IS A HYBRID JUST WHAT THE DOCTOR ORDERED? EVALUATING THE POTENTIAL USE OF ALTERNATIVE COMPANY STRUCTURES BY HEALTHCARE ENTERPRISES

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Introduction

There are many dramatic changes underway in the healthcare industry. These changes are being driven by various factors including health reform, information technology innovation, reimbursement changes, research and development, the aging Baby Boomer population and health trends such as the obesity epidemic. The myriad challenges faced by health industry companies are driving the need for innovative strategies and structures. Recent developments in the legal arena may create new and enhanced opportunities for organizations in the health industry; namely, the proliferation of "hybrid" or alternative structures that combine certain features common to both for-profit businesses and non-profit organizations.

As described in our initial article regarding "hybrid" organizational structures, *Are Hybrids Really More Efficient? A 'Drive-By' Analysis of Alternative Company Structures*,[1] the creation and growing adoption of these new hybrid models stems largely from dissatisfaction with the historic approach to business structuring in the United States.[2] Traditionally in the United States society has tended to view organizational structure as a binary function, with only two possible, often mutually exclusive, outcomes. Either an enterprise is organized as a "for-profit" or traditional business corporation, or as a "non-profit" organization.

The conflicts and limitations of this binary approach are real, and are becoming more acute as businesses face increased competition, rising costs and pressures to exercise corporate social responsibility, among other challenges. These conflicts and limitations are particularly acute within the healthcare industry in light of the numerous ongoing changes in the industry that are listed above. Many of these forces are creating greater demand for healthcare services and also challenging healthcare providers and others to enhance or improve quality of care and patient outcomes, while at the same time managing costs more efficiently.

These forces of change may require providers to make substantial upfront investments in new programs, systems, technologies and/or equipment that will deliver efficiencies, improve quality and maximize value over the longer term. They may also require various parties, including insurers, providers, vendors and others, to come together and find new and innovative ways to collaborate and/or integrate – to share knowledge, data and best practices to achieve these objectives. It would seem clear that efforts directed towards improving healthcare quality and maximizing value would have a significant public benefit typical of the public and nonprofit sectors. Such efforts and initiatives, however, may require or at least benefit from the involvement, institutional knowledge and capital raising potential of the private sector.

Although the hybrid entities combining for-profit and non-profit features are relatively new and untested, they may offer some promise in helping bridge the gap that exists between the historic approach to business structuring in the United States and the reality of the healthcare market and healthcare delivery as it exists today. Notwithstanding the inherent nature of healthcare as both a social good and a commercial service, given the relative newness and untested nature of hybrid entities, not many healthcare providers, vendors or other enterprises engaged in the healthcare industry have utilized them yet.

This article analyzes potential benefits and effects of two of the most commonly used hybrid organizational structures – the benefit corporation and the low profit limited liability company – for healthcare enterprises and on policymaking as it pertains to the structure and delivery of healthcare. The article first summarizes the salient features of the benefit corporation and the low-profit limited liability company. In order to assess their possible uses in the healthcare arena, the article next discusses potential use of the benefit corporation and the low-profit limited liability company structures for hypothetical healthcare enterprises. Finally, the article analyzes the potential impact of the availability and greater adoption of these hybrid organizational models on the policy considerations that underlie a key restriction on physician business activity and integration; namely, state restrictions on the corporate practice of medicine.

Overview of Most Common Hybrid Models

Benefit Corporation

Perhaps the most common and multi-purpose "hybrid" form of organization is the "benefit corporation," which was established as an alternative

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to the traditional for-profit or business corporation.[3] Benefit corporations enable a for-profit business to integrate a social mission with its profit-seeking goals. To date, at least 12 states, including states as widespread politically and geographically as California, Hawaii, Illinois, Louisiana, New York, South Carolina and Vermont, have enacted legislation enabling the formation of a benefit corporation, and approximately 14 additional states have introduced such legislation.[4] Under the model legislation and in most of the states that have passed legislation permitting them, benefit corporations generally share the following three principal characteristics:[5]

- A benefit corporation must pursue a "general public benefit" – namely, it must create "a material positive impact on society and the environment."[6] In addition to a general public benefit, benefit corporations may (but are not required to) also pursue one or more specific benefits.
- A benefit corporation expands the fiduciary responsibilities of directors of the corporation to affirmatively consider and pursue the corporation's general and specific purposes (rather than focusing solely on the maximization of shareholder value) and, importantly, protects them from legal liability for doing so. Directors must also consider the effect of corporate action not only on the corporation's shareholders but also on the corporation's employees, subsidiaries, vendors, customers, the community and the local and global environment.
- A benefit corporation is obligated to report on its overall social and environmental performance as assessed by a recognized third-party standard that is comprehensive, credible, independent, and transparent.

