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The Decay of California's Prohibition of the Corporate Practice of Medicine

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*"There is nothing worse than a sharp image of a fuzzy concept."*¹

In the 1990s, dentists in North Carolina began to whiten teeth.² A decade later, nondentists across the state began to provide the same services, but at a lower price.³ In 2006, the North Carolina State Board of Dental Examiners (the "N.C. Dental Board") responded by issuing more than 47 cease-and-desist letters to parties whitening teeth without degrees in dentistry, and in 2007 the N.C. Dental Board enlisted the aid of the North Carolina Board of Cosmetic Art Examiners to issue similar warnings, specifically to cosmetologists.⁴ Their combined efforts were successful, and North Carolina nondentists soon stopped offering teeth whitening services.⁵

The United States Federal Trade Commission (the "FTC") took exception to the actions by the N.C. Dental Board, and in 2010 the FTC filed an administrative complaint alleging that the N.C. Dental Board acted deliberately for the benefit of North Carolina dentists and to the detriment of North Carolina nondentists.⁶ According to the FTC, these anticompetitive and unfair tactics violated the Federal Trade Commission Act, and in particular Section 7.⁷

After multiple hearings before an administrative law judge, followed by the FTC's internal oversight and a review by the Court of Appeals for the Fourth Circuit,⁸ in February 2015, the United States Supreme Court agreed with the FTC's 2010 allegations, namely that the anticompetitive conduct of the N.C. Dental Board violated antitrust law, and in particular the Sherman Act.⁹ The Supreme Court also held that sovereign immunity did not protect the actions of the N.C. Dental Board.¹⁰

In its 6-3 decision referring to the roles of dentists and nondentists in North Carolina, the Supreme Court reached a far greater audience than those concerned with tooth color in the Tar Heel state.¹¹ In point of fact, the Court's ruling did much to undermine most, if not all, authority held by professional organizations in California, including in particular the Medical Board of California ("MBC").¹² This article explores how and why such change came about.



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The Corporate Practice of Medicine Doctrine in California

California's prohibition on the corporate practice of medicine has been clear and well-defined¹³ since 1980.¹⁴ California Business and Professions Code section 2400 states:

Corporations and other artificial legal entities shall have no professional rights, privileges, or powers. However, the Division of Licensing may in its discretion, after such investigation and review of such documentary evidence as it may require, and under regulations adopted by it, grant approval of the employment of licensees on a salary basis by licensed charitable institutions, foundations, or clinics, if no charge for professional services rendered to patients is made by any such institution, foundation, or clinic.¹⁵

California has a "long-standing public policy against permitting lay persons to practice any of the medical arts or to exercise control over decisions made by healing arts practitioners."¹⁶ California also prohibits any person from practicing medicine in the state without a valid certificate of licensure,¹⁷ and a physician may not "lend" his or her professional license to a corporation without risk of disciplinary action or even license revocation.¹⁸ At its core, this prohibition on the corporate practice of medicine is "designed to protect the public from possible abuses stemming from the commercial exploitation of the practice of medicine."¹⁹ California's prohibition includes direct medical

care as well as administrative services that directly influence clinical delivery.²⁰

Even though California's prohibition is one of the nation's strongest,²¹ practitioners and non-practitioners alike still enjoy certain options for engaging the services of a non-clinical manager. Statutory exemptions provide for establishing hospital clinics²² and outpatient settings operated by a nonprofit hospital,²³ subject to applicable state and federal law. Management services organizations ("MSOs") present another way in which for-profit hospitals can manage one or more physician practices, provided the manager does not exceed the appropriate scope of authority.²⁴

Should a manager overstep these boundaries, the MBC may receive a complaint or inquiry.²⁵ Regulating the practice of medicine through the state's police power, the MBC is authorized to license, investigate, and discipline medical practitioners.²⁶ Its basic authority is summed up as follows:

