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THE PRIZE IS RIGHT: AMENDING THE MPA TO PUT PATIENTS FIRST

I. INTRODUCTION

In *United States v. Universal Health Services Inc.*, unlicensed medical staff at a mental health clinic caused the treatment of a teenage girl to be delayed, ultimately leading to her death.¹ The teenager became a patient of Arbour Counseling Services (Arbour), in 2004.² After almost three years of being transferred from one unlicensed staff member to the next, the teenager began suffering from seizures and eventually died in 2009.³ After her death, the parents were informed that the counselors looking after their daughter were not properly licensed.⁴ The parents reached out to various state agencies in Massachusetts.⁵ During their investigation, a state agency found that since 1996, multiple physicians were working for the mental health clinic without a license.⁶

However, the state agency only suspended one of the physicians at the clinic.⁷ In 2015, the Supreme Court of the United States in *Universal Health Services, Inc. v. United States* decided the suit against the mental health clinic and obtained justice for the parents.⁸ Yet, this “justice” came after almost twenty years of multiple providers at the clinic practicing without a license.⁹ Could there not have been a solution that would have caught the unlicensed practice before harm was done to the teenage girl? With a considerable amount of unlicensed practice of medicine,¹⁰ what more proactive solutions should officials start considering?

1. *Universal Health Servs., Inc. v. United States*, 136 S. Ct. 1989, 1997 (2016), *rev'g* *United States v. Universal Health Servs., Inc.*, 780 F.3d 504, 509 (1st Cir. 2015). The court of appeals opinion is cited because it provides important factual information involved in the case.

2. *Universal Health Servs.*, 136 S. Ct. at 1997.

3. *Id.*

4. *Id.*

5. *United States v. Universal Health Servs., Inc.*, 780 F.3d at 510, *vacated*, *Universal Health Servs. v. United States*, 136 S. Ct. 1989 (2016).

6. *Id.*

7. *Id.* at 504. Two Arbour employees were prosecuted, however, only one of these physicians was suspended while the other had to pay \$1000 in civil penalties, but continued to practice. *Id.* at 510.

8. *Universal Health Servs.*, 136 S. Ct. at 1995–96.

9. *United States v. Universal Health Servs.*, 780 F.3d at 510.

10. *See infra* Part II.C.

The U.S. healthcare system is arguably the most regulated area of law; yet, with a lack of sufficient enforcement mechanisms, the unlicensed practice of medicine remains problematic.¹¹ Unlicensed practice is deadly for patients and remains alarmingly prevalent.¹² There are about 4,000 to 4,500 nationwide physician prosecutions per year.¹³ These violations include either cases of physicians exceeding the scope of their license or cases of physicians not comporting with the rules under their license; both constitute unlicensed practice.¹⁴ In 2015, there was a total of 1,238 individuals whose licenses were restricted, 655 individuals who were put on probation, 594 individuals who were suspended, and 267 individuals whose licenses were revoked.¹⁵ As demonstrated by this data, the system can catch unlicensed practice; however, the system does not have a way to proactively prevent and deter unlicensed practice before harm is done to patients. Unlicensed practice harms patients and the medical profession.¹⁶ When an individual lacks the medical education required and then provides uneducated care to patients, the care will be substandard compared to the care that could have been provided by a licensed individual.¹⁷ To illustrate, if the “physician” is not adequately educated, then the information the patient tells the “physician” will not be effectively used.¹⁸ The lack of proper licensure for the services provided leads to thousands of individuals committing unlicensed practice per year nationwide.¹⁹ This then leads to injuries from substandard care, improper treatments, or delays in receiving care.²⁰

11. See David C. Szostak, *Vertical Integration in Health Care: The Regulatory Landscape*, 17 DEPAUL J. HEALTH CARE L. 65, 67 (2015) (discussing the multiple statutory authorities involved in healthcare causing complex fragmentation); see also *U.S. Medical Regulatory Trends and Actions*, FED’N OF STATE MED. BDS., <http://www.fsmb.org/globalassets/advocacy/publications/us-medical-regulatory-trends-actions.pdf> (last visited Mar. 13, 2018) [hereinafter FED’N OF STATE MED. BDS.].

12. See *infra* Part II.C.

13. See also FED’N OF STATE MED. BDS., *supra* note 11, at 20 (showing how unlicensed practice remains prevalent even with the current amount of regulation involved).

14. See FED’N OF STATE MED. BDS., *supra* note 11, at 7 (showing state medical board data on unlicensed practice).

15. See FED’N OF STATE MED. BDS., *supra* note 11, at 19.

16. See *infra* Parts II.C–D.

17. See *infra* Part II.C.

18. See examples provided at notes 148–65 *infra*.

19. See FED’N OF STATE MED. BDS., *supra* note 11, at 20 (showing the prevalence of unlicensed practice).

20. See *e.g.*, *Jackson v. Conn. Dep’t of Pub. Health*, 3:15-CV-750 (CSH) 2016 WL 3460304, at *3 (D. Conn. June 20, 2016) (finding that the physician directly caused a delay in the patient receiving treatment with the physicians who diagnosed the tumor and this delay caused detrimental effects on the patient’s health).

Without a new system of deterrence, patients will continue to be injured. States currently regulate the practice of medicine through their respective Medical Practice Acts (MPA). In general, each state's MPA provides statutory enforcement to ensure public health and safety by keeping patients safe from unprofessional practices of medicine.²¹ However, the current prohibitions embodied in the MPA fail to effectively deter individuals, as evidenced by the number of violators who continuously practice without a license.²² Policymakers cannot deter this abuse in the healthcare system without implementing proper enforcement and oversight of the current regulations. Thousands of individuals violate their licensure or practice without a license each year; this is evidence of the need for proper enforcement.²³ Violators are finding new avenues for unlicensed practice daily, thus making the current enforcement futile.²⁴ Prior to an individual being injured, private citizens and the government have little incentive to proactively prevent unlicensed practice.²⁵ Thus, this practice will not be deterred without the implementation of such an incentive in state-created MPAs.

While the federal government has created financial incentive enforcements in the past, such as the False Claims Act (the FCA), the focus of these enforcements is typically based on claims that result in substantial financial harm to the government.²⁶ The FCA is a federal law that prevents individuals and companies from defrauding the government, and it is the primary tool in fighting fraud against the government.²⁷ The FCA provides a financial deterrence by authorizing private individuals to bring a lawsuit on behalf of the government and punish the violator that is defrauding the government.²⁸ Actions

21. See FED'N OF STATE MED. BDS., *supra* note 11.

22. See *infra* Part II.C and text accompanying notes 148–165.

23. See *infra* Part II.C.

24. See *infra* Part II.B.

25. *Whistleblowing History Overview*, WHISTLEBLOWERS INT'L, <https://www.whistleblowersinternational.com/what-is-whistleblowing/history/> (last visited Dec. 7, 2017) [hereinafter WHISTLEBLOWERS INT'L].

26. See *Universal Health Servs., Inc. v. United States*, 136 S. Ct. 1989 (2016); WHISTLEBLOWERS INT'L, *supra* note 25, at 2. The implementation of the FCA was justified for individuals who submit false or fraudulent claims because these types of claims have million-dollar reimbursements for the government. *Id.* Unlike unlicensed practice, which does not provide million-dollar reimbursements because the maximum penalty for it is ten thousand dollars. 225 ILL. COMP. STAT. 60/3.5(a) (2018).

27. 31 U.S.C. § 3730(b) (2012); Robert L. Vogel, *The False Claims Act and Its Impact on Medical Practices*, VOGEL, SLADE & GOLDSTEIN, LLP., <https://www.vsg-law.com/blog/the-false-claims-act-and-its-impact-on-medical-practices/> (last visited Mar. 13, 2018).

28. See Vogel, *supra* note 27.

brought by these private individuals are called qui tam suits.²⁹ The private individual, known as a “relator,” reports her findings to the government, and if the government chooses to join the suit, the relator will share a percentage of the damages recovered from the suit or settlement.³⁰ These recovery percentages range anywhere from fifteen to twenty-five percent of the proceeds.³¹ Such percentages provide million-dollar incentives that encourage relators to report physicians or companies that are defrauding the government.³² These financial incentives increase the likelihood of private individuals being willing to report, thus providing a deterrence for violators out of their fear of being reported.³³ Qui tam actions remain a strong deterrence for healthcare violations; in fact, qui tam actions under the FCA have recovered about \$40 billion.³⁴ However, the FCA focuses on catching fraudulent medical billing—not unlicensed practice.