Organizing as a benefit corporation may offer certain advantages to any business that is concerned with advancing a social or public objective. The benefit corporation model affords legal protection to a company's directors and officers against claims of breach of fiduciary duty in connection with their pursuit of the company's general and/or specific public benefits, while still allowing the company to raise private capital and generate and distribute profits like a traditional business corporation. Organizing as a benefit corporation may help a business establish or enhance legitimacy as a socially responsible business, which may create or enhance its competitive position in the marketplace and/or attract employees, vendors, customers, and investors who care about socially responsible business practices.

Despite the apparent advantages they offer, benefit corporations are relatively new and largely untested, and various factors may limit their adoption and widespread use. There are, as yet, no material tax advantages to organizing as a benefit corporation; a benefit corporation is generally taxed in the same manner as any traditional business corporation, notwithstanding that it is required to pursue a general public benefit (and may pursue one or more specific benefits). The case law regarding benefit corporations is largely undeveloped, and so has not yet had the opportunity to fill the gaps in and clarify the legislation in key areas. Among other things, it is not yet clear what the standards are for balancing the pursuit of the company's general and/or specific purposes as against each other, or how these objectives would weigh against the company's need (or desire) to generate revenues from operations and/or a profit for investors and against other concerns, such as the corporation's workforce, community and the environment. Finally, the assessment and reporting requirements for benefit corporations are fairly extensive, which may prove unduly burdensome to certain companies and inhibit broader adoption of the model.

Low-Profit Limited Liability Company ("L3C")

The "low-profit limited liability company," commonly called the "L3C," first became recognized under state law in Vermont in 2008. The L3C was originally designed to achieve a narrower objective than benefit corporations; namely, to attract capital from private foundations for socially beneficial ventures.

A private foundation is a specific type of tax-exempt organization that functions generally to make grants to other charitable organizations, like hospitals. The tax law permits private foundations to make certain investments in for-profit ventures that benefit the public and that are generally too risky or provide too low return to entice private investors, known as "program related investments" or "PRIs."[7]

Private foundations in the United States have tremendous assets that could be used for PRIs. However, they often avoid PRIs because the tax requirements are complex, require extensive due diligence and oversight and impose significant risks for noncompliance. Given the risks, private foundations that do fund PRIs often seek IRS approval or a legal opinion beforehand, which can be expensive and time-consuming.

L3Cs were designed to make it easier and more attractive for private foundations to invest in for-profit ventures that produce meaningful public benefits through PRIs. The L3C incorporates tax law requirements imposed

on private foundations that invest in PRIs into the actual legal framework of the L3C entity, with the intent of ensuring compliance with the PRI requirements and the hope of avoiding the need for a private foundation to obtain a legal opinion or IRS approval for a PRI and to reduce the risk of legal non-compliance. L3Cs do not qualify for tax exemption, but unlike tax-exempt charities, L3Cs may distribute their profits to investors.

An L3C is generally required to satisfy three key criteria: (1) it is required to significantly further a "charitable" purpose as defined under the tax law; (2) its significant purposes may not include producing income or appreciating property; and (3) it may not conduct lobbying or political campaign activities.[8]

Although the L3C structure integrates PRI requirements under the tax law, the IRS has not, to date, officially determined that L3Cs comply with the PRI rules or relieve private foundations that invest in L3Cs from the burdens of PRI compliance, which the creators of the L3C hoped for. It seems unlikely that the IRS will address the matter anytime soon. Accordingly, if the L3C form does not reduce the burden on private foundations for entering into PRIs, some may question whether an L3C offers any meaningful advantages for PRIs over a traditional business entity.[9] However, the IRS has recently provided additional guidance on PRIs generally that may give private foundations greater comfort when entering into PRIs.[10] And regardless, formation as an L3C may have value in signaling to the world that the L3C is legally dedicated to socially beneficial purposes, like the benefit corporation, but that the charitable purpose and other requirements of the L3C are materially more restrictive than the requirements of the benefit corporation.

A key advantage of L3Cs is that they can help attract capital for social ventures where the profit-making potential is too low to entice investment by traditional private investors. Specifically, investments in an L3C may be in layers (or "tranches"). A private foundation could serve as an early investor, taking on riskier positions subordinated to other investors and having a lower rate of return, with the objective of advancing the charitable purposes of the venture rather than maximizing its investment return. With such initial capital from private foundations, an L3C may appear more stable and attractive to other investors, who could make a later-stage investment designed to yield a higher rate of return.

Although only approximately nine states currently recognize L3Cs and a number of others have or have had pending legislation,[11] an L3C is a limited liability company and should be able to register as such to do business in other states.

