59660 and (ovrld in part on other grounds as stated in Mohanty v St. John Heart Clinic, S.C., 358 Ill App 3d 902, 295 Ill Dec 490, 832 NE2d 940 (1st Dist)).

56. Carter-Shields v Alton Health Inst., 317 Ill App 3d 260, 250 Ill Dec 806, 739 NE2d 569 (5th Dist 2000), app gr 194 Ill 2d 566, 254 Ill Dec 311, 747 NE2d 351 and (criticized in Prairie Eye Ctr., Ltd. v Butler, 329 Ill App 3d 293, 263 Ill Dec 654, 768 NE2d 414 (4th Dist)) and affd in part and vacated in part on other grounds 201 Ill 2d 441, 268 Ill Dec 25, 777 NE2d 948, 19 BNA IER Cas 139, 147 CCH LC P 59660 and (ovrld in part on other grounds as stated in Mohanty v St. John Heart Clinic, S.C., 358 Ill App 3d 902, 295 Ill Dec 490, 832 NE2d 940 (1st Dist)).

57. Carter-Shields v Alton Health Inst., 317 Ill App 3d 260, 250 Ill Dec 806, 739 NE2d 569 (5th Dist 2000), app gr 194 Ill 2d 566, 254 Ill Dec 311, 747 NE2d 351 and (criticized in Prairie Eye Ctr., Ltd. v Butler, 329 Ill App 3d 293, 263 Ill Dec 654, 768 NE2d 414 (4th Dist)) and affd in part and vacated in part 201 Ill 2d 441, 268 Ill Dec 25, 777 NE2d 948, 19 BNA IER Cas 139, 147 CCH LC P 59660 and (ovrld in part as stated in Mohanty v St. John Heart Clinic, S.C., 358 Ill App 3d 902, 295 Ill Dec 490, 832 NE2d 940 (1st Dist)). See also, Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association (Section 9.2).

The Carter court, relying on Dowd & Dowd, Ltd. v. Gleason, a case where the Illinois Supreme Court refused to enforce a non-compete clause for attorneys on the basis that Illinois Rule of Professional Conduct 5.6 prohibits employment agreement, restricting a lawyer's right to practice law, argued that the AMA's code of ethics should have the same import for physicians.

58. Prairie Eye Ctr., Ltd. v Butler, 329 Ill App 3d 293, 263 Ill Dec 654, 768 NE2d 414 (4th Dist 2002).

codified as law. Thus, the Prairie court determined that it must follow previous Illinois precedent and enforce the non-compete provision.[59]

A few months after the Prairie decision, the Illinois Supreme Court handed down its decision in the Carter-Shields' appeal. The Supreme Court held that the public policy portion of the Carter-Shields opinion was unnecessary to the decision itself and was therefore only advisory.[60]

Thus, it is currently unclear whether or not Illinois courts will uphold non-competition covenants as routinely as they once did.

§ 8:10. Non-solicitation clauses

In addition to non-compete or non-competition clauses, many physician employment agreements also contain non-solicitation clauses. These clauses typically state that a physician may not solicit any patients of the practice that the physician treated while employed by the practice. In Illinois, such clauses are generally upheld by the courts so long as they are reasonable in terms of geographic scope and length. However, there is still some concern that such clauses violate the American Medical Association's ethical policies since they may interfere with physician-patient relationships and/or a patient's freedom to choose his or her physician.[61]

§ 8:11. Termination

There are two types of termination provisions "with cause" or "without cause." Termination without cause generally allows a party to terminate without giving any reason for such termination, by giving notice to the other party. The notice can range anywhere from thirty (30) to one hundred eighty (180) days, though between thirty (30) and sixty (60) days is typical. It should be noted that an employee always has a right to quit—for good cause, bad cause, or no cause at all. Otherwise, it would constitute involuntary servitude.

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59. Prairie Eye Ctr., Ltd. v Butler, 329 Ill App 3d 293, 263 Ill Dec 654, 768 NE2d 414 (4th Dist 2002).

60. Carter-Shields v Alton Health Inst., 201 Ill 2d 441, 268 Ill Dec 25, 777 NE2d 948, 19 BNA IER Cas 139, 147 CCH LC P 59660 (2002).

61. Principles of Medical Ethics, American Medical Association, June 17, 2001.

Termination "for cause" typically allows a party to terminate an agreement because there has been a breach or other wrongdoing.