The Board's investigators have the status of peace officers [citation], and possess a wide range of investigative powers. In addition to interviewing and taking statements from witnesses, the Board's investigators are authorized to exercise delegated powers [citation] to "[i]nspect books and records" and to "[i]ssue subpoenas for the attendance of witnesses and the production of papers, books, accounts, documents and testimony in any inquiry [or] investigation . . . in any part of the state."²⁷

As for its investigative prowess, the MBC has broad discretion and power to "[investigate] complaints from the public, from other licensees, from health care facilities, or from a division of the board that a physician and surgeon may be guilty of unprofessional conduct."²⁸ The MBC also has "authority to discipline a physician for unprofessional conduct by restricting, suspending, or revoking the physician's license to practice medicine."²⁹

Federal Antitrust Enforcement in Health Care

The United States Supreme Court stated in 1958:

The Sherman Act was designed to be a comprehensive charter of economic liberty aimed at preserving free and unfettered competition as the rule of trade. It rests on the premise that the unrestrained interaction of competitive forces will yield the best allocation of our economic resources, the lowest prices, the highest quality, and the greatest material progress, while at the same time providing an environment conducive to the preservation of our democratic political and social institutions. But even were that premise open to question, the policy unequivocally laid down by the Act is competition.³⁰

Historically, the health care industry retained anticompetitive elements that did not face regulatory scrutiny.³¹ Today, however, the Federal Government actively enforces antitrust laws in health care.³² In 1996, the FTC and the U.S. Department of Justice issued "Statements of Antitrust Enforcement Policy in Health Care," which focused on (1) mergers among hospitals, (2) hospital joint ventures involving high technology or other expensive health care equipment, (3) hospital joint ventures involving specialized clinical or other expensive health care services, (4) providers' collective provision of non-fee-related information to purchasers of health care services, (5) providers' collective provision of fee-related information to purchasers of health care services, (6) provider participation in exchange of price and cost information, (7) joint purchasing arrangements among health care providers, (8) physician network joint ventures, and (9) multiprovider networks.³³ Since then, the FTC has issued additional publications in an effort to maintain transparency with respect to the transactions the agency may challenge.³⁴

Recently, in *Saint Alphonsus Medical Ctr. v. St. Luke's Health System*, the U.S. Court of Appeals for the Ninth Circuit affirmed the district court's judgment in favor of the FTC, holding that the 2012 merger of St. Luke's Health Systems, Ltd. and Saltzer Medical Group, P.A. violated the Clayton Act as well as state law.³⁵ St. Luke's had acquired the assets of Saltzer Medical Group while concurrently entering into a professional service agreement with the group's physicians. The district court noted that "St. Luke's and Saltzer genuinely intended to move toward a better health care system," yet the court still held that the "huge market share" of the post-merger entity "creates a substantial risk of anticompetitive price increases" in the applicable market.³⁶ By ordering divestiture of the merger, the District Court rejected St. Luke's argument that "anticipated post-merger efficiencies excused the potential anticompetitive price effects."³⁷

The ninth circuit affirmed the lower court's decision, holding that "Section 7 [of the Clayton Act] does not require proof that a merger or other acquisition has caused higher prices in the affected market. All that is necessary is that the merger create an appreciable danger of such consequences in the future."³⁸ In rejecting the efficiencies defense raised by St. Luke's, the ninth circuit opined that there must be a showing that a merger is not anticompetitive, and perhaps even proof of "extraordinary efficiencies" to "offset the anticompetitive concerns."³⁹

The North Carolina State Board of Dental Examiners Decision

In *North Carolina State Board of Dental Examiners*, the FTC "alleged that the [N.C. Dental Board's] concerted action to exclude nondentists from the market for teeth whitening services in North Carolina constituted an anticompetitive and unfair method of competition."⁴⁰ In response to the action by the FTC, the N.C. Dental Board argued that it had immunity from prosecution, as "its members were invested by North Carolina with the power of the State and that, as a result, the Board's actions are cloaked with *Parker* immunity."⁴¹

The Supreme Court disagreed, explaining that a nonsovereign board like the N.C. Dental Board enjoys immunity under *Parker* only after satisfying two conditions: (1) the "challenged restraint . . . be one clearly articulated and affirmatively expressed as state policy," and (2) that the state actively supervises the policy.⁴² The Supreme Court noted that North Carolina prohibits the unauthorized practice of dentistry, but North Carolina did not articulate through legislation a similar prohibition on teeth whitening. As a result, the N.C. Dental Board never received proper oversight to the extent the issue was teeth whitening.