Hypothetical Examples of Hybrid Forms for Healthcare Enterprises

As noted above, relatively few healthcare enterprises have embraced a hybrid form of organization. Nonetheless, hybrid organizational models may offer certain advantages or create some intriguing possibilities vis-à-vis more traditional company structures in the healthcare industry. At minimum, the application of one or more hybrid organizational forms to even fairly generic healthcare enterprises or transactions raises some interesting policy and other considerations. As political and legislative fiat coalesces around one or more prevailing hybrid models, the case law develops so as to clarify the duties of the board of directors, owners and/or officers of an enterprise and the public gains a greater familiarity and comfort with these new models, these models could help facilitate the creation of novel structures and help drive greater innovation, enhanced collaboration and more active integration in the healthcare industry.

Hypothetical Benefit Corporation

A benefit corporation could be an attractive vehicle for a pioneering life sciences company that is focused on research and development of a new medical treatment therapy. Assume that the founders of such a company are scientists and entrepreneurs who are just as interested in bringing a breakthrough treatment to the public as they are in making at least a modest return on investment for their time and efforts. In fact, the founders may feel strongly about providing the therapy at little or no cost to qualified patients (either domestically or overseas) who may not otherwise have adequate insurance coverage or be able to afford to purchase the therapy at market rates. Nonetheless, they wish to realize at least some of the profits from their labor and to raise capital from private sources and therefore do not wish to assume the restrictions and burdens of acquiring and maintaining tax-exempt, charitable or non-profit status.

Young life sciences companies would typically require a large amount of upfront capital investment to conduct their initial research and sponsor clinical trials needed in order to obtain the requisite approvals for a therapy before they can bring it to market. If the therapy is ultimately determined to be successful and is able to reach the market before competing new therapies, the company could become very financially successful while providing patients with a much needed treatment option. However, among other things, research and development, approvals by the Food and Drug Administration and approvals for reimbursements by governmental and private payors for the therapy could take years before the therapy reaches the market or the company can turn a profit. In sum, the venture is capital intensive with the potential to provide both a much needed medical benefit – a "social good" – and the potential for a

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generous monetary return to investors, but only after several years.

Such a company could be organized as a benefit corporation to take advantage of certain features unique to the benefit corporation that would not be available to it as a regular business corporation or a tax-exempt entity. However, the newness of the benefit corporation as a legal entity could create some legal and business uncertainties for the company that should be considered as it becomes an established entity and explores exit strategies.

Given the founders' interests in bringing a breakthrough therapy to market and also to be able to provide it to qualified patients at little or no cost, a benefit corporation may provide the company with legal protections that a regular business corporation or a tax-exempt entity may not be able to provide. As a benefit corporation, the company would be legally required to pursue a "general public benefit," which, in most states that allow benefit corporations, means that it must create "a material positive impact on society and the environment." It would be hard to argue that a company that is focused on bringing new medical treatments to market, particularly where it intends to provide access to such treatments on an as-needed basis without making profit, is not providing a general public benefit.

However, such a benefit is not specific to the environment, but rather to the healthcare of human patients, and therefore, it is questionable whether the company is fully meeting the required legal standard ascribed to a "general public benefit." Would the company also need to have an environmental focus in addition to its healthcare focus? What qualifies as a "material" positive impact? Can the material positive impact be limited to the company's immediate community with respect to the environment but be more widespread as to society (through its patient outreach)? Could it meet the environmental requirement by dedicating a certain portion of profits to environmental causes?

The standard ""a material positive impact on society and the environment" makes it seem unlikely that a benefit corporation would meet the "general public benefit" standard if it simply focused on its healthcare mission without harming the environment (*e.g.*, taking reasonable precautions during disposal of medical waste during clinical trials); yet, one would be hard-pressed to believe that benefit corporations were intended only to be used by organizations that are focused on the environment as one of their primary purposes. Thus, while the directors of the corporation would be legally protected in pursuing causes that may not necessarily maximize shareholder value (*i.e.*, not only selling the treatments commercially and for profit but also distributing them on an as needed basis without making a profit), it is not clear whether not having a comparable environmental purpose could create a legal issue for the company.

As a benefit corporation, the life sciences company could also distinguish itself in a marketplace where life sciences companies are often criticized for their focus on profit in the face of the critical human need that they serve. The legal requirement to provide a general public benefit, as well as to report on the benefit as assessed against an independent, recognized third-party standard, could be helpful to the company's reputation in the marketplace (and therefore, good for its business).