Without implementation of an incentive system like that of the FCA, each state MPA continues to allow a high presence of unlicensed practice and zero incentive to report it. Considering the success of qui tam actions within the FCA as an incentive system to prevent fraud, employing qui tam actions in the MPA may provide the needed incentive to prevent unlicensed practice. Incorporating a qui tam action into the MPA could provide the necessary incentives for private individuals to report unlicensed practice and thus, deter violators from unlicensed practice out of their fear of being reported. The MPA qui tam could be a superior solution to unlicensed practice. By shifting the responsibility of preventing unlicensed practice from the federal and state government to private individuals, a more concentrated framework develops.³⁵ Private individuals could begin researching, investigating, and assisting in the prosecution of unlicensed practice and thus, better prevent unlicensed practice.³⁶ Yet, the government may not be willing to employ the qui tam action for the

29. WHISTLEBLOWERS INT’L, *supra* note 25, at 2.

30. See Vogel, *supra* note 27.

31. Vogel, *supra* note 27.

32. Vogel, *supra* note 27. With the largest private individual reward being \$100 million, private individuals are incentivized by the possibility of winning this amount, therefore will report the fraud. WHISTLEBLOWERS INT’L, *supra* note 25.

33. See Vogel, *supra* note 27.

34. B. Nathaniel Garrett, *Dodd-Frank’s Whistleblower Provision Fails to Go Far Enough: Making the Case for a Qui Tam Provision in a Revised Foreign Corrupt Practice Act*, 81 U. CIN. L. REV. 765, 771 (2012).

35. See, for example, the False Claims Act, 31 U.S.C. § 3730 (2012), discussed in Part II.E *infra*.

36. See WHISTLEBLOWERS INT’L, *supra* note 25 (stating the financial incentives given to private individuals for their information have been as steep as \$100 million).

MPA. Fraudulent billing causes extensive financial harm to the government, and the implementation of the FCA qui tams provides substantial financial reimbursement for the government, thus justifying its implementation.³⁷ The financial harm is the key justification in implementing qui tam actions.³⁸ Implementing the qui tam action for unlicensed practice would likely not be justified because unlicensed practice does not cause such extensive financial harm to the government relative to the harm from fraudulent billing.³⁹ Rather than harming the federal government, the harm from unlicensed practice is to the patients.⁴⁰ Under the MPA, any financial incentive to the government from qui tams would be considered insignificant when compared to the reimbursement provided by the FCA.⁴¹

So, what remedies are left for smaller claims, such as unlicensed practice, that may not meet the financial threshold of governmental harm needed to justify implementation of qui tam actions? The government does have an interest in proper healthcare, so how can the government incentivize private individuals to assist in the enforcement of the MPA, without qui tam-like awards? Incentives schemes for claims that are unattractive to the government, yet still hold a governmental interest, have been considered in other areas of law.⁴² Incentives such as prizes and patent rights are considered within the intellectual property debate. Intellectual property provides patent benefits for an individual's innovations by granting "intellectual property rights" and giving the individual the ability to charge "monopoly prices for [her] inventions."⁴³ However, patent incentives under the intellectual property system are "offset by the deadweight loss from allowing innovators to charge monopoly prices."⁴⁴ To correct the dead weight loss, academics have considered replacing the intellectual

37. WHISTLEBLOWERS INT'L, *supra* note 25.

38. See David Mitchell, *An Introduction to the False Claims Act*, 51 ARK. LAWYER, no. 3, 2016, at 27. The MPA "was originally enacted in 1863 in response to concerns that suppliers to the Union Army were defrauding the government." *Id.* Therefore, in order for qui tam actions to be implemented in an area of law, substantial financial harm to the government must be shown. *Id.*

39. FCA claims have million-dollar reimbursements for the government. See WHISTLEBLOWERS INT'L, *supra* note 25. Unlike unlicensed practice, which provides a maximum penalty of ten thousand dollars. 225 ILL. COMP. STAT. 60/3.5(a) (2018).

40. See, e.g., *Universal Health Servs., Inc. v. United States*, 136 S. Ct. 1989 (2016).

41. Compare WHISTLEBLOWERS INT'L, *supra* note 25 (explaining that FCA claims potentially yield million-dollar reimbursements for the government) with 225 ILL. COMP. STAT. 60/3.5(a) (providing a maximum civil penalty of ten thousand dollars for unlicensed practice).

42. See *infra* notes 283–299 for a discussion of the use of qui tam actions to enforce federal regulations in the housing and financial sectors.

43. Benjamin N. Roin, *Intellectual Property versus Prizes: Reframing the Debate*, 81 U. CHI. L. REV. 999, 1001 (2014).

44. *Id.*

property system with a prize system.⁴⁵ In this system, a prize is a “payment funded out of general revenue that is made to a[n] [individual] conditional on delivering a specified” action.⁴⁶ The incentives from these prize systems are the payouts that are based on the innovation’s social value.⁴⁷ The innovator receives these payouts, but the innovator does not retain the right to keep the innovation from the public and charge monopoly prices.⁴⁸ This sort of incentive scheme has been said to prevent pointless innovation payouts, thus providing “superior incentives for innovation.”⁴⁹ Yet, the debate over how to determine the payout price of these prizes is highly contested.⁵⁰ The concept of setting the “perfect” price for the prize—the “perfect” price being one that will recoup research costs while still benefiting the government—brings concerns of corruption and unfairness.⁵¹ Corruption may stem from how the government determines the prize price.⁵² The possibility of unfairness in the method the government uses to set the price, rather than allowing for private individuals to set the price, brings the risk of the government undervaluing the innovation.⁵³ However, these concerns are subsided due to regulations such as the Freedom of Information Act (FOIA).⁵⁴ Regulations like FOIA provide barriers to the possible corruption and unfairness conceivably present in the prize system.⁵⁵ FOIA would allow private citizens to investigate the basis of the government’s prize valuation and possibly challenge it, thus resolving concerns that could arise in setting the perfect price.

45. *Id.*

46. Nancy T. Gallini & Suzanne Scotchmer, *Intellectual Property: When Is It the Best Incentive System?*, 2 INNOVATION POL’Y & ECON. 51, 52 (2002).

47. Roin, *supra* note 43, at 1002.

48. Roin, *supra* note 43, at 1009–10.

49. *See* Roin, *supra* note 43, at 1003. Roin explains that pointless payouts are prevented in the prize system because the prize granted to the private individual for their innovation is quantified after the innovation is on the market and its social value is determined. Roin, *supra* note 43, at 1002. Whereas the intellectual property system quantifies the innovation prior to releasing it on the market. Roin, *supra* note 43, at 1002.

50. Roin, *supra* note 43, at 1006–07.

51. Roin, *supra* note 43, at 1027 (discussing the presence of government corruption in determining the value of the reward, explaining the government may purposely undervalue the innovation in order to prevent a high prize payout, but retain the benefit of the innovation).

52. *See* Roin, *supra* note 43, at 1018, 1027.

53. Shavell & Ypersele, *infra* note 208, at 541–42 (“consider[ing] how good innovators’ information is [about demand for the innovation in] . . . relation to the government’s”).

54. 5 U.S.C. § 552 (2012); FOIA, U.S. DEP’T JUSTICE, <https://www.foia.gov> (last visited Mar. 13, 2018).

55. FOIA is a regulation that allows private individuals to request access to government information. *See* FOIA, U.S. DEP’T JUSTICE, <https://www.foia.gov> (last visited Mar. 13, 2018). The regulation helps prevent government corruption by ensuring the government’s compliance with regulations. *Id.* This is ensured by providing transparency into government action and giving private individuals access to observe government action. *Id.*

The prize system is a valid incentive system for financially smaller claims like unlicensed practice. The system would provide an incentive to report unlicensed practice and thus, the fear of being scrutinized by patients would effectively deter violators. This Note extracts the prize argument from the intellectual property debate and applies it to unlicensed practice as an incentive system to motivate private individuals to report unlicensed practice.

This Note will analyze which enforcement system should be added to the Illinois MPA to prevent *ex ante* unlicensed practice. The analysis will compare which system will incentivize private individuals to get involved and which system is more likely to be implemented. First, this Note will discuss the forms of unlicensed practice and the current prevention measures under the Illinois MPA. Second, the focus will shift to the success of qui tam suits within the FCA by examining past qui tam suits. This discussion will then evaluate the derivative findings of unlicensed practice in these FCA qui tam suits and examine whether the FCA disproportionately focuses on false claim submissions in comparison to unlicensed practice, thus justifying the addition of qui tams to the MPA. Third, this Note will discuss the intellectual property debate between the patent system and the prize system. Afterwards, this Note will explain why remedies, such as higher civil damages or additional state funding, will not help prevent or deter unlicensed practice. This Note will go on to recommend and analyze whether the addition of qui tam actions to Illinois' MPA could act as a new barrier to unlicensed practice. Finally, this Note will recommend the addition of the prize system to the Illinois MPA and analyze the likely implications of this addition.