The Supreme Court also noted that states have control over the existence of *Parker* immunity by "adopting clear policies to displace

competition; and, if agencies controlled by active market participants interpret or enforce those policies, the States may provide active supervision."⁴³ Ultimately, however, the Supreme Court concluded that while the Sherman Act protects competition and still respects federalism, it did not authorize North Carolina to "abandon markets to the unsupervised control of active market participants, whether trade associations or hybrid agencies."⁴⁴ Indeed, states can confirm that *Parker* immunity is available to agencies only "by adopting clear policies to displace competition." While North Carolina delegates control over dentists and the ways in which they practice, there is no statutory oversight with respect to teeth whitening, "a practice that did not exist when it was passed."⁴⁵

Certain of the Justices disagreed, noting in their dissenting opinion: "North Carolina's Board of Dental Examiners is unmistakably a state agency created by the state legislature to serve a prescribed regulatory purpose and to do so using the State's power in cooperation with other arms of state government."⁴⁶ The dissenting opinion also issued a warning to other professions about the implications of the *North Carolina State Board of Dental Examiners* decision, and in particular that "it will create practical problems and is likely to have far-reaching effects on the State's regulation of professions."⁴⁷

California's Future Oversight

The MBC has struggled over the past several years to maintain effective regulatory oversight.⁴⁸ While budgetary concerns were usually blamed for these shortcomings,⁴⁹ the decision in *North Carolina State Board of Dental Examiners* brings to the MBC its greatest challenge. The Supreme Court has set another foundational component of the Affordable Care Act, albeit one not found directly in the opinion, in the dissent, or even in dicta. With regulatory themes such as efficiency, performance, and innovation leading reform today,⁵⁰ the health care industry in California has responded to these challenges with collaboration and consolidation as required by the ACA,⁵¹ but also at times when necessary, closure.⁵² To be sure, California has much at stake, although the recent Supreme Court decision puts into question whether California's regulatory intent will win the day.

In many ways, reliance upon the Supremacy Clause⁵³ in *North Carolina State Board of Dental Examiners* leaves California with more issues, but with fewer options with which to address modern challenges.⁵⁴ The Supreme Court's focus on "whether anti-competitive conduct engaged by [nonsovereign actors] should be deemed state action and thus shielded from antitrust laws"⁵⁵ overshadows the conduct of any such state regulatory professional board, whether or not its conduct is "efficient, well-functioning, or wise."⁵⁶ With consolidation and cooperation increasing under the ACA,⁵⁷ the FTC may be the only remaining line of defense to protect the public interest, relying upon the laws of competition only and without consideration to California's prohibition on the corporate practice of medicine.

While California law on the propriety of corporate oversight in medicine differs from other states, a position that some may oppose, the greater risk is a compromise to the ACA's reliance on traditional notions of federalism. Although the ACA has already afforded meaningful opportunities for the battle between state autonomy and federal supremacy to take place,⁵⁸ under *North Carolina State Board of Dental Examiners*, the Federal Government prevailed on this issue, doing so with some unexpected help from the Supreme Court.⁵⁹

Unlike *Douglas v. Independent Living Centers of Southern California*, in which the Supreme Court ignored the Supremacy Clause and suggested the Administrative Procedure Act to form the basis for relief,⁶⁰ in California the CMB "may adopt, amend, or repeal in accordance with the provisions of the Administrative Procedure Act, those regulations as may be necessary to enable it to carry into effect the provisions of law relating to the practice of medicine."⁶¹ Such is the system of give and take between a sovereign nation and its states that defines the federalism for which our country is known. While traditional notions of federalism encourage states to independently craft their allocation of balance, the ways in which each state opts to mold its particular helping of power often speaks volumes. Hopefully the CMB has not lost its voice.