☛*Illustration:* Examples of "for cause" termination in physician employment contracts include:
1. Suspension or revocation of employee's license to practice medicine in any state;
2. Professional misconduct or violation of the canons of professional ethics;
3. Death of an employee;
4. Inability to secure malpractice coverage;
5. Conviction of a crime of moral turpitude;
6. Breach of the company's rules and regulations or policies and procedures;
7. Revocation, suspension, termination or reduction of employee's privileges as a member of the Medical Staff of any hospital; or
8. Disability of employee.

Generally, revocation of licensure and other types of regulatory or professional association actions or censure lead to immediate termination, whereas other types of breaches may provide a grace period within which to remedy the breach prior to termination.

☛*Practice Guide:* It should also be noted that termination provisions are often tied to non-competition or restrictive covenants in physician employment agreements. For example, if the employer terminates the employee without cause or the employee terminates for cause it seems clear that the non-compete should not apply since the employee was fired for no reason and/or the employer breached the employment agreement in some manner. Similarly, if the employee terminates without cause or the employer terminates for cause it would be appropriate for the non-compete to remain in place.

§ 8:12. Advertising

The Illinois Medical Practice Act of 1987 governs the manner in which physicians may advertise. Specifically, this law states that

"[A]ny person licensed under this Act may advertise the availability of professional services in the public media or on the premises where such professional services are rendered."[62] A licensee must include in every advertisement for services regulated under this Act his or her title as it appears on the license or the initials authorized under this Act.[63] Such advertising may only contain the following information:

(1) Publication of the person's name, title, office hours, address and telephone number;

(2) Information pertaining to the person's areas of specialization, including appropriate board certification or limitation of professional practice;

(3) Information on usual and customary fees for routine professional services offered, which information shall include, notification that fees may be adjusted due to complications or unforeseen circumstances;

(4) Announcement of the opening of, change of, absence from, or return to business;

(5) Announcement of additions to or deletions from professional licensed staff; and

(6) The issuance of business or appointment cards."[64]

Additionally, an individual may not advertise for professional services which the individual is not licensed to render, nor may the advertiser use statements which contain false, fraudulent, deceptive or misleading material or guarantees of success, statements which play upon the vanity or fears of the public, or statements which promote or produce unfair competition.[65] Furthermore, it is unlawful for any person licensed under the act to use testimonials or claims of superior quality of care to entice the public. It is also unlawful to advertise fee comparisons of available services with those of other persons licensed

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62. 225 ILCS 60/26.
63. 225 ILCS 60/26.
64. 225 ILCS 60/26.
65. 335 ILCS 60/26.

under this Act.[66] Finally, it is unlawful for any person licensed under the act to knowingly advertise that the licensee will accept as payment for services rendered by assignment from any third party payor the amount the third party payor covers as payment in full, if the effect is to give the impression of eliminating the need of payment by the patient of any required deductible or copayment applicable in the patient's health benefit plan.[67]

§ 8:13. Anti-Trust considerations in physician hiring

Even when a hospital has formal, detailed conditions and a clear process for credentialing and granting medical staff privileges, physicians have increasingly challenged these membership and privileging decisions under federal and state antitrust laws.[68] Congress enacted the Sherman Antitrust Act in 1890 to preserve competition,[69] and in 1914 the Clayton Act was passed to provide Congress with greater abilities to enforce the Sherman Act.[70]

§ 8:14. Sherman Act

Most challenges of decisions regarding staff privileges are brought under Section 1 of the Sherman Act, which prohibits contracts, combinations and conspiracies that unreasonably restrain trade.[71] There are four (4) elements that a plaintiff must prove to successfully allege an antitrust violation under Section 1 of the Sherman Act: (1) a contract, combination, or conspiracy; (2) a substantial impact on interstate commerce; (3) an anti-competitive purpose or effect; and (4) an effect on relevant services and markets.[72]

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66. 225 ILCS 60/26.

67. 225 ILCS 60/26.

68. For discussion of hospital's medical staff peer review and credentialing, see Chapter 3.

69. 15 USCS, part 1.

70. 15 USCS § 7, part 17.

71. 15 USCS §§ 1 and 2.

72. 15 USCS § 1.