Part II provides: (1) history on the creation of the Illinois MPA; (2) an introduction of the current forms of unlicensed practice; (3) data on the number of claims brought for unlicensed practice in the U.S. and Illinois; (4) a description of the current prosecution practices under Illinois' MPA; (5) background information on the FCA, the FCA's impact, and current qui tam examples; and (6) background information on incentive schemes debated by intellectual property academics.

Part III will discuss alternative remedies to unlicensed practice and why they are inadequate. Next, Part III will explore how adding qui tam actions to Illinois' MPA could provide a better solution to preventing unlicensed practice when compared to the current qui tam actions under the FCA. Finally, Part III will explain why the prize incentive system would motivate private individuals to report unlicensed practice, and therefore is the best solution for preventing unli-

censed practice. Lastly, Part IV of this Note will discuss possible critiques and the advantages and disadvantages of implementing the prize system for the MPA.

II. BACKGROUND

This section provides an overview of the history behind the Illinois MPA and a brief description of its sections. It will then go on to highlight the types of unlicensed practice in today's society, while exploring its emerging avenues. Afterwards, this section will provide a summary of data showing the prevalence of unlicensed practice in Illinois. Next, this Part will describe what constitutes unlicensed practice in Illinois under the MPA and examine the current success of prosecuting unlicensed practice. Thereafter, this section will discuss the history of the FCA and provide examples of its failed attempts at catching unlicensed practice in a timely manner. Finally, this Part will explore the background of incentive schemes within intellectual property with a concentration on the prize system.

A. *History of Illinois' MPA*

Prior to the MPA, any individual had the ability to practice medicine. In fact, prior to the 1900's, officials estimated that 3,600 of the physicians practicing in Illinois were not graduates from any medical school.⁵⁶ Simply putting up a sign on the outside of an office or even a house deemed the individual as licensed to practice.⁵⁷

By 1900, almost every state passed its own MPA to enforce licensed medical practice.⁵⁸ Distinctively, Illinois' MPA gave broad enforcement powers to the Illinois Board of Health (Illinois Board). For example, while some states only required an individual to register with local authorities in order to practice medicine, Illinois created the Illinois Board and gave it extensive authority. This board was tasked with strictly regulating all types of physicians; testing applicants; creating and implementing necessary policies; and enforcing policies upon applicants and physicians.⁵⁹ After the passage of the MPA, an estimated 1,400 unlicensed individuals fled Illinois in order to avoid prosecution.⁶⁰ Such action was largely due to the complaints that were re-

56. Clinton Sandvick, *Enforcing Medical Licensing in Illinois: 1877-1890*, 82 *YALE J. BIOLOGY & MED.* 67, 69 (2009).

57. *Id.* at 67.

58. *Id.*

59. *See id.* at 68-69.

60. Sandvick, *supra*, note 56, at 69.

ported to the Illinois Board by private individuals and by other physicians.⁶¹

The effort to stop unlicensed practice quickly failed when individuals and physicians began maliciously accusing other professionals of false allegations, and when unlicensed individuals found loopholes in the licensing system.⁶² In an effort to build back trust, the Illinois Board created “quasi-judicial hearings.”⁶³ These hearings provided a fast-track route to investigating and resolving accusations against physicians. However, the system was infiltrated once again when individuals unlawfully practiced under false identities to prevent being reported. In looking for monetary opportunities, these individuals inhumanely took advantage of vulnerable classes by providing astonishingly inadequate medical care.⁶⁴

The MPA provides that the Illinois Department of Financial and Professional Regulation (IDFPR), as it operates today, shall: (1) make standards of education requirements; (2) effectuate policies of medicine to ensure quality medical training in licensing; and (3) formulate rules for administration of the MPA.⁶⁵ Moreover, IDFPR was given the authority to prosecute disciplinary actions on licenses such as revocation, suspension, probation, and any other action IDFPR deems proper.⁶⁶ Within the IDFPR, there is a Complaint Committee responsible for investigating and prosecuting complaints against physicians.⁶⁷ Additionally, there is a Medical Licensing Board composed of seven members, five of which are licensed physicians.⁶⁸ The Medical Licensing Board reviews policies regarding licensure, examination, and promulgation of rules.⁶⁹ These provisions allow IDFPR to assist Illinois in actively thwarting unlicensed practice.

In the hopes of being able to prosecute more violators, Illinois expanded the definition of “licensed practice” to provide more avenues of prosecution and close the loopholes in the licensing system.⁷⁰ Today, the licensure requirement states that professionals shall not practice any branch of medicine to treat human ailments without a valid

61. Sandvick, *supra*, note 56, at 69.

62. Sandvick, *supra*, note 56, at 69.

63. Sandvick, *supra*, note 56, at 69.

64. Sandvick, *supra*, note 56, at 71–72.

65. 225 ILL. COMP. STAT. 60/10 (2018).

66. 225 ILL. COMP. STAT. 60/22 (2018).

67. See 225 ILL. COMP. STAT. 60/7.5 (2018) (allowing the Board to do all the following: recommend a complaint to be closed, refer a complaint for review, and make a decision regarding action to be taken on a complaint file).

68. 225 ILL. COMP. STAT. 60/8(A) (2018).

69. 225 ILL. COMP. STAT. 60/8(F) (2018).

70. Sandvick, *supra*, note 56, at 72.

and active license.⁷¹ The Illinois MPA states that any individual who practices, attempts to practice, or offers to practice medicine without a license shall be subject to civil penalties and any other penalty provided by law.⁷² The Illinois MPA employs the term “medicine” as to include “curative or remedial” care or processes such as “the healing art” and “the science preserving health and treating disease for the purpose of cure—whether such treatment involves the use of medical substances or not.”⁷³ The term “practice” is used to mean the “exercise of a calling or profession which is the application of science or knowledge to the wants of men in the recurring incidents of life.”⁷⁴ However, broadening the meaning of the practice of medicine to include more violators remains ineffective, as new forms of unlicensed practice emerge.⁷⁵

B. *What Are the Forms Unlicensed Practice Can Take?*

Many states differ in which forms of licensed practices are regulated under their respective MPA and the standards that apply.⁷⁶ For example, there are varying laws for “corporate medicine” and “delegation of medicine.”⁷⁷ While there is no set definition of corporate medicine, it is typically used to describe when a hospital, or healthcare organization, manages the practice of medicine. Hospitals can practice corporate medicine by exercising too much control over the physicians, which affects the manner in which medicine is delivered to patients.⁷⁸ Hence, “corporate practice” is essentially when a corporation “indirectly practices” medicine with a licensed physician.⁷⁹ In Illinois, corporate practice is not prohibited by the MPA, as it broadly states, “[n]othing in this Act prohibits . . . entities authorized by law to employ physicians from also employing other licensed healthcare workers”⁸⁰ However, some states have found corporate practice

71. 225 ILL. COMP. STAT. 60/50 (2018).

72. *Id.*

73. *People v. Barnett*, 240 Ill. App. 357, 361 (1926) (quoting *People ex rel. Gage v. Siman*, 115 N.E. 817, 818 (1917); see also 225 ILL. COMP. STAT. 60/50).

74. *People v. Blue Mountain Joe*, 129 Ill. 370, 377 (1889).

75. See *infra* Part II.B.

76. *Telehealth & Multi-State Physician Licensure: Don't Get Caught in the Tangled Web of Inconsistent and Troublesome State Physician Licensure Laws*, INTERMOUNTAIN HEALTHCARE, https://www.hcca-info.org/Portals/0/PDFs/Resources/Conference_Handouts/Compliance_Institute/2016/111print2.pdf (last visited Dec. 1, 2017) [hereinafter INTERMOUNTAIN HEALTHCARE].

77. *Id.*

78. Michael E. Schaff & Glenn P. Prives, *The Corporate Practice of Medicine Doctrine: Is it Applicable to Your Client?*, AHLA BUS. LAW & GOVERNANCE PRACTICE GRP., May 2010, at 2.