Endnotes

1 Ansel Adams, photographer (1902-1984). [Back](#)

2 *N.C. State Bd. of Dental Examiners v. Fed. Trade Comm'n*, 135 S. Ct. 1101, 1108 (2015). See Wikipedia, *Tooth bleaching*, http://en.wikipedia.org/wiki/Tooth_bleaching (last visited May 18, 2015) ("Dental bleaching" or "tooth whitening" is the use of "carbamide peroxide which reacts with water to form hydrogen peroxide. . . . The peroxide oxidizing agent penetrates the porosities in the rod-like crystal structure of enamel and breaks down stain deposits on dentin"). [Back](#)

3 *N.C. State Bd. of Dental Examiners*, 135 S. Ct. at 1108. [Back](#)

4 *Id.* [Back](#)

5 *Id.* [Back](#)

6 *Id.* at 1109. [Back](#)

7 38 Stat. 719, as amended, 15 U.S.C. § 45. [Back](#)

8 *N.C. State Bd. of Dental Examiners v. Fed. Trade Comm'n*, 717 F.3d 359 (4th Cir. 2013), *cert. granted*, 134 S. Ct. 1491 (2014) [Back](#)

9 26 Stat. 209, as amended, 15 U.S.C. § 1 (prohibiting "every contract, combination . . . or conspiracy in restraint of trade"); see also 15 U.S.C. § 2 (prohibiting monopolization, attempted monopolization, and conspiracies to monopolize); 15 U.S.C. § 18 (prohibiting "unfair methods of competition" and "unfair or deceptive acts or practices"). [Back](#)

10 *N.C. State Bd. of Dental Examiners*, 135 S. Ct. at 1110. The United States Supreme Court has interpreted antitrust laws "to confer immunity on anticompetitive conduct by the States when acting in their sovereign capacity." *Parker v. Brown*, 317 U.S. 341, 350-51 (1943). [Back](#)

11 See, e.g., Milton Ready, *The Tar Heel State, A History of North Carolina* at 6 (University of South Carolina 2005) (suggesting that the origin of "Tar Heel" comes from the small distilleries and sawmills in North Carolina that produced sizeable amounts of pitch, tar, turpentine, and rosin to other British colonies). [Back](#)

12 This article focuses primarily on the CMB's enforcement of California's statutory prohibition on the corporate practice of medicine. See, e.g., Cal. Bus. & Prof. Code § 2400; see also *People v. Cole*, 38 Cal. 4th 964, 970-71 (2006) ("In general, under California's long-standing 'policy . . . against [the] corporate practice of the learned professions,' for-profit corporations 'may not engage in the practice of . . . medicine.'"). This article does not address the impact on other professional boards in California after the Supreme Court's decision. See, e.g., *N.C. State Bd. of Dental Examiners*, 135 S. Ct. at 1122-23 (Alito, J., Thomas, C., Scalia, A., Justices Dissenting) ("As a result of today's decision, States may find it necessary to change the composition of medical, dental, and other boards, but it is not clear what sort of changes are needed to satisfy the test that the Court now adopts."). [Back](#)

13 See *infra* note 14; see also Cal. Bus. & Prof. Code § 2415(b) (2) ("The professional practice of the applicant or applicants is wholly owned and entirely controlled by the applicant or applicants."); see also Cal. Bus. & Prof. Code § 1050 (applying the prohibition to chiropractic medicine); Cal. Bus. & Prof. Code § 1625 (applying the prohibition to dentistry); Cal. Bus. & Prof. Code § 3000 (applying the prohibition to optometry). California also has regulations accompanying the statutes. See, e.g., Cal. Code Regs. tit. 16 § 1300 (medicine); Cal. Code Regs. tit. 16 § 301 (chiropractic medicine); Cal. Code Regs. tit. 16 § 1000 (dentistry); Cal. Code Regs. tit. 16§ 1500 (optometry). [Back](#)