The Sherman Act carries criminal penalties for certain violations.[73] The government can also seek civil penalties, including single damages and injunctive relief.[74]

There are two types of antitrust violations and a court must first determine which type of violation is alleged when an antitrust case is filed. The two types of violations are: (i) per se,[75] and (ii) "rule of reason."[76]

A per se anti-trust violation occurs as the result of certain conduct which is automatically considered to be so detrimental to the market that it is seen as being without possible redeeming merit and therefore an immediate violation of the law.[77] Courts generally do not allow any defense in justification of per se violations, but rather see such violations as without justification.[78] In the majority of anti-trust cases,

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73. § 1 Sherman Act, 15 USC § 1, § 2 Sherman Act, 15 USCS § 2, § 3 Sherman Act, 15 USCS § 3.

74. § 1 Sherman Act, 15 USCS § 1, § 2 Sherman Act, 15 USCS § 2, § 3 Sherman Act, 15 USCS § 3.

75. Section 1 of the Sherman Act literally prohibits "every contract, combination, or conspiracy... in restraint of trade." 15 USCS § 1.

The Supreme Court, however, decided long ago that Section 1 prohibits only "unreasonable" restraints. Board of Trade v United States, 246 US 231, 38 S Ct 242, 62 L Ed 683 (1918); Standard Oil Co. v United States, 221 US 1, 31 S Ct 502, 55 L Ed 619 (1911); accord, Business Electronics Corp. v Sharp Electronics Corp., 485 US 717, 108 S Ct 1515, 99 L Ed 2d 808, 1988-1 CCH Trade Cases P 67982 (1988) ("Sharp"); National Collegiate Athletic Ass'n v Board of Regents, 468 US 85, 104 S Ct 2948, 82 L Ed 2d 70, 1984-2 CCH Trade Cases P 66139 (1984).

76. Over the last two decades, the Supreme Court has stated repeatedly that the rule of reason is "the standard traditionally applied for the majority of anticompetitive practices challenged under § 1 of the [Sherman] Act." Continental T. V. v GTE Sylvania, 433 US 36, 97 S Ct 2549, 53 L Ed 2d 568, 1977-1 CCH Trade Cases P 61488 (1977), on remand 461 F Supp 1046, 1979-1 CCH Trade Cases P 62467 (ND Cal), affd 694 F2d 1132, 1982-2 CCH Trade Cases P 64962 (CA9 Cal), amd 1982-83 CCH Trade Cases P 65150 (CA9) ("Sylvania").

77. "An Antitrust Primer For Federal Law Enforcement Personnel," Antitrust Division U.S. Department of Justice, September 2003, http://www.usdoj.gov/atr/public/guidelines/201436.htm.

78. "An Antitrust Primer For Federal Law Enforcement Personnel," Antitrust Division U.S. Department of Justice, September 2003, http://www.usdoj.gov/atr/public/guidelines/201436.htm.

however, courts apply a "rule of reason" analysis. When applying a "rules of reason" analysis, the court balances the harm to an individual against the justification for implementing the restraint on competition.

A federal court addressed the Sherman Act in regards to a peer-review committee proceeding. In Matthews v. Lancaster General Hospital,[79] an orthopedic surgeon's hospital staff privileges were terminated for alleged substandard medical care. The surgeon filed a lawsuit against the hospital and a group of competing orthopedic surgeons who sat on the hospital's board of trustees, alleging antitrust conspiracy to curtail his practice for competitive reasons. The chairperson of the hospital's department of surgery had appointed an ad hoc committee to review the surgical cases performed by the plaintiff orthopedic surgeon, and later had more than 200 of the surgeon's cases reviewed by an independent third party. The independent reviewer and the committee concluded that the plaintiff orthopedic surgeon's medical care was inadequate and below acceptable standards.

A federal court of appeals court ruled that the conduct of the hospital and its reviewing physicians was immune and not subject to antitrust laws. The hospital was immune due to the Health Care Quality Improvement Act of 1986,[80] which grants limited immunity to professional peer review participants. The court determined that in order to find an antitrust violation the plaintiff orthopedic surgeon must prove (1) that there was a contract or conspiracy, in restraint of commerce; (2) concerted action by the defendants; (3) anti-competitive effects were produced within the relevant produce and geographic markets; (4) that the concerted actions were illegal; and (5) that the plaintiff was injured as a proximate result of the concerted action.[81] The court reasoned that the essence of the claim was that there was the existence of an agreement and that the plaintiff orthopedic surgeon

79. Mathews v Lancaster Gen. Hosp., 87 F3d 624, 1996-1 CCH Trade Cases P 71451 (CA3 Pa 1996).

80. 42 USCS §§ 11101- 11152.