As a benefit corporation, the life sciences corporation would also have certain advantages that it would not have as a tax-exempt entity. For example, the company could seek investment from private equity sources, including socially responsible funds, and distribute profits to its investors. It would also be competitive in attracting and retaining management talent because it would not be constrained by the fair market value standards applicable to a non-profit entity. Of course, it would not be a tax-exempt entity and would be taxed on any profits, and its investors would be taxed on any distributions.

Successful life science companies often seek to either go public or become acquired by another, larger life science company. Given that the benefit corporation legislation is only a few years old, there may be little to no precedent for the market reaction to these exit strategies. Acquiring companies or investment bankers may not be comfortable with the legal requirements applicable to the benefit corporation and how they would apply to the acquiring company or be received by investors in a public offering. To overcome such issues, the benefit corporation could reorganize as a regular business corporation prior to the sale or public offering; however, this may not be a simple task for an established company with complex operations and relationships.

Hypothetical L3C

L3Cs may be helpful in the healthcare industry (and in general) in situations where funding from philanthropic sources is desired and where the threshold criteria for forming an L3C suit the entity's circumstances, namely: (1) its primary purpose is a more traditional charitable/tax-exempt purpose; (2) maximizing profits is not a major focus; and (3) no efforts will be made to influence legislation or participate in political campaigns.

For example, an ambulatory surgery center in a rural area with an under-served population could be formed as an L3C.[12] One or more private foundations or other funders would provide the initial capital in return for a riskier position with a

lower rate of return and subordinated to other investors, with the goal of making healthcare available to the local community. With the initial funding in place, physicians and/or other investors are more likely to find investing in the L3C more stable and attractive. The ambulatory surgery center could not be operated primarily to maximize profits, given that the significant purposes of an L3C may not include producing income, but an L3C may be profitable and distribute a steady stream of profits to its investors. The investors would earn a better profit than they would without the private foundation's charitable investment while also serving an important public need, and the community as a whole would be benefit from the newly available services of the ambulatory surgery center that might otherwise not exist.

Other examples of where L3Cs could potentially be advantageous in the healthcare arena include hospitals or urgent care centers in uninsured or distressed areas, organizations with a scientific or medical research component and organizations that sell vaccines or provide healthcare in third-world countries. L3Cs may also be particularly helpful for activities that appeal to investors focused on socially responsible investments.

Hybrid Organizational Structures and the Corporate Practice of Medicine Doctrine

The laws, rules, regulations and/or attorney general opinions of many states prohibit an unlicensed individual or entity from engaging in the practice of medicine and from employing licensed physicians to provide medical services. The availability of "hybrid" or alternative business models may provide a means for licensed physicians and unlicensed individuals or business entities to jointly engage with one another in ventures intended to help improve healthcare delivery and outcomes, without triggering the policy concerns that are at the root of many corporate practice restrictions.[13]

The so-called corporate practice of medicine ("CPOM" or "CPM") doctrine traces its origins to the turn of the 19th century and efforts by the American Medical Association ("AMA") to protect the status of medical doctors and ensure public safety.[14] The doctrine (sometimes referred to as the CPM "bar") has its roots in public policy considerations. These include concerns that a profit motive could unduly influence physician decision-making and/or create conflicts between doctors and their patients, and that lay (*i.e.*, unlicensed) individuals or entities should not be in a position to direct or control clinical decision-making or the provision of medical care.[15]

The approximately 30 or so states that have affirmatively adopted some form of the CPOM doctrine[16] have done so in a variety of ways. A common approach is to prohibit business entities or organizations from employing physicians to provide medical services, or from owning or controlling a physician or medical practice.[17] Another common tactic is to permit business entities to provide medical services only if they are owned and operated by licensed physicians.[18] Some states prohibit payment of compensation or fee sharing (or "fee splitting") between licensed professionals and non-licensed individuals or entities.[19] Even among states that have not affirmatively or fully adopted a CPOM bar, many have embraced certain of the principles or presumptions that underlie the doctrine.[20]

A number of exceptions and exemptions to the CPOM doctrine have emerged, even in states that adopt a more conservative approach to CPOM. Some states allow hospitals, hospital affiliates or even health maintenance organizations to practice medicine and/or employ physicians.[21] Other states permit medical schools to employ physicians, treat patients and/or charge for services provided by physicians who hold faculty appointments or otherwise to advance the educational, teaching or research mission of the institution.[22] A patchwork of other exceptions exists, as well.[23]

A small number of states have in recent years reaffirmed their commitment to the CPOM doctrine.[24] Other states have taken or are pursuing different approaches. Some states have not historically prohibited CPOM,[25] and a few have not provided meaningful guidance as to whether CPOM is prohibited (and whether any exceptions apply).[26] Other states prohibit CPOM, but have, for one reason or another, ceased to enforce (or, at minimum, to aggressively prosecute) internal laws, rules, regulations or other proscriptions on CPOM.[27] Finally, some states have in recent years repealed or overturned legislation, adopted new legislation or issued new opinions intended to eliminate at least certain CPOM restrictions.[28]