14 See, e.g., 63 Op. Cal. Att'y Gen. 723 (1980) (holding that a commercial entity employing active practitioners is practicing medicine without a license). [Back](#)

15 See also 65 Op. Cal. Att'y Gen. 223 (1982) (focusing on the damage to the doctor-patient relationship with too much corporate oversight); 58 Op. Cal. Att'y Gen. 571 (1975) (confirming that California law prohibits corporate oversight of physician practices). [Back](#)

16 *Cal. Ass'n of Dispensing Opticians v. Pearle Vision Ctr., Inc.*, 143 Cal. App. 3d 419, 427 (1983); see also 65 Op. Cal. Att'y Gen. 223 (expressing concern over the damage to a doctor-patient relationship from the corporate practice of medicine as it would "give rise to divided loyalties on the part of the professional and would destroy the professional relationship into which it was cast"). [Back](#)

17 Cal. Bus. & Prof. Code § 2052. [Back](#)

18 *Steinsmith v. Med. Bd.*, 85 Cal. App. 4th 458, 462 (2000). Moreover, a corporation may not engage in the practice of medicine by contracting with health care practitioners to provide health care services. See, e.g., *People v. Pacific Health Corp.*, 12 Cal. 2d 156, 158-59; *Cal. Ass'n of Dispensing Opticians*, 143 Cal. App. 3d at 427. [Back](#)

19 *County of Los Angeles v. Ford*, 121 Cal. App. 2d 407, 413 (1953); see also *Bowland v. Municipal Ct.*, 18 Cal. 3d 479, 491 (1976). [Back](#)

20 See, e.g., *Painless Parker v. Board of Dental Examiners*, 216 Cal. 285, 296 (1932) ("The law does not assume to divide the practice of dentistry into two sides, one the side relating to the actual performance of dental work upon the patient and the other the 'business side', but treats the subject as a whole."); *Marik v. Superior Ct.*, 191 Cal. App. 3d 1136, 1140 (1987) (holding that the purchase of medical equipment may require medical skill and judgment). [Back](#)

21 See, e.g., *Midtown Med. Grp., Inc. v. State Farm Mut. Auto. Ins. Co.*, 220 Ariz. 341, 345 (Ariz. Ct. App. 2008) ("A professional corporation does not somehow magically transfer the licenses of the individuals who own it to the corporate body as a whole."); Colo. Rev. Stat. § 12-43-211 (no prohibition for the corporate practice of certain mental health professions); *Baker v. Hedstrom*, 284 P.3d 400, 405 (N.M. Ct. App. 2012). Prohibition of the corporate practice of medicine in other states is not as clear. Compare *Hsu v. Marian Manor Apts., Inc.*, 743 N.W. 2d 672 (N.D. 2007) (holding it unlawful for unlicensed individuals or entities to employ licensed physicians) with N.D. Cent. Code § 10-31-01 (permitting the employment of physicians by hospitals, but not addressing the prohibition for corporations which are not hospitals, professional corporations, or HMOs); compare *State Electro-Med. Inst. v. State*, 103 N.W. 1078 (Neb. 1905), with Neb. Rev. Stat. 38-121 (Nebraska's Uniform Credentialing Act requires health care practitioners to be licensed under Nebraska law); but see Va. Code § 54.1-111(D) (providing that Virginia corporations and limited liability companies, as well as professional corporations, professional limited liability companies and foreign corporations and foreign limited liability companies that have obtained a certificate of authority and employ or contract with individuals licensed by a health regulatory board are not prohibited from practicing medicine directly or as a manager). [Back](#)