81. Mathews v Lancaster Gen. Hosp., 87 F3d 624, 1996-1 CCH Trade Cases P 71451 (CA3 Pa 1996).

was unable to prove that the hospital board acted in concert with the orthopedic surgeon's competitors in taking the professional review action against the plaintiff orthopedic surgeon.

The Sherman Act has also been used to attempt to prevent the merger of hospitals. For example, in United States v. Rockford Memorial Corporation,[82] the United States sought to enjoin the two largest not-for-profit hospitals in a particular area from merging. The court held that regardless of their not-for-profit status, the hospitals were under the jurisdiction of the Federal Trade Commission, but the proposed merger was not subject to § 7 of the Clayton Act. However, the court found that the proposed merger did violate § 1 of the Sherman Act because the merger was likely to hurt consumers by making it easier for the hospitals to collude, and thereby force prices above the competitive level. Specifically, the hospitals held around two-thirds of the market for inpatient services in their geographical service area. Since the hospitals failed to dispel this inference regarding their market share approaching the threshold of monopoly power, their merger was held to be unlawful.

§ 8:15. Clayton Act

The Clayton Act regulates general practices that potentially may be detrimental to fair competition. Some of these general practices regulated by the Clayton Act are: (i) price discrimination; (ii) exclusive dealing contracts; (iii) tying agreements; (iv) requirement contracts; (v) mergers and acquisitions; and (vi) interlocking directorates.[83]

In recent years, the Antitrust Division of the Department of Justice ("DOJ") and the Federal Trade Commission ("FTC") have brought numerous hospital merger cases, but have been unsuccessful in their quest.[84] For example, in California v. Sutter Health System, the DOJ

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82. United States v Rockford Memorial Corp., 898 F2d 1278, 1990-1 CCH Trade Cases P 68978 (CA7 Ill 1990).

83. 15 USCS § 12.

84. California v Sutter Health Sys., 130 F Supp 2d 1109, 2001-1 CCH Trade Cases P 73255 (ND Cal 2001); FTC v Tenet Healthcare Corp., 17 F Supp 2d 937, 1998-2

and the FTC brought an antitrust action against defendant hospitals under § 7 of the Clayton Act to prevent a merger and filed a motion for a preliminary injunction to enjoin the merger. The court found that the DOJ's and FTC's expert's method of ordering zip codes by market share did not delineate the area from which hospitals drew their patients as accurately as the hospitals' expert's method of ordering zip codes by the actual numbers of patients that sought inpatient services. As the hospitals demonstrated, since several hospitals' service areas overlapped, patients could turn to other hospitals in the event of a significant price increase after the proposed merger. Additionally, since the DOJ's and FTC's own study indicated that in many instances travel time to hospitals outside the proposed merged geographic market was actually less than traveling to the merged hospital's proposed market, the court concluded that the government had failed to prove its prima facie case that the proposed merger would substantially lessen competition. Finally, one of the merging hospitals showed that it had $ 8,900,000 in overdue bills and was put on cash-on-delivery terms with several suppliers. Since this hospital could not assume any more debt to meet its financial obligations and no reasonable alternative purchaser existed, it had no choice but to merge. Thus, the court concluded that the merger was appropriate.

In FTC v. Tenet Healthcare Corp., two hospitals, sought review of the order of the United States District Court for the Eastern District of Missouri, which granted the motion for a preliminary injunction filed by the FTC enjoining the merger between the hospitals because it

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CCH Trade Cases P 72227 (ED Mo 1998), later proceeding 128 FTC 793, later proceeding 1999 FTC LEXIS 268 (FTC), cause dismd 1999 FTC LEXIS 190 (FTC) and cause dismd 1999 FTC LEXIS 267 (FTC) and revd 186 F3d 1045, 1999-2 CCH Trade Cases P 72578 (CA8 Mo), reh, en banc, den 1999 US App LEXIS 24855 (CA8); United States v Long Island Jewish Med. Ctr., 983 F Supp 121, 1997-2 CCH Trade Cases P 71960 (ED NY 1997); FTC v Butterworth Health Corp., 946 F Supp 1285, 1996-2 CCH Trade Cases P 71571 (WD Mich 1996), injunction den 1996 US Dist LEXIS 17529 (WD Mich), affd 1997-2 CCH Trade Cases P 71863 (CA6 Mich) and affd 121 F3d 708 (CA6 Mich) and related proceeding 124 FTC 424; FTC v Freeman Hosp., 911 F Supp 1213, 1995-1 CCH Trade Cases P 71037 (WD Mo 1995), affd 69 F3d 260, 1995-2 CCH Trade Cases P 71167 (CA8 Mo); United States v Mercy Health Servs., 902 F Supp 968, 1995-2 CCH Trade Cases P 71162 (ND Iowa 1995), vacated as moot, remanded 107 F3d 632, 1997-1 CCH Trade Cases P 71729 (CA8 Iowa).