The CPOM doctrine, at its core, involves the relatively simple or narrow question of whether an individual or small group of physicians can or should be employed by an unlicensed organization that profits from the physicians' provision of medical services. In practice, however, CPOM restrictions may have effects that reach far beyond this narrow consideration. At least one commentator has observed that the term "corporate practice of medicine" can refer to or encompass (and thus proscribe) a wide range of corporate or business involvement in healthcare delivery, including "the aggregation of medical groups into larger health care systems, or the coordination of physicians in more efficient, effective or profitable ways by adopting organizational practices from the larger corporate sector."[29] The doctrine can also be applied to "health care organizational practices including privatization,

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conversion of non-profits to for-profit entities, and the emergence of multi-state, multi-product insurance plans."[30]

Various forces are causing healthcare providers to look at new and creative ways to lower costs and improve healthcare outcomes, as described above. New, or at least improved, models of collaborative and/or integrated care are being developed and implemented. Providers are making substantial capital investments to implement electronic health records, improve diagnostic capabilities and affect targeted or more individualized care. Physician involvement is key to ensuring that these efforts remain aligned with patient interest and effective care delivery, and that clinical decision-making is not impaired or constrained.

The various pressures on the healthcare industry have also created opportunities for and have attracted business organizations, investors and others. Many private sector players who are not traditional healthcare providers believe that they can apply market principles and strategies to encourage efficiencies in healthcare delivery, implement best practices in financial and operational management, identify and take advantage of economies of scale and implement effective technology solutions, with the same objectives of improving care and lowering costs.

Unfortunately, in the many states that have adopted some form of the CPOM doctrine, licensed physicians and unlicensed individuals and entities, who each play a role in effecting reform of the healthcare delivery system, are held apart from one another at arm's length, prevented from co-owning or managing healthcare enterprises or from aligning or integrating in any meaningful fashion. A "binary" approach to the intersection of healthcare and business – one which holds that the objectives of providing quality healthcare and of generating a reasonable profit are, of necessity, wholly incompatible with one another – can inhibit innovation in healthcare delivery models.

The availability of new hybrid organizational structures may facilitate movement beyond the limitations of binary thinking, and allow an approach to potential transactions by and among licensed healthcare professionals and unlicensed individuals or entities from a fresh perspective. At a minimum, the potential application of the various hybrid forms raises interesting questions that deserve consideration. For example:

- Does the practice of medicine or delivery of healthcare constitute a "public benefit" or social good such that a physician practice or healthcare provider should be entitled to organize under an alternative structure, such as a benefit corporation?[31] Even if not, should certain types of practices or providers – for instance, those that provide specialty care, or those that commit to provide a certain amount of charity or indigent care – nonetheless be entitled to organize under these hybrid models?
- If a physician practice or healthcare provider chooses to organize, for the sake of argument, as a benefit corporation, is the stated pursuit of a general public benefit and one (or more) special benefits sufficient to provide comfort that the practice or provider would not sacrifice clinical decision-making or patient care to a pure profit motive? Would it justify permitting certain alliances or investment by unlicensed persons in a CPOM state? After all, by organizing as a benefit corporation, the practice or provider may be indicating that profit generation is not the only, or even the paramount, consideration for the enterprise.
- In any state that has adopted the benefit corporation model, is there a meaningful rationale for continuing to prohibit the ownership of any practice or provider that has organized as such from including individuals or entities that are not licensed to practice medicine?
- Even if a professional corporation is entitled to organize as a benefit corporation, assuming the same state permits certain practices or providers to organize as benefit corporations, should they nonetheless also be required to be organized as a "professional corporation" (assuming such "dual" organization is possible)?
- Is it important to the foregoing considerations whether the governing body (as opposed to the ownership) of the practice or provider is comprised only of licensed physicians? Is it significant whether the designated "benefit officer" (if applicable), the preparation and filing of annual reports regarding the entity's progress in achieving its "social" purpose(s), and/or any audit process, for example, are within the purview of licensed providers, as opposed to lay parties?
- Will the increased availability and adoption of hybrid organizational structures have any impact on the development of or involvement by licensed physicians in new or emerging business or care delivery models or approaches including accountable care organizations ("ACOs")?[32]

There may be substantial benefits to be gained from allowing licensed physicians and unlicensed individuals and entities to co-own or manage and/or to more closely integrate with one another in connection with a range of healthcare-related ventures. Among other things, allowing physicians to be more closely involved in developing, funding and/or executing new models of care coordination and delivery, and/or new healthcare products and services, may help improve

quality of care and lower costs.[33] At a minimum, any initiative that results in the elimination of, or at least an alignment of the various states' approaches to, the CPOM doctrine could bring a measure of certainty to the marketplace and help facilitate innovation and growth, to the benefit of healthcare consumers everywhere.