22 Cal. Health & Safety Code § 1206(d). [Back](#)

23 Cal. Health & Safety Code § 1206(l). [Back](#)

24 See *supra* note 20; see also Dan J. Tennenhouse, M.D., J.D., F.L.C.M., 1 Attorneys Medical Deskbook § 9.6 (4th ed. 2014); Alice G. Gosfield, *The New Playing Field*, 41 St. Louis U. L.J. 869, 876-77 (Summer 1997). [Back](#)

25 See, e.g., *Med. Bd. of Cal. v. Chiarottino*, 225 Cal. App. 4th 623, 629 (2014); Cal. Bus. & Prof. Code § 2001(a) ("There is in the Department of Consumer Affairs a Medical Board of California that consists of 15 members, 7 of whom shall be public members."). The public members shall not be doctors, but the other eight must be physicians and surgeons in California. Cal. Bus. & Prof. Code § 2007. [Back](#)

26 Cal. Bus. & Prof. Code § 2004; see also *Chiarottino*, 225 Cal. App. 4th at 629. [Back](#)

27 *Id.* at 630. [Back](#)

28 *Arnett v. Dal Cielo*, 14 Cal. 4th 4, 7-8 (1996). [Back](#)

29 *Leone v. Med. Bd. of Cal.*, 22 Cal. 4th 660, 664 (2000). [Back](#)

30 *N. Pac. Ry. Co. v. United States*, 356 U.S. 1, 4-5 (1958). [Back](#)

31 "Over the years, health care service has been treated pretty much as a 'natural monopoly.' It has been assumed that a community could support only so many hospitals; that providers just naturally control supply and demand. . . . Isn't it just possible, some are asking, that turning competition loose, at least in some sections, may not only lower the costs of health care but improve its quality?" See Senator Philip A. Hart, Hearings Before the Subcomm. on Antitrust & Monopoly of the Senate Comm. On the Judiciary, 93rd Cong., 2nd Sess. 1 (1974). [Back](#)

32 See generally *Promedica Health Sys., Inc. v. Fed. Trade Comm'n*, 749 F.3d 559 (6th Cir. 2014) (upholding the decision by the FTC to block a hospital merger in Ohio); *Fed. Trade Comm'n v. Phoebe Putney Health System, Inc.*, 133 S. Ct. 1003 (2013) (holding that immunity did not apply for local governmental entity when FTC challenged its acquisition of a second hospital); see also Edith Ramirez, J.D., *Antitrust Enforcement in Health Care - Controlling Costs, Improving Quality*, 371 N. Engl. J. Med. 2014, 2245-47 (Dec. 11, 2014) ("The success of health care reform in the United States depends on the proper functioning of our market-based health care system. Antitrust laws play a crucial role in ensuring that consumers benefit."). [Back](#)

33 U.S. Dep't of Justice and the Fed. Trade Comm'n, Statement of Enforcement Policy In Health Care (1996), available at https://www.ftc.gov/sites/default/files/attachments/competitionpolicy-guidance/statements_of_antitrust_enforcement_policy_in_health_care_august_1996.pdf. [Back](#)

34 See, e.g., 76 Fed. Reg. 67026 (Oct. 28, 2011) (Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program); *Medicare Prescription Drug, Improvement, and Modernization Act of 2003*, Pub. L. 108-173 (Dec. 8, 2003) (requiring brand-name drug manufacturers and generic drug applicants file certain agreements with the FTC and the Assistant Attorney General before executing an agreement); *Overview of FTC Antitrust Actions in Health Care Services and Products*, F.T.C. (Mar. 2013), available at <https://www.ftc.gov/system/files/attachments/competition-policy-guidance/hcupdaterev.pdf>. [Back](#)

35 *Saint Alphonsus Med. Ctr. v. St. Luke's Health Sys., Ltd.*, 778 F.3d 775 (9th Cir. 2015). [Back](#)