79. *Id.*

80. 225 ILL. COMP. STAT. 60/22.3 (2018).

provisions constitute unlicensed practice of medicine because the unlicensed entity or individual is camouflaged by a business, and in effect uses the benefits of another individual's license.⁸¹ Under the Illinois MPA, corporate practice, however permitted, can amount to unlicensed practice when used incorrectly.⁸² In a publication by the American Health Lawyers Association, Michael E. Schaff and Glenn P. Prives provide guidance on corporate practice of medicine with the following example: C is a licensed chiropractor and P is a licensed physician and they agree to form an LLC together. C is responsible for running the day-to-day business operations while P provides treatment and supervision. C exercises control over all of the company's affairs, including medical matters. The limited control that P has creates the appearance of control, but it could be argued that P is a mere employee. Consequently, P does not have the power to control the medical matters of the company, which violates the MPA for corporate practice of medicine because C is not a physician and C has control over medical matters.⁸³

Third parties that conduct business with the hospital can also be charged with unlicensed corporate practice if their control affects the medical matters of the hospital.⁸⁴ Violations involving third parties can also be termed as the "aiding and abetting" of unlicensed practice.⁸⁵ The aiding and abetting provision in Illinois' MPA prohibits physicians from allowing unlicensed individuals to practice.⁸⁶ The aiding and abetting of unlicensed practice and the corporate practice of medicine can occur when a corporation has majority control over the hospital that employs licensed physicians.⁸⁷ Another example of aiding and abetting occurs when a management services corporation contracts with a physician's organization to treat patients.⁸⁸ Physician organizations often construct such agreements with management services because they assist the physicians in securing employment with a

81. Schaff & Prives, *supra* note 78, at 2.

82. 225 ILL. COMP. STAT. 60/22.3.

83. Schaff & Prives, *supra* note 78, at 4–5.

84. *Corporate Practice of Medicine*, MED. BD. OF CAL. (Jan. 29, 2015), http://www.mbc.ca.gov/Licensees/Corporate_Practice.aspx [hereinafter MED. BD. OF CAL.].

85. See Louis Fine, *Beware of "Aiding and Abetting" the Unlicensed Practice of Medicine*, LAW OFFICE OF LOUIS R. FINE, <http://www.lrlaw.com/beware-of-aiding-and-abetting-the-unlicensed-practice-of-medicine/> (last visited Oct.16, 2017).

86. MED. BD. OF CAL., *supra* note 84.

87. MED. BD. OF CAL., *supra* note 84. When an unlicensed corporate officer has the power to make business decisions that influence a licensed physician's medical decisions, the corporate officer is said to be practicing medicine without a license. And by complying to the business decisions, the physician is aiding and abetting the unlicensed practice of medicine.

88. MED. BD. OF CAL., *supra* note 84.

hospital.⁸⁹ A management corporation will typically consist of non-physicians, who receive a fee or a portion of the physician organization's profits in return for securing employment contracts with hospitals for the physicians.⁹⁰ So far, the described arrangement is legal under the MPA; however, if the management corporation mistakenly retains 50% of the physician organization's profits, the arrangement constitutes unlicensed practice of medicine.⁹¹ This form of unlawful practice can continue if the management corporation uses the physicians' licenses to conduct business with other companies or if the corporation becomes involved in selecting medical staff for hospitals.⁹² This level of impermissible control emerges into a situation analogous to an employer-employee relationship and constitutes unlicensed practice of medicine.⁹³ The aiding and abetting provision is necessary because arrangements controlling more than 50% of a physician's corporation's profits typically lead to a physician's inability to control her own practice, thereby increasing the likelihood that the management company will unduly influence the physician's judgment.⁹⁴ Additionally, this unlawful situation can lead to derivative conflicts of interest for the physician's patients.⁹⁵ Moreover, from a policy standpoint, this type of unlawful practice of medicine is prohibited because it is "incongruous in the workings of a professional regulatory licensing scheme which is based on personal qualification, [personal] responsibility and [personal] sanction."⁹⁶ In theory, preventing a management company from obtaining a majority of profits from a physician's practice may seem avoidable; however, in practice, this is more complicated.⁹⁷

In accordance with aiding and abetting medical practice, the legal authorization to "delegate" medical tasks to assistants, nurses, or other employees can be lawful to a certain extent.⁹⁸ Delegation occurs when a licensed individual, acting within the scope of their individual

89. Medical Board of California, *Corporate Practice of Medicine Presentation*, YOUTUBE (July 18, 2016), <https://youtu.be/OUEN-nYLomo> [hereinafter *Corporate Practice of Medicine Presentation*].

90. *Cf. Kalechstein v. Abbassian*, No. 15C5929, 2017 WL 3394721 (N.D. Ill. Aug. 8, 2017) (showing a professional organization improperly permitting fee sharing between a physician and a non-physician).

91. MED. BD. OF CAL., *supra* note 84.

92. MED. BD. OF CAL., *supra* note 84.

93. MED. BD. OF CAL., *supra* note 84.

94. MED. BD. OF CAL., *supra* note 84.

95. MED. BD. OF CAL., *supra* note 84.

96. *Corporate Practice of Medicine Presentation*, *supra* note 89 (quoting 65 Ops. Cal. Atty. Gen. 223, 225 (1982)).

97. *Corporate Practice of Medicine Presentation*, *supra* note 89.

98. Fine, *supra* note 85.

license, assigns a medical task to an unlicensed individual.⁹⁹ The Illinois MPA limits the forms that delegations of medical practice can take. For example, the MPA regulates prescription dispensing, stating the dispensing must be “the personal act of the person licensed under this Act and may not be delegated to any other person not licensed under this Act . . . unless such delegated dispensing functions are under the direct supervision of the physician. . . .”¹⁰⁰ However, when a physician chooses to delegate they must sufficiently supervise, remain aware of *whom* they are delegating to, and remain aware of *what* they are delegating.¹⁰¹ Delegation of patient care tasks to unqualified or unsupervised individuals is prohibited, and some tasks like diagnosis, treatment planning, and prescribing can never be delegated—supervised or not.¹⁰² Delegating does not constitute unlicensed practice as long as the delegator assigns tasks that are within the delegatee’s title of employment.¹⁰³ Physicians that hire unlicensed healthcare professionals often make mistakes when delegating medical tasks.¹⁰⁴

In addition, exceeding the scope of a physician’s license is likely to occur due to new inventions of healthcare access and treatments like telemedicine, crowdsourcing, and controlled substances.¹⁰⁵ For example, exceeding the scope of a license can occur either by purposefully or accidentally overprescribing or by fraudulently prescribing a controlled substance.¹⁰⁶ Overprescribing and fraudulently prescribing clearly exceed the scope of a physician’s license, and thus constitute unlicensed practice.

Exceeding the scope of a license can be less obvious when physicians falsely represent themselves as a different type of physician and when physicians give medical advice to patients on medical proce-

99. 225 ILL. COMP. STAT. 60/54.2 (2018).

100. 225 ILL. COMP. STAT. 60/33 (2018).

101. Fine, *supra* note 85.

102. Fine, *supra* note 85.

103. Fine, *supra* note 85.

104. *Use of Unlicensed Healthcare Personnel*, OR. MED. BD., <http://www.oregon.gov/omb/board/philosophy/Pages/Use-of-Unlicensed-Healthcare-Personnel.aspx> (last visited Mar. 13, 2018).

105. 225 ILL. COMP. STAT. 60/49.5 (2018); 225 ILL. COMP. STAT. 60/33 (2018); *Crowdsourcing Medicine?*, STANFORD LAW SCH. BLOGS: LAW & BIOSCIENCES BLOG, <https://law.stanford.edu/2015/04/23/lawandbiosciences-2015-04-23-crowdsourcing-medicine/> (last visited Oct. 16, 2017).

106. 225 ILL. COMP. STAT. 60/33 (permitting physicians to prescribe drugs in the ordinary course of practicing medicine and to dispense them in good faith, thus prohibiting acts such as overprescribing medicine, inferring from which would be exceeding the scope of one’s license); *see also* *Olefsky v. Ill. Dep’t of Fin. & Prof’l Regulation*, No. 1-15-2842, 2016 WL 7380548 (Ill. App. Ct. Dec. 16, 2016) (holding a physician liable for fraudulently filling prescriptions).

dures that they are not licensed to perform.¹⁰⁷ While false representations are frequently a result of differing opinions in medical studies, innocently advising on procedures that are outside a physician's knowledge of practice amounts to unlicensed practice of medicine.¹⁰⁸ Two areas of growth in such unlicensed practice include providing Botox injections and laser hair removal services to patients.¹⁰⁹ Additionally, technological developments in telemedicine continue opening dangerous avenues to aiding and abetting unlicensed practice. In nearly all states, including Illinois, physicians must have a license in each state they intend to practice.¹¹⁰ However, with the advancement of telemedicine, medical practice has moved towards permitting the practice of medicine across state lines.¹¹¹ But, each state has varying statutory and licensing requirements. The variance of requirements is important to acknowledge when trying to ensure enforcement of MPA provisions throughout the healthcare system. Telemedicine poses problems due to the varying definitions of the "practice of medicine" across states.¹¹² Additionally, each state has a medical board that imposes differing standards of conduct on physicians.¹¹³

Above all, the expanding avenues of unlicensed practice imposes the harshest backlash on vulnerable classes of patients. Certain classes of patients face risks with violators because of the circumstances they are placed in, thus imposing a susceptibility to violators of the licensing system.¹¹⁴ These vulnerable classes include psychological patients, immigrant patients, and patients requiring pharmaceuticals. Psychological patients are susceptible because they put an immense amount of trust into their physician's hands—more trust than with a general

107. *Phillips v. Ill. Dep't of Fin. & Prof'l Regulation*, No. 1–15–1284, 2016 WL 1066075 (Ill. App. Ct. Mar. 16, 2016).