would substantially lessen competition in the area in violation of § 7 of the Clayton Act. The hospitals, the only two hospitals in a small city, filed a pre-merger certificate with the FTC pursuant to the Hart-Scott-Rodino Act and the FTC, then, filed a complaint under § 7 of the Clayton Act, to enjoin the merger. After a hearing, the district court granted the FTC's motion for a preliminary injunction, and enjoined the merger. On appeal, the court held that the evidence showed that the hospitals were underutilized and that a significant percentage of the residents in the market area, as defined by the FTC, used a number of other hospitals just outside the market area. The merger of the hospitals, the court concluded, was likely to increase the services available from the merged hospital thereby making it more competitive with the other hospitals in the area. The court therefore concluded that the FTC had not demonstrated that it was likely to succeed on its complaint that the merger was anti-competitive and no injunction was granted.

Similarly, in United States v. Long Island Jewish Medical Center,[85] two competitive not-for-profit groups of hospitals primarily located in Queens County, Nassau County, and Suffolk County, New York proposed a merger. The government alleged that the proposed merger would effectively eliminate competition between hospitals in the area and that health care costs would potentially increase by 20%. The hospitals, however, argued that the merger would result in increased efficiencies and would benefit consumers by a reduction in hospital costs. The court held that the government failed to meet its burden of proof that the merger would violate § 7 of the Clayton Act since there was significant competition from other hospitals in the area and the merged entity would not have an undue share of the relevant product and geographic markets. Additionally, the court noted that there was no evidence that the merged hospital entity would result in reduced service or treatment of patients or that cost reductions would not occur.

The merger of two large practices in a small town can also have

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85. United States v Long Island Jewish Med. Ctr., 983 F Supp 121, 1997-2 Trade Cas. (CCH) P 71960 (EDNY 1997).

anti-trust concerns if it has the effect of limiting the choices of patients and health plans in their purchase of healthcare services. In FTC v. Butterworth Health Corporation,[86] the FTC sought to prevent the merger of two of the largest hospitals in Grand Rapids, Michigan because it believed (i) that the merger would result in a significant increase in concentration in the markets for primary and general acute inpatient services, and (ii) the merged entity would control an undue percentage share of each of those markets. The court, however, concluded that the public's best interest would be served by permitting the hospitals to achieve the efficiencies that would allegedly result from the proposed merger, which was to enable the board of directors of the combined entity to establish world class health facilities in West Michigan. Additionally, the court reasoned that the hospitals' non-profit status would mitigate the merged entities' combined market share of approximately 62 %.

Given the number of mergers the government has tried to block, health care entities seeking to merge should carefully consider their antitrust exposure. One way to do this is by reviewing the Statements of Anti-Trust Enforcement Policy in Health Care.

In 1996, the DOJ and the FTC issued "Statements of Anti-trust Enforcement Policy in Health Care."[87] These statements discuss the DOJ's and FTC's policies on (i) mergers of hospitals; (ii) hospital joint ventures involving high technology or other expensive health care equipment; (iii) hospital joint ventures involving specialized clinical or other expensive services; (iv) providers' collective provision of non-fee-related information to purchasers of health care services; (v) providers' collective provision of fee-related information to purchasers of health care services; (vi) provider participation in exchanges of price and cost information; (vii) joint purchasing

86. FTC v Butterworth Health Corp., 946 F Supp 1285, 1996-2 CCH Trade Cases P 71571 (WD Mich 1996), injunction den 1996 US Dist LEXIS 17529 (WD Mich), affd 1997-2 CCH Trade Cases P 71863 (CA6 Mich) and affd 121 F3d 708 (CA6 Mich) and related proceeding 124 FTC 424.

87. Statements of Anti-Trust Enforcement Policy in Health Care, issued by the Justice Department and Federal Trade Commission, August 28, 1996.

arrangements among health care providers; (viii) physician network joint ventures; and (ix) multi-provider networks.