Conclusion

The question of whether any health industry provider or other business should consider organizing under a hybrid model will depend on the unique facts and circumstances facing that provider or business. These include the type of activities in which the provider or business will engage, the market/client/patient population involved and the amount and type of financing the enterprise seeks to attract. As noted above, hybrid models are relatively new, and their ostensive protections and advantages remain largely untested. These may be among the reasons that the health industry has been slower to adopt or embrace these models in significant numbers. However, hybrid forms of organization may offer valuable advantages to health industry enterprises, such as enabling them to attract new funding sources. Increased adoption and acceptance of such models may have policy ramifications, as well. Among other things, it may help change the way physicians and lay individuals and entities are able to do business with one another, and facilitate greater integration and coordination between them.

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Endnotes

1 American Bar Association's *Business Law Today*, September 2012. *See* www.ebglaw.com/showarticle.aspx?Show=16595.

2 Various states have adopted legislation permitting different forms of hybrid entities, for example, the benefit corporation, the low-profit limited liability company, the flexible purpose corporation and the social purpose corporation. In this article, the authors focus only on the hybrid entities that appear to have been most frequently adopted across the states and are the most frequently used hybrid forms by socially responsible enterprises, i.e., the benefit corporation and the low-profit limited liability company.

3 As discussed in the authors' prior article *supra* note 1, benefit corporations are not to be confused with "B Corporations" or "B Corps". A "benefit corporation" is a form of legal entity that is established under state law. In contrast, a "B Corp" or "Certified B Corp" refers to a company that has obtained a certification from a nonprofit organization called B Lab. Any company that meets the standards of overall social and environmental performance established by B Lab may request certification as a B Corporation. A benefit corporation can apply for and become certified as a B Corporation (as can any traditional for profit or non-profit entity that meets B Lab's standards), but a benefit corporation (or any other hybrid entity discussed in this article) is not automatically considered a B Corporation, or *vice versa*.

4 *See e.g.* www.benefitcorp.net.

5 See, e.g., Vermont's Benefit Corporations Law, 11A V.S.A. Ch. 21.; and New York's B.C.L. Art. 17. Beyond the statutory requirements that are directly applicable to benefit corporations, a benefit corporation is generally subject to the other provisions of the enacting state's existing corporation code.

6 See, e.g., 11A V.S.A. §21.03(a)(4); and 17 N.Y. B.S.C. §1702(b).

7 Section 4944 of the Internal Revenue Code of 1986, as amended, and the regulations thereunder exclude program-related investments from treatment as jeopardizing investments that trigger the imposition of excise taxes.

8 *See e.g.*, T.11 V.S.A. §3001(27).

9 See, e.g., www.nonprofitlawblog.com/home/2011/08/the-l3c-3-years-later.html for a related discussion.

10 In May 2012, the IRS issued proposed regulations on PRIs. See Internal Revenue Bulletin 2012-21 (May 21, 2012).

11 Illinois, Louisiana, Maine, Michigan, North Carolina, Rhode Island, Utah, Vermont and Wyoming, and the Oglala Sioux Tribe and the Crow Indian Nation of Montana. States that are or have pending legislation include: California, Georgia, Hawaii, Iowa, Massachusetts, New York and Oklahoma. See, e.g., www.info.nationalcorp.com/blog/?Tag=Vermont%20L3C and www.americansforcommunitydevelopment.org/legislation.html.

12 Assuming regulatory and other legal requirements permit, such as the licensing approval process of the state-level health department.

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13 There are statutes and regulations, including the so-called "Stark law" and physician self-referral proscriptions, which affect or even limit the extent to which doctors may engage in or be compensated for their involvement in health industry enterprises. The nature, extent and policy rationale for such limitations, as well as the potential impact of the availability and greater adoption of "hybrid" models of business organization on them, are outside the scope of this article.

14 For a more thorough examination of the origins and history of the COPM doctrine and the role of the AMA in promoting the doctrine, *see, e.g.*, Michele Gustavson & Nick Taylor, *At Death's Door — Idaho's Corporate Practice of Medicine Doctrine*, 47 IDAHO L. REV. 480 (2011) and Michael F. Schaff & Glenn P. Prives, *The Corporate Practice of Medicine Doctrine: Is it Applicable to Your Client?*, BUS. LAW & GOVERNANCE, May 2010, at 1, *available at* www.wilentz.com/business-articles-and-publications.