108. *Id.*

109. Pablo Lopez, *Fresno doctor, three nurses in trouble for Botox injections and laser hair removal*, THE FRESNO BEE, <http://www.fresnobee.com/news/local/crime/article119849728.html> (last visited Mar. 13, 2018).

110. 225 ILL. COMP. STAT. 60/3 (2014); *see also* FED'N OF STATE MED. BDS., *supra* note 11, at 5–6.

111. INTERMOUNTAIN HEALTHCARE, *supra* note 76.

112. INTERMOUNTAIN HEALTHCARE, *supra* note 76.

113. INTERMOUNTAIN HEALTHCARE, *supra* note 76.

114. *See, e.g., Senno v. Dep't of Healthcare & Family Serv's*, 44 N.E.3d 1123, 1126 (Ill. App. 2015) (charging a physician with seven counts of: inadequately treating a patient with congestive heart failure; inadequately managing a patient with diabetes mellitus; prescribing antibiotics without any clinical indication; improperly evaluating a patient with urethral discharge; improperly prescribing medications; not addressing abnormal lab results; and not evaluating a patient with a possible ulcer while the patient was taking nonsteroidal drugs).

practitioner.¹¹⁵ Immigrants are especially susceptible to individuals maneuvering around the licensing system. Immigrant patients are often forced to avoid the healthcare system out of fear of deportation, thus turning to healthcare offered under the radar.¹¹⁶ Faced with limited access to physicians, immigrants may lack knowledge of whether the physician they turn to is properly licensed and whether the procedures used are safe.¹¹⁷ Consequently, these patients are unknowingly settling for care delivered by unlicensed physicians.¹¹⁸ Even more, unlicensed physicians charge these vulnerable patients more than what they would pay for traditional care.¹¹⁹ While these violators are providing a higher quality of care to these patients than they would get without seeking treatment, the lack of proper licensure places these patients in danger.¹²⁰ Providing licensed practice to these patients must be achieved in order to prevent patients from being injured.

C. *Data on Unlicensed Practice in the U.S. and Illinois*

Currently, the MPA is attempting to prevent unlicensed practice by providing broad powers for prosecution.¹²¹ The IDFPR has successfully prosecuted many violators, yet its efforts to take a proactive step in unlicensed practice and deter it remain unsuccessful. This begs the question—How must the MPA be changed to better deter unlicensed practice? Current enforcement measures for violation of the MPA include “termination of license, revocation, suspension, probation, reprimand, and censure.”¹²² During the month of July 2015, IDFPR reprimanded forty individuals for violating their license under the

115. See, e.g., *Reddy v. Dep’t of Prof’l Regulation*, 785 N.E.2d 876 (2002) (holding a physician liable for “pronouncing his love” for his patient during a private therapy session to treat multiple mental health issues); *Ikpoh v. Dep’t of Prof’l Regulation*, 789 N.E.2d 442, 445 (2003) (discussing what the permissible reprimands are on a physician’s license who is convicted of sexual misconduct with his patients).

116. Jan Hoffman, *Sick and Afraid, Some Immigrants Forgo Medical Care*, N.Y. TIMES (June 26, 2017), <https://www.nytimes.com/2017/06/26/health/undocumented-immigrants-health-care.html>; Eric Boodman, *After Trump’s Immigration Crackdown, A Desert Clinic Tried to Save Lives Without Breaking the Law*, STAT NEWS (July 6, 2017), <https://www.statnews.com/2017/07/06/immigration-desert-clinic/>.

117. Hoffman, *supra* note 116; Jennifer Steinhauer, *For Many Immigrants, a Health Care System Underground*, N.Y. TIMES (Aug. 20, 2000), <https://www.nytimes.com/2000/08/20/nyregion/for-many-immigrants-a-health-care-system-underground.html>.

118. Steinhauer, *supra* note 117.

119. Steinhauer, *supra* note 117.

120. Steinhauer, *supra* note 117.

121. ILL. COMP. STAT. 60/3.5 (2018).

122. *Statewide Enforcement Section*, ILL. DEP’T OF FIN. & PROF’L REGULATION, <https://www.idfpr.com/DPR/DPRSWE.asp> (last visited Mar. 13, 2018).

MPA.¹²³ The types of violations included: (1) prescribing controlled substances to a patient without proper evaluation and documentation; (2) practicing with deficiencies in skill, knowledge, and judgment; (3) committing healthcare or Medicare fraud; (4) executing a scheme to obtain money from healthcare programs by submitting services that were not performed; (5) putting minor patients in danger; (6) performing surgery on incorrect body parts; (7) practicing with a debilitating mental and physical illness; (8) delegating improperly; (9) practicing medicine while under the influence; (10) failing to oversee prescription medications; and (11) having improper relations with patients.¹²⁴

On average, IDFPR reprimands 30 individuals per month.¹²⁵ During the past eight years, physician prosecution has remained prevalent without fluctuating.¹²⁶ There are about 4,000 to 4,500 physician prosecution actions in the U.S. per year.¹²⁷ In 2015, there were a total of 1,238 individuals whose licenses were restricted, 655 individuals who were put on probation, 594 individuals who were suspended, and 267 individuals whose licenses were revoked.¹²⁸ When a license has been restricted that means the physician's ability to practice medicine is limited (i.e., the physician loses prescribing privileges).¹²⁹ A license being put on probation is due to the need for the physician to be monitored for a specified period.¹³⁰ This probation data presented is not solely from unlicensed practice because probation is also an appropriate punishment for individuals committing Medicare fraud.¹³¹ Yet, the data presented in this section still exemplifies how prevalent unlicensed practice is.

D. *The Current Structure of MPA Prosecution*

The current Illinois MPA provides a straightforward process of prosecuting a complaint; however, it lacks any incentive to prompt individuals to report a complaint. Once a private individual chooses to

123. News, ILL. DEP'T OF FIN. & PROF'L REGULATION, 8–11 https://www.idfpr.com/Forms/DISCIPLN/2015_07enf.pdf (last visited Mar. 13, 2018).

124. *Id.*

125. *Cf. id.* In January 2017, the IDFPR reprimanded twenty-six individuals. *Id.* at 9–11. In February 2017, twenty-four individuals. *Id.* at 15–17. In March 2017, twenty-eight individuals. *Id.* at 19–21. In December 2017, thirty-seven individuals. *Id.* at 18–21. In January 2018, thirty-six individuals. *Id.* at 10–13.

126. See FED'N OF STATE MED. BDS., *supra* note 11, at 19–23.

127. FED'N OF STATE MED. BDS., *supra* note 11, at 19–23.

128. FED'N OF STATE MED. BDS., *supra* note 11, at 19–23.

129. FED'N OF STATE MED. BDS., *supra* note 11, at 19–23.

130. FED'N OF STATE MED. BDS., *supra* note 11, at 19–23.

131. FED'N OF STATE MED. BDS., *supra* note 11, at 19–23.

file a complaint, the IDFPR analyzes the alleged violation using the MPA to decide what the occurrence was and whether the occurrence was in fact the unlawful practice of medicine.¹³² Private individuals typically learn about the unlicensed practice once they research the physician's credentials and background.¹³³ Patients should check a physician's qualifications to ensure that the physician they choose is reputable. Individuals can check a physician's qualifications through their respective state's website.¹³⁴ Medical Boards typically include websites known as "physician profiles" and provide records for violators that have been prosecuted in the past.¹³⁵ The first indication of a problem the individual should note is whether their physician is not on the website or has a prior history of prosecution.¹³⁶ Another important step for patients to take in evaluating their healthcare provider is to play an active role in their care.¹³⁷ Being active includes asking questions about your health and the physician's suggested route for care. The physician should be able to provide extensive information about the procedure and why the procedure is the recommended route.¹³⁸ A lack of reasoning for the recommended route is another red flag in considering what physician to choose.