Whenever physicians consider joint activities they should look to these statements to determine what activities are permissible. These statements, similar to the Anti-Kickback and Stark statutes, contain zones which, if the criteria are met, protect certain actions from being considered anti-trust violations. For instance, when physicians consider forming an independent practice association ("IPA") they should be aware of the possible anti-trust ramifications.

An IPA is an entity composed of separate physicians and physician groups that bargains and negotiates with health plans on behalf of the various physicians and groups. Since the physicians and groups are competitors, jointly establishing prices through the IPA is prohibited unless it is done in a manner that meets the anti-trust safety zone requirements. Specifically, the DOJ/FTC require that assembling collective fee or other reimbursement information to present to health care plans must satisfy certain conditions:

1. The collection must be managed by a third party (e.g., the IPA);

2. Although current fee-related information may be provided to purchasers, any information that is shared among or is available to the competing providers furnishing the data must be more than three months old; and

3. For any information that is available to the providers furnishing data, there are at least five providers reporting data upon which each disseminated statistic is based, no individual provider's data may represent more than 25% on a weighted basis of that statistic and any information disseminated must be sufficiently aggregated such that it would not allow recipients to identify the prices charged by any individual provider.[88]

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88. Statement of Anti-Trust Enforcement Policy in Health Care, issued by the Justice Department and Federal Trade Commission, August 28, 1996.

§ 8:16. Peer review

The Illinois Hospital Licensing Act provides immunity for civil damages to all hospitals and physicians who participate in peer-review activities.[89] In pertinent part this act states that:

"No hospital and no individual who is a member, agent, or employee of a hospital, hospital medical staff, hospital administrative staff, or hospital governing board shall be liable for civil damages as a result of the acts, omissions, decisions, or any other conduct, except those involving wilful or wanton misconduct, of a medical utilization committee, medical review committee, patient care audit committee, medical care evaluation committee, quality review committee, credential committee, peer review committee, or any other committee or individual whose purpose, directly or indirectly, is internal quality control or medical study to reduce morbidity or mortality, or for improving patient care within a hospital, or the improving or benefiting of patient care and treatment, whether within a hospital or not, or for the purpose of professional discipline including institution of a summary suspension in accordance with Section 10.4 of this Act [21 ILCS 85/10.4] and the medical staff bylaws."[90]

Thus, in Tabora v. Gottlieb Mem. Hospital,[91] the court held that where a doctor's comments may have prompted investigation, but the final decision to terminate the plaintiff was made by the board of governors after it reviewed the recommendation of an ad hoc investigating committee, that neither the doctor nor the hospital were liable for any damages.

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89. 210 ILCS 85/1 et. seq.

For further discussion of hospital peer review activities, quality assurance and medical staff credentialing, see Chapter 3.

90. 210 ILCS 85/10.2.

It should be noted that this restriction on the remedies available to physicians aggrieved by hospital's peer review committees does not limit a party's right to pursue other remedies, such as cease and desist orders or reinstatement. Rockford Memorial Hosp. v Department of Human Rights, 272 Ill App 3d 751, 209 Ill Dec 471, 651 NE2d 649 (2d Dist 1995).

91. Tabora v Gottlieb Mem. Hosp., 279 Ill App 3d 108, 215 Ill Dec 870, 664 NE2d 267 (1st Dist 1996).

Similarly, in Cardwell v. Rockford Mem. Hosp.,[92] peer review committee members and a hospital were held immune where they, allegedly falsely and maliciously, confronted a doctor about a drug, alcohol, mental or emotional problem and the doctor sued for, among other things, intentional infliction of emotional distress and slander.

§ 8:17. National Labor Relations Act's and the Labor Management Relations Act's applicability to health care institutions

Although people in the United States had the right to be members of trade unions and to withdraw their labor during industrial disputes, employers also had the right to dismiss employees because they had joined unions or had gone on strike. During the economic depression it was easier for an employer to find another employee than it was for an employee to find another job.[93] People therefore became reluctant to join trade unions and by 1933 only ten percent (10%) of America's workforce were union members.

In 1933, Robert W. Wagner chairman of the National Recovery Administration, introduced a bill in Congress to help protect trade unionists from their employers. With the support of Frances Perkins, the US Secretary of Labor, Wagner's proposals became the National Labor Relations Act.[94]

§ 8:18. National Labor Relations Act

In 1935, the National Labor Relations Act ("NLRA") was enacted. The NLRA gives employees the right to form, join, or assist labor organizations, to engage in collective bargaining, and to engage in concerted activities for collective bargaining or mutual aid or protec-

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92. Cardwell v Rockford Memorial Hosp., 136 Ill 2d 271, 144 Ill Dec 109, 555 NE2d 6, 5 BNA IER Cas 1524 (1990).