15 *Corporate Practice of Medicine*, AM. HEALTH LAWYERS ASS'N (Aug. 10, 2012, 11:05 AM), www.healthlawyers.org/hlresources/Health%20Law%20Wiki/Corporate%20Practice%20of%20Medicine.aspx (citing Nili S. Yolin, *The Corporate Practice of Medicine Prohibition and the Hospital-Captive PC Relationship — Can they Coexist?*, AM. HEALTH LAWYERS ASS'N, Sept. 2010). *See, also*, Allegra Kim, *The Corporate Practice of Medicine Doctrine*, CAL. RESEARCH BUREAU, Oct. 2007, at 4, *available at* www.library.ca.gov/crb/07/07-011.pdf.

16 *See* AM. HEALTH LAWYERS, *supra* note 3 at 17. Others have estimated the figure at as high as approximately 38 states. The difference in estimates relates largely to the commentator's or analyst's view of what types of restrictions do (or do not) fall under the CPOM doctrine.

17 *See* Jennifer Brunkow, *3 Steps to Navigate Through the Corporate Practice of Medicine*, BECKER'S HOSP. REV. (Mar. 26, 2012), www.beckershospitalreview.com/legal-regulatory-issues/3-steps-to-navigate-through-the-corporate-practice-of-medicine.html.

18 *See* Jenn Lee, *The Corporate Practice of Medicine Doctrine*, FORWARD MOVEMENT (Dec. 27, 2009), www.ourforwardmovement.blogspot.com/2009/12/corporate-practice-of-medicine-doctrine.html.

19 *See id.*

20 For instance, many states allow business entities to employ physicians, but only if the company does not exercise control over the physician's independent medical judgment. *See, e.g.*, 2001 Ala. Op. Att'y Gen. 089; Iowa Op. Att'y Gen. 91-7-1 (Jul. 12, 1991).

21 *See, e.g.*, CAL. BUS. & PROF. CODE, §2401 (2013) (allows a non-profit university medical school to charge for professional services rendered by physicians who hold faculty appointments); COLO. REV. STAT. §25-3-103.7 (2012) (allows a hospital to employ physicians); 210 ILL. COMP. STAT. 85/10-8 (2005) (allows licensed hospitals and hospital affiliates to employ licensed physicians); IND. CODE. §25-22.5-1-2(c) (2012) (allows employment relationships among licensed physicians and hospitals (including psychiatric hospitals) and HMOs); and MI Op. Att'y Gen. No. 6770 (Sept. 17, 1993) (indicates non-profit corporations, including hospitals, may employ physicians).

22 *See Albany Med. Coll. v. McShane*, 104 A.D.2d 119 (N.Y. App. Div. 1984); aff'd 489 N.E.2d 1278 (N.Y. 1985) (Under New York law, a medical school may hire physicians and treat patients as part of its mission to promote medical science and instruction).

23 *See e.g.*, CAL. BUS & PROF. CODE, §2401 (2013) (allows non-profit medical research corporations and narcotic treatment programs, among others, to charge for professional services rendered by employed licensed physicians) and N.J. ADMIN. CODE tit. 13 §35-6.16(f) (2006) (allows a corporation licensed by the New Jersey Department of Health, a long or short-term care facility or ambulatory care facility to employ physicians to provide healthcare services).

24 *See* Rachel Irving & Ellen Janos, *Massachusetts Corporate Practice of Medicine Regulations Finalized*, HEALTH LAW AND POLICY MATTERS (Feb. 17, 2012), www.healthlawpolicymatters.com/2012/02/15/massachusetts-corporate-practice-of-medicine-regulations-finalized.

25 *See, e.g.*, UTAH CODE ANN. §58-67-802(1)(b) (LexisNexis 2012) (providing that an individual licensed physician may be employed by another person); *State Electro-Med. Inst. v. Platner*, 103 N.W. 1079, 1082 (Neb. 1905) (finding that a corporation that contracted with a physician did not constitute the practice of medicine or violate the law or public policy of Nebraska); 1992 Va. Op. Att'y Gen. 147 (noting "there is no court decision or statute in Virginia adopting the 'corporate practice of medicine' doctrine").

26 These jurisdictions include Delaware, the District of Columbia, Hawaii and New Hampshire. *See* Mary H. Michal et. al., *Corporate Practice of Medicine Doctrine — 50 State Survey Summary*, NAT'L HOSPICE AND PALLIATIVE CARE ORG., Sept. 2006, *available at* http://www.nhpco.org/files/public/palliativecare/corporate-practice-of-medicine-50-state-summary.pdf.