Once reported, the IDFPR first determines whether the occurrence would constitute grounds for discipline under the MPA, in other words whether it is the "practice of medicine."¹³⁹ After determining that the occurrence was the unlawful practice of medicine, the IDFPR must then put the accused on notice of the alleged transgression and that hearings will follow.¹⁴⁰ If the IDFPR can prove by clear and convincing evidence that the accused violated the MPA, the IDFPR can employ various disciplinary actions.¹⁴¹ Generally, the IDFPR will order a cease and desist of the unlicensed practice and charge a civil penalty.¹⁴² However, the civil penalty for an offense may not exceed ten thousand dollars.¹⁴³ Additionally, the MPA permits information

132. 225 ILL. COMP. STAT. 60/22 (2018).

133. FED'N OF STATE MED. BDS., *supra* note 11, at 9.

134. FED'N OF STATE MED. BDS., *supra* note 11, at 9.

135. FED'N OF STATE MED. BDS., *supra* note 11, at 9.

136. FED'N OF STATE MED. BDS., *supra* note 11, at 9.

137. FED'N OF STATE MED. BDS., *supra* note 11, at 9.

138. FED'N OF STATE MED. BDS., *supra* note 11, at 9.

139. 225 ILL. COMP. STAT. 60/22 (2018); *see also* 225 ILL. COMP. STAT. 60/9(B)(4) (2018) ("The Licensing Board may condition or restrict any license, subject to the same terms and conditions as are provided for the Disciplinary Board under Section 22 of this Act.").

140. 225 ILL. COMP. STAT. 60/36 (2018).

141. 225 ILL. COMP. STAT. 60/22; *Reddy v. Dep't of Prof'l Regulation*, 785 N.E.2d 876, 877 (2002); *Ikpoh v. Dep't of Prof'l Regulation*, 789 N.E.2d 442, 445 (2003).

142. 225 ILL. COMP. STAT. 60/22; *Reddy*, 785 N.E.2d at 878 (2002); *Ikpoh*, 789 N.E.2d at 445.

143. 225 ILL. COMP. STAT. 60/3.5(a) (2011).

from the proceedings to be disclosed to federal, state, or local law enforcement agencies; therefore, subsequent criminal or civil actions against the accused may follow.¹⁴⁴ If those proceedings do follow, the court may impose criminal and civil charges on the individual after hearing the case.¹⁴⁵ The charged individual also has the ability to appeal IDFPR's findings to federal, state, or local law enforcement agencies either to reverse the IDFPR findings or to adjust the severity of the sanctions.¹⁴⁶ The Illinois MPA has dedicated a great amount of effort towards stopping unlicensed practice; however, the goal of exclusively licensed medical practice remains sought after.

The regulations discussed above are not deterring unlicensed practice. For example, in *Reddy v. Department of Professional Regulations*, a doctor professed his love for his patient during a treatment session, moved her into his home, and married the patient.¹⁴⁷ The physician was treating the woman for various mental health issues.¹⁴⁸ The IDFPR instituted a complaint against the physician under the MPA seeking to sanction him for the misconduct.¹⁴⁹ In this case, it was clear to the IDFPR and the court that the physician's behavior was unethical, unprofessional, and exceeded the scope of his license.¹⁵⁰ However, the physician's license was only placed on probation for six months with minor restrictions of the physician's practice.¹⁵¹

Another example occurred in 2016, in *Jackson v. State of Connecticut Department of Public Health*.¹⁵² The plaintiff claimed she held a license through the "American Medicine Licensing Board, Inc."¹⁵³ She claimed this licensing board was "'an organization authorized by the United States Patent and Trademark Office to license an individual as a Doctor of Medicine, N.D.," which had registered a certification mark, "Doctor of Medicine," with the United States Patent and Trademark Office.¹⁵⁴ The "Medicine" Board issued licenses to individuals,

144. 225 ILL. COMP. STAT 60/36(e) (2014) ("All information gathered by the Department during its investigation . . . shall be kept for the confidential use . . . except that the Department may disclose information and documents to a federal, State, or local law enforcement agency . . .").

145. *Reddy*, 785 N.E.2d, at 877.

146. 225 ILL. COMP. STAT 60/41 (2014).

147. *Reddy*, 785 N.E.2d, at 877.

148. *Id.*

149. *Id.*

150. *See id.* at 879.

151. *Id.* at 877 (inferring that, after six months, the physician can continue his or her unlicensed practice).

152. *Jackson v. Conn. Dep't of Pub. Health*, 3:15-CV-750 (CSH) 2016 WL 3460304, at *1 (D. Conn. June 20, 2016).

153. *Id.*

154. *Id.* at *3.

like the plaintiff, for diagnosing ailments, treating patients, and practicing alternative medicine.¹⁵⁵ The plaintiff undertook treatment of a patient with a brain tumor, and the plaintiff directly caused a delay in the patient receiving treatment with the physicians who diagnosed the tumor.¹⁵⁶ This delay caused the patient's tumor to increase in size, producing detrimental effects on the patient's health.¹⁵⁷ The Connecticut Department of Public Health began an investigation of the plaintiff in 2013; however, the plaintiff then brought suit demanding the investigation end.¹⁵⁸ The court held the plaintiff was not entitled to her license simply due to the trademark and the plaintiff failed to comprehend that the trademark is not a license for her to practice medicine.¹⁵⁹ The court then dismissed plaintiff's claims and provided no additional oversight of the plaintiff to ensure her practice no longer continued.¹⁶⁰ Thus, with only a six-month suspension, physicians are likely not fearful of unlicensed practice prosecution.

Further, in 2016, in *Wen Xuan v. Illinois Department of Financial and Professional Regulation*, an acupuncturist appealed IDFPR's charge of unlicensed practice of medicine.¹⁶¹ The plaintiff exceeded the scope of his acupuncturist license by representing himself as a medical doctor on his business card, stationery, billing statements, and office signage.¹⁶² He suggested to one patient to stop taking medically prescribed drugs for congestive heart failure, high blood pressure, and a heart arrhythmia.¹⁶³ The IDFPR and a civil court sanctioned appropriate fines for the individual. However, the MPA prosecutorial process lasted for five years, meaning that during this time the plaintiff was able to continue his practice.¹⁶⁴ This exemplifies that the current MPA does not prevent *ex ante* unlicensed practice. In *Reddy*, *Wen Xuan*, and *Jackson* the plaintiffs were not deterred from their unlicensed practice.

155. *Id.*

156. *Id.*

157. *Id.* at *3.

158. *Jackson*, 2016 WL 3460304, at *3–4.

159. *Id.* at *19.

160. *Id.*

161. *Xuan v. Ill. Dep't. of Fin. & Prof'l Regulation*, No. 1-14-3949, 2016 WL 5724222, at *1 (Ill. Ct. App. Sept. 30, 2016).

162. *Id.*

163. *Id.* at *2–3.

164. *Id.* at *1–4.

E. The History and Breakdown of the False Claims Act

In 1863, the False Claims Act (the FCA) was enacted due to concerns throughout the Civil War that suppliers were defrauding the government.¹⁶⁵ In the face of a growing federal deficit and fears of contractors defrauding the government, Congress amended the FCA and created incentives by allowing private individuals to bring their own actions against fraudsters.¹⁶⁶ When a private individual brings a claim against an alleged violator, the action is called a *qui tam* action. The term *qui tam* is short for “*qui tam pro domino rege quam pro se ipso in hac parte sequitur*,” meaning, “he who prosecutes for himself as well as for the King.”¹⁶⁷ In 1986, the FCA implemented *qui tam* actions for healthcare as one of the biggest steps toward combatting fraud in federally funded programs.¹⁶⁸ Congress created the *qui tam* action in response to the government lacking the proper oversight capabilities to prevent corrupt actors from financially harming the government by taking healthcare funds that the government had provided to programs.¹⁶⁹ *Qui tam* actions provide an incentive for private individuals to share their information with the government. The *qui tam* also allows the government to return billions of dollars to the healthcare programs.¹⁷⁰

165. See Mitchell, *supra* note 38, at 27. States also have their own FCA *qui tam* actions. See, e.g., 740 Ill. Comp. Stat. 175/1 et seq. (2018).

In 1991, the State of Illinois adopted the Illinois False Claims Act . . . its own version of the federal False Claims Act. . . . The Illinois FCA prohibits false claims against the State of Illinois and allows private individuals who know about fraud against the Illinois state government to bring a *qui tam* case against the offending party on behalf of the State. Like the FCA, the Illinois FCA offers financial rewards. . . . If the State decides to intervene in a case, the whistleblower may receive 15-25% of the recovery. If the State does not intervene and the whistleblower pursues the case on their own, they may receive 25-30% of any eventual recovery.

Illinois False Claims Act, BERGER MONTAGUE, PC, <https://bergermontague.com/illinois-false-claims-act/> (last visited Oct. 5, 2018). “The State of Illinois has its own False Claims Act, which generally follows the provisions of the federal law. . . .” *Qui Tam*, CHI. OVERTIME LAW CTR., <https://www.chicagovertime.com/qui-tam.html> (last visited Oct. 15, 2018). With this in mind, the scope of this article will be discussing the FCA within the federal government context.