93. The Presidency of Franklin Delano Roosevelt, available at http://www.spartacus.schoolnet.co.uk/USARnlra.html.

94. The Presidency of Franklin Delano Roosevelt, available at http://www.spartacus.schoolnet.co.uk/USARnlra.html.

tions.[95] The NLRA also declared certain employer conduct "unfair labor practices," as well as created the National Labor Relations Board (the "NLRB") to interpret and administer the NLRA.

§ 8:19. Labor Management Relations Act

In 1947, Congress, then dominated by a Republican majority, sought to curb the growing power of organized labor by enacting the passage of the Labor Management Relations Act of 1947 ("LMRA").[96] This law embodied a series of amendments to the NLRA. For example, it (i) excluded supervisory employees from the benefits and protection of the NLRA and prohibited states from extending such benefits to supervisory employees; (ii) emphasized the right of all employees not to join a union and not to participate in collective action; and (iii) forbade the negotiation of any closed-shop agreement between employers and employees and permitted a union-shop agreement of a limited type only if authorized by state law and voted upon by a majority of the employees in a secret-ballot election.

In the 1970s, the LMRA was expanded to include employees of the U.S. Postal Service, private health-care facilities, colleges and universities, and law firms, among others. This expansion of the LMRA's jurisdiction brought protection to workers who otherwise would not have such rights.

§ 8:20. Application to healthcare facilities

There are three provisions of the NLRA which apply specifically to health care organizations: (i) advance notice to the Federal Mediation and Conciliation Service (FMCS) of contract disputes; (ii) ten (10) days notice of strikes or picketing under Section 8(g); and (iii) FMCS involvement in health care industry labor disputes.

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95. 29 USCS § 151.

96. The LMRA was introduced in the Senate by Robert Taft of Ohio and in the House by Fred Hartley of New Jersey, and is therefore sometimes referred to as the Taft-Hartley Act. 29 USCS § 141.

§ 8:21. Advance notice to the Federal Mediation and Conciliation Service of contract disputes

The NLRA provides for all employers, at § 8(d),[97] a means of ensuring that a "cooling off" period occurs between the decision of one party to a collective bargaining agreement to terminate the agreement and resort to the use of economic weapons, such as strikes or concerted activities.[98] Specifically, §8(d) requires: (1) sixty (60) days' notice of proposed termination or modification of the agreement; (2) thirty (30) days' notice to the Federal Mediation and Conciliation Service ("FMCS") of the existence of a bargaining dispute; and (3) continuation of the agreement for the sixty (60) day period. Since these rules are stringently enforced against both employers and employees, the NLRA, recognizing the disruptive impact that labor unrest can have on patient care, decided to modify these requirements.

Specifically, Section 8(d) was amended to increase the notice period from sixty (60) to ninety (90) days for parties to collective bargaining agreements in the healthcare industry. Also, the FMCS notice must be given within sixty (60) days, as opposed to thirty (30) days for non-health care employers. Finally the parties in the healthcare industry are prohibited from resorting to strikes, lockouts, or other disruptive activities for a period of ninety (90) days as opposed to sixty (60) days in the case of other employers.

§ 8:22. Ten-Day notice of strike or picketing under section 8(g)

Before engaging in any strike, picketing, or other concerted refusal to work at any health care institution, Section 8(g) of the NLRA requires a labor organization to provide the employer with at least ten (10) days notice in order to make arrangements for continuity of patient care.[99]

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97. 29 USCS § 158(d).

98. Healthcare Facilities Law, Anne M. Dellinger, Critical Issues for Hospitals, HMOs, and Extended Care Facilities.

99. Healthcare Facilities Law, Anne M. Dellinger, Critical Issues for Hospitals, HMOs, and Extended Care Facilities pp. 88-93.

The NLRB's general counsel has, however, indicated in published guidelines[1] that such notice would not be required if the employer committed "serious" or "flagrant" unfair labor practices, or if the ten (10) day period is used to undermine the bargaining relationship that would otherwise exist.