36 *Id.* at 782. [Back](#)

37 *Id.* [Back](#)

38 *Id.* at 787-88. [Back](#)

39 *Id.* at 790. [Back](#)

40 *N.C. State Bd. of Dental Examiners*, 135 S. Ct. at 1109. The Court also explained that "[w]hile the Sherman Act confers immunity on the States' own anticompetitive policies out of respect for federalism, it does not always confer immunity where, as here, a state delegates control over a market to a non-sovereign actor." *Id.* at 1110. See also *Goldfarb v. Va State Bar*, 421 U.S. 773, 791 (1975) ("The fact that the State Bar is a state agency for some limited purposes does not create an antitrust shield that allows it to foster anticompetitive practices for the benefit of its members."). [Back](#)

41 *N.C. State Bd. of Dental Examiners*, 135 S. Ct. at 1104. The FTC contended that the Board, comprised of six members who are licensed dentists, one licensed and practicing dental hygienist, and one "consumer" appointed by the governor. According to the FTC, the Board was a "public/private hybrid" that must be actively supervised by the State to claim immunity." *Id.* at 1109. In *Parker*, the Supreme Court "interpreted the antitrust laws to confer immunity on anticompetitive conduct by the States when acting in their sovereign capacity." *Id.* at 1110 (citing *Parker*, 317 U.S. at 350-51). [Back](#)

42 *Id.* [Back](#)

43 *Id.* at 1115. The Supreme Court previously rejected the argument that antitrust laws should not apply to professional regulation:

[Respondents] contend that effective peer review is essential to the provision of quality medical care and that any threat of antitrust liability will prevent physicians from participating openly and actively in peer-review proceedings. This argument, however, essentially challenges the wisdom of applying the antitrust laws to the sphere of medical care, and as such is properly directed to the legislative branch. To the extent that Congress has declined to exempt medical peer review from the reach of the antitrust laws, peer review is immune from antitrust scrutiny only if the State effectively has made this conduct its own.

Id. at 1115-16 (citations omitted). [Back](#)

44 *Id.* at 1117. "If a State wants to rely on active market participants as regulators, it must provide active supervision if state-action immunity under *Parker* is to be involved." *Id.* [Back](#)

45 *Id.* at 1116. [Back](#)

46 *Id.* at 1120 (Alito, J., dissenting). [Back](#)

47 *Id.* [Back](#)

48 See, e.g., Michael Hiltzik, *Legislature should pull plug on inept Medical Board of California*, L.A. Times (Apr. 26, 2013), available at <http://articles.latimes.com/2013/apr/26/business/la-fi-hiltzik-20130428>;

Nannette Miranda, *Medical Board of California accused of laxity in doctor oversight*, Eyewitness News (Mar. 11, 2013), available at <http://abc7.com/archive/9023709/>; Susan J. Landers, *California licensing backlog keeping doctors from starting jobs*, American Medical News (Nov. 9, 2009), available at <http://www.amednews.com/article/20091109/profession/311099976/6/> [Back](#)

49 See *supra* note 48. [Back](#)

50 See, e.g., 42 U.S.C. § 1395ww(o)(7)(c)(5)(2013) (Hospital Value Based Purchasing Program, wherein reductions to the base operating DRG for hospitals increases to two percent in 2017); 42 U.S.C. § 1395ww(q)(3)(C)(iii) (2013) (Hospital Readmission Reduction Program, wherein reductions to the base operating DRG for hospitals can increase to as much as three percent in 2015); 42 U.S.C. § 1395ww(p)(1) (2013) (Hospital-Acquired Conditions, which can decrease hospital Medicare revenue by one percent starting in 2015); Lisa Rosenbaum, *The Whole Ball Game-Overcoming the Blind Spots in Health Care Reform*, 368 N. ENGL. J. MED. 959 (2013) ("If we focus on physicians and patients separately, we lose any sense of how their goals match up and whether patients value care that the evidence indicates is necessary."). [Back](#)