166. See *Riley v. St. Luke’s Episcopal Hosp.*, 252 F.3d 749, 751 (5th Cir. 2001).

167. See WHISTLEBLOWERS INT’L, *supra* note 25, at 2 (italics omitted).

168. Saskia de Melker, *Top Payouts to Federal False Claims Whistleblowers in Fiscal Year 2014*, PUB. BROAD. SYS. (Dec. 21, 2014, 1:24 PM), <http://www.pbs.org/newshour/updates/fortune-fraud-top-5-biggest-payouts-federal-whistleblowers-2014>; Mark S. David, *The Effects of False Claims Act Whistleblowers on the Pharmaceutical Industry*, DIG. ACCESS TO SCHOLARSHIP AT HARVARD, <https://dash.harvard.edu/bitstream/handle/1/8965590/Davis06.pdf?sequence=1> (last visited Oct. 16, 2017).

169. See WHISTLEBLOWERS INT’L, *supra* note 25, at 6–7.

170. See Mitchell, *supra* note 38, at 27.

The FCA focuses on claims for Medicare and Medicaid violations, Anti-Kickback Statute, Stark Law, up-coding, and submitting claims for services that were not rendered.¹⁷¹ These all involve fraudulent billing. The FCA imposes liability on:

[A]ny person who—

(A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;

(B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;

(C) conspires to commit a violation of subparagraph (A), (B), (D), (E), (F), (G);

. . . or

(G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government.¹⁷²

The FCA has remained significant in its scope through amendments such as the Patient Protection and Affordable Care Act of 2010 (the ACA).¹⁷³ In recent years, the ACA has aggressively targeted health-care abuse.¹⁷⁴ In fact, the *qui tam* has accounted for \$40 billion recovered under the FCA, and in 2011 alone \$4 billion was recovered.¹⁷⁵ Claims against alleged violators can be brought by either the Department of Justice, private individuals, or both.¹⁷⁶ When a private individual brings a *qui tam* claim, they are given the title *relator*.¹⁷⁷ The relator will stand in place of the government and file a complaint. An individual must file the complaint in compliance with three requirements: (1) the individual filing the claim is the “original source” of the knowledge of the alleged fraud; (2) the individual filing the claim is the first to file the claim; and (3) the alleged fraud has not already been publicly disclosed.¹⁷⁸ The complaint will remain under seal and the government will investigate the claim for sixty days to determine whether to intervene and join the case.¹⁷⁹ After the investigation is complete, the government can either “(i) intervene in the case and

171. Mitchell, *supra* note 38, at 27.

172. 31 U.S.C. § 3729(a)(1) (2012).

173. See Mitchell, *supra* note 38, at 27.

174. Mitchell, *supra* note 38, at 27.

175. Garrett, *supra* note 34, at 771.

176. See Mitchell, *supra* note 38, at 27.

177. Mitchell, *supra* note 38, at 27.

178. 31 U.S.C. § 3730(e) (2012).

179. See Mitchell, *supra* note 38, at 27.

assume control over the suit, or (ii) decline to intervene and allow the relator to continue to pursue his or her claims.”¹⁸⁰

If the government declines to intervene, and the relator chooses to pursue the action alone, the case will be unsealed and the relator could receive between twenty-five to thirty percent of the recovery.¹⁸¹ Whereas when the government joins the case, the relator could receive between fifteen to twenty-five percent.¹⁸² Qui tam actions provide high financial incentive for individuals whether the government intervenes or not. The FCA permits a maximum penalty of ten thousand dollars for each offense and allows for treble damages.¹⁸³ The treble damages provision permits the court to consider the amount of damages calculated, multiply this amount by three, and award the resulting figure.¹⁸⁴ The qui tam suit under the FCA provides sufficient fines to deter individuals from defrauding the government, and it may produce the same deterrent effect for individuals practicing without a license. The FCA is the primary tool in fighting fraud and refunding money to the healthcare system; however, unlicensed practice slips through the cracks of the FCA.¹⁸⁵

In 2015, the Supreme Court in *Universal Health Services, Inc. v. United States*, decided a case against a mental health clinic after the relator’s daughter died of a seizure when various unlicensed and unsupervised staff treated her.¹⁸⁶ In 2013, the Massachusetts state agency punished only one of the physicians at the clinic with a penalty of one thousand dollars.¹⁸⁷ Afterwards, the relators filed a qui tam action against the defendant clinic and obtained justice by the Supreme Court.¹⁸⁸ However, this case presents the anomaly within the FCA.¹⁸⁹ Only after nearly twenty years of multiple providers practicing without a license, did the government stop the clinic’s unlicensed practice. Is there a solution that will deter unlicensed practice before harm is

180. Mitchell, *supra* note 38, at 27.

181. Mitchell, *supra* note 38, at 27.

182. *United States v. N.Y. Soc’y for the Relief of the Ruptured & Crippled, Maintaining the Hosp. for Special Surgery*, No. 07 Civ. 292 (PKC), 2014 WL 3905742, at *7 (S.D.N.Y. Aug. 7, 2014).

183. 31 U.S.C. § 3729(a)(1).

184. *See id.*

185. *See, e.g., N.Y. Soc’y*, 2014 WL 3905742; *Universal Health Servs., Inc. v. United States*, 136 S. Ct. 1989 (2016).

186. *Universal Health Servs., Inc.*, 136 S. Ct. at 1993.

187. *United States v. Universal Health Servs.*, 780 F.3d 504, 510 (1st Cir. 2015).

188. *Universal Health Servs., Inc.*, 136 S. Ct. at 1993.

189. *Id.* The anomaly being that the FCA was designed to prevent fraud within the healthcare system, yet if it happens to catch unlicensed practice too, it will only be after a physician has been unlawfully practicing for such a long period of time that he or she has incurred and concealed thousands of dollars from the government and the government notices.

done? Must patients wait for the financial harm to the government to be great enough to grab its attention? Should officials start considering other solutions involving private citizens focused on proactively deterring unlicensed practice?

In *United States. ex rel. Putnam v. Eastern Idaho Regional Medical Center*, a relator initiated suit against the defendant who worked with child speech services.¹⁹⁰ The relator alleged the defendant fraudulently submitted claims to Medicare and Medicaid.¹⁹¹ Specifically, the defendant used unlicensed aides to provide services to Medicare and Medicaid patients, and the defendant knowingly and fraudulently billed both programs for the work performed by the aides.¹⁹² In 1997, the defendant began a speech pathology practice and hired aides to help provide service to patients.¹⁹³ From 2003 to 2007, the defendant began billing for services provided by these aides in violation of Medicare and Medicaid requirements.¹⁹⁴ The relator disclosed the defendant's practices to the Department of Health and Welfare (IDHW) and asked them to begin an investigation of the defendant's practice.¹⁹⁵ The relator sent the IDHW multiple letters describing the defendant's unlawful practice.¹⁹⁶ The IDHW began an investigation.¹⁹⁷ The investigation was centered on the billing practices for the fiscal years of 2003 to 2007 and the individuals responsible for the fraudulent billing.¹⁹⁸ The relator initiated the qui tam claim in 2007; in 2010 the court found the presence of fraudulent claims and prosecuted the individuals that conducted the false billing.¹⁹⁹ However, the defendant was able to practice for thirteen years with unlicensed aides, thus showing a lack of deterrence from the unlicensed practice.

In *United States v. New York Society for the Relief of the Ruptured and Crippled*, a relator brought a qui tam action asserting that starting in 1986 the hospital "orchestrated several long-running schemes to defraud Medicare and Medicaid" by seeking reimbursement for procedures performed and improperly billed by two unlicensed radiology

190. *United States. ex rel. Putnam v. E. Idaho Reg'l Med. Ctr.*, 696 F. Supp. 2d 1190, 1192 (D. Idaho 2010).

191. *Id.*

192. *Id.* at 1194.

193. *Id.* at 1193.

194. *Id.* at 1199.

195. *Id.* at 1193–94.

196. *United States ex rel. Putnam v. E. Idaho Reg'l Med. Ctr.*, No. CIV. 07-192 E-BLW, 2009 WL 2901233, at *3–4 (D. Idaho Sept. 8, 2009).

197. *Id.* at *4.

198. *United States. ex rel. Putnam v. E. Idaho Reg'l Med. Ctr.*, 696 F. Supp. 2d at 1194.