For example, an unannounced 15-minute walkout by union employees did not violate 8(g) because they were goaded beyond endurance by the employer's repeated postponements of a grievance meeting.[2]

The ten (10) day notice requirement also raises an issue with respect to the effect of the NLRB "ally" doctrine. The "ally" doctrine provides that a union can direct its picketing activities at a second employer if such employer has enmeshed itself in the primary dispute of the first (e.g. primary) employer by performing work that would normally be performed by the first employer.[3] Such work is referred to as "struck work" and one of the questions that arises in the healthcare industry is whether a second hospital is performing "struck work" when it receives and treats patients from the first employer hospital. To date, the NLRB has not yet issued a ruling on this issue.

§ 8:23. FMCS involvement in health care industry labor disputes

After receiving notice under Section 8(g) of the NLRA, the FMCS is required to promptly communicate with the parties and use its best efforts, by mediation and conciliation, to bring the parties to agreement and the parties are required to fully participate in any meetings undertaken by FMCS for the purpose of aiding in a settlement of the dispute.[4]

Furthermore, during the negotiation process, FMCS has the author-

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1. See Initial Guidelines Issued by the NLRB General Counsel to NLRB Field Offices for Processing Unfair Labor Practice Cases under the 1974 Non-Profit Hospital Amendments to the Federal Labor Act, August 20, 1974.

2. Hospital & Health Care Employees, District 1199-E (CHC Corp.), 229 NLRB 1010, 95 BNA LRRM 1214, 1977-78 CCH NLRB P 18203 (1977).

3. 29 USCS §158 (d), and (g).

4. 29 USCS §158 (d), and (g).

ity to appoint a board of inquiry to investigate issues that arise. In the event a board of inquiry is established, once the board has issued its report there can be no change in the status quo in effect prior to the expiration of the contract for a period of fifteen (15) days.[5] The recommendations of the board of inquiry are not, however, binding on the parties.

One of the problems encountered with respect to these requirements has to do with the interpretation of when the thirty (30) day period in which the FMCS can appoint a board of inquiry commences. FMCS has maintained that the thirty (30) day period begins with the last permissible date on which FMCS must be notified of the existence of the dispute; that is, no later than sixty (60) days prior to contract expiration.[6]

Health care employers have, however, argued that the thirty (30) day period begins when the FMCS actually receives the notice of the dispute. This would mean that if a notice is received earlier than the sixty (60) days prior to the contract expiration, the FMCS could be forced to decide whether to appoint a board of inquiry long before it had enough information to make an informed decision. Thus, in Affiliated Hosp. of San Francisco v. Scearce, the court rejected the FMCS' interpretation and stated that the FMCS must appoint the board of inquiry within thirty (30) days after the date by which notice is required.[7] In particular, in this case, on June 11, 1976, the union gave the hospital association notice that the union intended to reopen its collective bargaining agreement. On June 28, 1976, the union notified the FMCS that it had notified the hospital association. On August 31, 1976, the FMCS gave notice that a board of inquiry had been appointed. The hospital association contended that the FMCS's action on August 31 occurred too late because the FMCS's authority

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5. Labor Relations for Health Care Institutions under the National Labor Relations Act, Seyfarth, Shaw, Fairweather & Geraldson (Eighth Edition).

6. Labor Relations for Health Care Institutions under the National Labor Relations Act, Seyfarth, Shaw, Fairweather & Geraldson (Eighth Edition).

7. Affiliated Hospitals of San Francisco v Scearce, 418 F Supp 711, 93 BNA LRRM 2307, 79 CCH LC P 11771 (ND Cal 1976), affd 583 F2d 1097, 99 BNA LRRM 3197, 84 CCH LC P 10884 (CA9 Cal).

was limited to establishing a board within thirty (30) days after the union gave notice. The FMCS contended that § 213 of the LMRA should be interpreted as requiring establishment of a board of inquiry within thirty (30) days after the last day permitted for the giving of the notice of strike. The court agreed with the hospital association and granted the injunction. The court held that although § 213 was not the epitome of careful draftsmanship, it was sufficiently clear not to permit such a strained construction. Further, the court noted that the legislative history failed to support the construction urged by the FMCS. The court therefore concluded that the establishment of the board came too late and was unauthorized. This holding was affirmed by the Fourth Circuit Court of Appeals in Sinai Hosp. of Baltimore, Inc. v. Scearce.[8]

After these court decisions, FMCS began asking parties to sign a joint stipulation that would permit the appointment of a fact finder at a later date. The fact finder, when appointed, would operate the same as a board of inquiry.

8. Sinai Hospital of Baltimore, Inc. v Scearce, 561 F2d 547, 96 BNA LRRM 2355, 82 CCH LC P 10118 (CA4 Md 1977).