51 See Samuel R. Maizel and Craig B. Garner, *The Poor Get Poorer: The Fate of California Hospitals Under the ACA*, 32 Cal. Health L. News 10, 12 (Fall 2014/Winter 2015). [Back](#)

52 See, e.g., Craig B. Garner, *Another healthcare crisis: Closing hospitals*, Los Angeles Times (Feb. 26, 2014), available at <http://articles.latimes.com/2014/feb/26/opinion/la-oe-garnerhospital-closures-healthcare-20140226>. [Back](#)

53 U.S. Const., art. 6, cl. 2. [Back](#)

54 See *N.C. State Bd. of Dental Exam'rs*, 135 S. Ct. at 1111 ("So it follows that, under *Parker* and the Supremacy Clause, the States' greater power to attain an end does not include the lesser power to negate the congressional judgment embodied in the Sherman Act through unsupervised delegations to active market participants."). [Back](#)

55 *Id.* (quoting *Patrick v. Burget*, 486 U.S. 94, 100 (1988)). [Back](#)

56 *Id.* at 1112. [Back](#)

57 See, e.g., Mark T. Morrell and Alex T. Krouse, *Accountability Partners: Legislated Collaboration for Health Reform*, 11 Ind. Health L. Rev. 225, 284-85 (2014). [Back](#)

58 See generally *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751 (2014) (holding that plaintiff did not have to provide contraception coverage for its employees); *National Federation of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012) (upholding the ACA by identifying the taxing authority as the basis for the individual mandate and approving Medicaid Expansion with certain modifications); *King v. Burwell*, 759 F.3d 358 (4th Cir. 2014), *cert. granted*, 135 S. Ct. 475 (determining the constitutionality of subsidies for health insurance exchanges controlled by the Federal Government). [Back](#)

59 A majority opinion is not the only voice from which precedents are made. On occasion a Justice may issue a dissenting opinion that resonates long after interest in the majority opinion has waned, and in many cases a dissenting opinion has provided a foreshadowing of things to come. See, e.g., *Plessy v. Ferguson*, 163 U.S. 537, 559 (Harlan, J., dissenting) ("But in view of the constitution, in the eye of the law, there is in this country no superior, dominant, ruling class of citizens. There is no caste here. Our constitution is color-blind, and neither knows nor tolerates classes among citizens."); *Sch. Dist. of Abington Twp. v. Schempp*, 374 U.S. 203, 309 (1963) (Stewart, J., dissenting) ("We err in the first place if we do not recognize, as a matter of history and as a matter of the imperatives of our free society, that religion and government must necessarily interact in countless ways."); *Morrison v. Olson*, 487 U.S. 654, 697 (Scalia, J., dissenting) ("This is what this suit is about. Power. The allocation of power among Congress, the President, and the courts in such fashion as to preserve the equilibrium the Constitution sought to establish."). While dissenting opinions have a certain degree of flexibility in scope and focus, the Supreme Court generally follows its own prohibition from issuing judicial advisory opinions. See *Flast v. Cohen*, 392 U.S. 83, 96 (1968) ("When the federal judicial power is invoked to pass upon the validity of actions by the Legislative and Executive Branches of the Government, the rule against advisory opinions implements the separation of powers prescribed by the Constitution and confines federal courts to the role assigned them by Article III."); *but see Douglas v. Indep. Living Ctr. of S. Cal.*, 132 S. Ct. 1204, 1213-14 (2012) (Roberts, C.J., dissenting) (arguing that not only was there no viable claim under the Supremacy Clause in the first instance, but more importantly, the majority took it upon itself to answer a question that had not been asked, even going so far as to vacate the Ninth Circuit rather than simply remand). [Back](#)

60 *Indep. Living Ctr. of S. Cal.*, 132 S. Ct. at 1213-14. [Back](#)

61 Cal. Bus & Prof. Code § 2018. [Back](#)

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