27 *See* Gustavson and Taylor, *supra* note 14, at 499.

28 *See* Mary Frost, *Gov. Cuomo's Brooklyn For-Profit Hospital Proposal Worries Hospital Workers and Local Reps*, BROOKLYN DAILY EAGLE (Feb. 4, 2013), *available at* www.brooklyneagle.com/articles/gov-cuomos-brooklyn-profit-hospital-proposal-worries-hospital-workers-and-local-reps (which describes New York Governor Andrew Cuomo's recent legislative proposal to establish a pilot program that would allow business corporations to own and operate two hospitals located in the state, subject to approval by the Public Health and Health Planning Council); *Health Care Alert: State Medical Board of Ohio Declares that Ohio Law Does Not Prohibit the Corporate Practice of Medicine*, VORYS, SATER, SEYMOUR AND PEASE LLP, Apr. 4, 2012, *available at* www.vorys.com/publications-589.html; Christine Cassetta, *Arizona Court of Appeals Addresses Non-Physician Ownership of Health Care Clinics*, MARTENDALE.COM (Feb. 18, 2009), www.martindale.com/health-care-law/article_Quarles-Brady-LLP_618358.htm (citing *Midtown Med. Grp, Inc. v. State Farm Mut. Auto. Ins. Co.*, 220 Ariz. 341 (Ariz. Ct. App. 2008), which found that Arizona law expressly allows an unlicensed business corporation to own an outpatient treatment center).

29 *See* Kim, *supra* note 15, at 3.

30 *Id.*

31 It is worth noting that at least one state that has adopted the "benefit corporation" form of organization expressly permits a professional corporation to organize as a benefit corporation. *See Benefit Corporations*, SEC'Y COMMONWEALTH OF MASS., *available at* www.sec.state.ma.us/cor/corpdf/Notice%20regarding%20Benefit%20Corporations.pdf. It is difficult to determine whether any Massachusetts professional corporation has yet organized as a benefit corporation; the authors are not aware that any have done so.

32 A great deal has been written about the development and operation of both Medicare and commercial ACOs. *See, e.g.*, Bob Spoerl, *A Closer Look At Iowa Health's ACOs: 5 Ways Medicare, Commercial Agreements Differ*, BECKER'S HOSP. REV. (June 6, 2012), www.beckershospitalreview.com/hospital-physician-relationships/a-closer-look-at-iowa-healths-acos-5-ways-medicare-commercial-agreements-differ.html; Steven Lieberman, *Pioneer ACOs: Promise and Potential Pitfalls*, HEALTH AFFAIRS BLOG (Dec. 29, 2011), www.healthaffairs.org/blog/2011/12/29/pioneer-acos-promise-and-potential-pitfalls; Kaiser Commission on Medicaid and the Uninsured, *Emerging Medicaid Accountable Care Organizations: The Role of Managed Care*, (May 2012), *available at* http://www.kff.org/medicaid/8319.cfm. There are a range of approaches to organizing an ACO – while it is possible to use an existing entity or organize a new legal entity to operate an ACO, it is also possible for an ACO to be created via contractual arrangement(s). Licensed physicians and physician practice organizations have led or been integrally involved the development of numerous ACO-like arrangements, although others have been developed or are led by non-physician organizations. *See, e.g.*, Diana Yap, *Walgreens Forms Three New ACOs*, AMERICAN PHARMACISTS ASS'N (Jan. 22, 2013), http://www.pharmacist.com/walgreens-forms-three-new-acos (identifying Walgreens as the first pharmacy to create an ACO); Erin McCann, Seven States Sign On To Accountable Care Initiative, HEALTHCARE IT NEWS (Oct. 19, 2012) (which describes a Cigna-led accountable care program). Given the wide range of possibilities in terms of structuring an ACO, and the varying regulatory requirements and limitations that apply to ACOs

depending in part on whether they are Medicare or "private" or commercial ACOs, a full examination of the utility or effect of the availability of the various hybrid organizational models on "accountable care" type arrangements falls outside the scope of this article.

[33] *See, e.g.*, Jennifer Lubell, *IOM: Physicians Play Key Role in Stopping Health System Waste*, AMERICAN MEDICAL NEWS (Sept. 24, 2012), www.ama-assn.org/amednews/2012/09/24/gvsb0924.htm (discussing a recent Institute of Medicine report "recommending that physicians and other health professionals become part of a 'learning' system that uses new clinical support tools and payment models linking performance to patient outcomes....", in which Jeremy A. Lazarus, MD, president of the American Medical Association, is reported to have stressed "that new health care delivery models should be patient-centered ***and physician-led***." (emphasis added)).