199. *Id.* at 1205.

facilities.²⁰⁰ The relator alleged that the hospital fraudulently claimed \$788 million of government money during their long-running scheme.²⁰¹ The relator brought the action in 2007.²⁰² However, it was not until 2013 that the government declined to intervene; and in 2014 the relator's claims were dismissed for lack of proper pleading.²⁰³ In this case, the defendant continued to put patients in danger by practicing almost twenty-one years without a license, followed by six more years of delay by the federal government. After twenty-one years of putting patients in danger, should officials start considering *ex ante* solutions that will incentivize private individuals to report unlicensed practice, thus imposing fear onto violators and providing the needed deterrence?

F. Background of Incentive Schemes Within Intellectual Property

The intellectual property system and the prize system have long been considered as the two main incentive schemes for innovation. Intellectual property emerged as early as the 1400's and spread throughout the world by the eighteenth century.²⁰⁴ As it evolved, criticism developed due to the "monopolistic characteristic" that the intellectual property system imposed on the economy.²⁰⁵ The system ultimately imposed high prices on products and hindered subsequent innovations due to restricting their uses for others' innovations.²⁰⁶ Consequently, the prize system evolved as an alternative method to spur innovation.²⁰⁷ Intellectual property concentrates on protecting innovations, whereas the prize system concentrates on incentivizing innovation by allowing the public to use the innovations. Because only a few recent papers discuss the prize system, it has been labelled as the "neglected innovation incentive."²⁰⁸ However, this system is superior in the sense that it incentivizes innovations and avoids social losses.²⁰⁹ Under the prize system, the government "gives a reward to the innovator if he succeeds with an innovation," then, unlike the in-

200. *United States v. N.Y. Soc'y for the Relief of the Ruptured & Crippled, Maintaining the Hosp. for Special Surgery*, No. 07 Civ. 292 (PKC), 2014 WL 3905742, at *14 (S.D.N.Y. Aug. 7, 2014).

201. *Id.* at *1.

202. *Id.* at *7.

203. *Id.*

204. Steven Shavell & Tanguy Van Ypersele, *Rewards versus Intellectual Property Rights*, 44 J. LAW & ECON. 525, 526 (2001).

205. *Id.*

206. *Id.*

207. *Id.* at 526–27.

208. Roin, *supra* note 43, at 1022; Shavell & Ypersele, *supra* note 204, at 526.

209. Shavell & Ypersele, *supra* note 204, at 526–27.

tellectual property system, the innovation is made available to the public.²¹⁰ Hence, the incentive to innovate is “due entirely to the reward.”²¹¹ Setting the reward at the perfect price is of concern; however, determining such a reward would not “prove insurmountable.”²¹²

The prize system’s rationale is that providing individuals with the proper incentives to innovate is for the good of all, and this “for all” includes the government. As Brian Wright and Suzanne Scotchmer suggest, the incentive to innovate is good for the government because innovators “possess superior information to the government.”²¹³ Thus, the government can only benefit from tapping into a private individual’s information and incentivizing these individuals to come forward with such information.²¹⁴ Tapping into a private individual’s information is essential in the case of innovations. Scotchmer suggests that private information is useful, but only when used efficiently.²¹⁵ The intellectual property system does not use private information efficiently because it creates patent races.²¹⁶ The races cause research and development to be duplicated due to the private nature of the system.²¹⁷ Under the prize system, this inefficient use of private information would not occur. There is no race to discover the innovation first because the information discovered and rewarded is then made public and others have access to it. The innovation information would be publicized and whatever subsequent value private individuals could add to it would be rewarded. Further, if this efficiency is great enough, Scotchmer suggests that a reward system may be optimal compared to an intellectual property system.²¹⁸

Wright states that a private individual’s information can provide value to the government, however, he also suggests that quantifying this value is challenging.²¹⁹ The government would need the ability to set the “perfect” price in valuing how important the information is (its

210. Shavell & Ypersele, *supra* note 204, at 534.

211. Shavell & Ypersele, *supra* note 204, at 534.

212. Shavell & Ypersele, *supra* note 204, at 528.

213. Shavell & Ypersele, *supra* note 204, at 528 (citing Brian Wright, *The Economics of Invention Incentives: Patents, Prizes, and Research Contracts*, 74 AM. ECON. REV. 691 (1983)); Suzanne Scotchmer, *On the Optimality of the Patent Renewal System*, 30 RAND J. ECON. 181 (1999).

214. Shavell & Ypersele, *supra* note 204, at 528(citing Wright, *supra* note 213); Scotchmer, *supra* note 213).

215. Scotchmer, *supra* note 213, at 181.

216. Scotchmer, *supra* note 213, at 181.

217. Scotchmer, *supra* note 213, at 181.

218. Scotchmer, *supra* note 213, at 191.

219. Wright, *supra* note 213, at 703.

social value).²²⁰ Facing this challenge involves the moral hazard of the government undervaluing the innovation from the viewpoint of the private individual.²²¹ Yet, this burden is considerably higher within the intellectual property system than within the prize system because the intellectual property system values the innovation before its social value is discovered.²²² On the other hand, the prize system values the innovation after it is on the market and its social value is objectively determined.²²³ In the prize system, the incentive to invest in research is based on the reward the individual would receive.²²⁴ The system provides greater incentives to the individuals who research innovations that the government views as important. Under this system, it follows that by setting the reward at the perfect price, the individual would choose the best investment in research and the government would achieve the best outcome.²²⁵ However, setting the perfect price that will incentivize individuals, recoup research losses, and benefit the government depends on the sufficiency of the information that the government has about the value of the innovation.²²⁶

Consequently, the drawback within the prize system is the difficulty to set the perfect price without “knowledge of consumers’ willingness to pay.”²²⁷ This lack of knowledge is due to the prize system being public, rather than private, thus losing the ability to estimate monopolistic cost margins. The lack of consumer knowledge also makes setting a perfect price difficult without corruption or incompetence.²²⁸ The benefit of the intellectual property system is its ability to offer incentive prizes that are valued based on the market of consumers’ willingness to pay.²²⁹ Intellectual property is appreciated because it carries valuable information about consumers; however, it is flawed due to the *ex ante* undervaluing of innovation.²³⁰

In the prize system, once the market reaction quantifies the innovation and a reward is disbursed, the innovation is available to competi-

220. Wright, *supra* note 213, at 703. The perfect price is a price that will motivate individuals to innovate and recoup research costs, while still motivating the government to provide the reward. See Wright, *supra* note 213, at 695 n.7.

221. See Wright, *supra* note 213, at 703.

222. Wright, *supra* note 213, at 703.

223. Wright, *supra* note 213, at 703.

224. Shavell & Ypersele, *supra* note 204, at 529.

225. Shavell & Ypersele, *supra* note 204, at 534.

226. Shavell & Ypersele, *supra* note 204, at 536.

227. Roin, *supra* note 43, at 1018 (emphasis omitted).

228. Roin, *supra* note 43, at 1018.

229. Roin, *supra* note 43, at 1001.

230. Wright, *supra* note 213, at 703.

tors with zero dead weight loss.²³¹ “Dead weight loss” is defined as the loss of economic efficiency in terms of the utility for consumers.²³² Within the intellectual property system, new innovators lack public access to innovation information; this creates a gap in the system known as dead weight loss. Dead weight loss has been considered the intellectual property system’s biggest drawback and the benefit of the prize system has been viewed as its “ability to avoid it.”²³³

Outside of the prize system, incentives for private individuals to invest in new ideas are typically inadequate. This is due to both the “intangibility of ideas” as well as the risk and expense that the innovation could fail, which are unavoidable.²³⁴ Without the prize system, the risk and expense of failure may prevent innovators from innovating. Additionally, “‘knowledge spillovers’ generated by a successful invention” that will prevent reward payouts deter innovators.²³⁵ The derivative benefits from the knowledge spillover go unrewarded, and the “inability of competitive markets to adequately compensate and incentivize their creation” without the prize system becomes problematic.²³⁶

Setting an incentive for private individuals to innovate is good for the government because innovators “possess superior information to the government.”²³⁷ Rewarding individuals who come forward with private information is beneficial for the government because it can then obtain knowledge not otherwise available.²³⁸ A prize system is optimal compared to an intellectual property system because it provides private information without concealing it from the public.²³⁹ If the price is right, the prize system provides greater incentives for individuals to put research into innovations that the government views as important. The prize system could be available as a proactive solution that will incentivize private individuals to report unlicensed practice.

III. ANALYSIS

This Part analyzes the need for reform in the Illinois MPA. Faced with impractical solutions to unlicensed practice, Illinois needs a new

231. Shavell & Ypersele, *supra* note 204, at 529.

232. Definition of ‘Deadweight Loss,’ THE ECON. TIMES, <https://economictimes.indiatimes.com/definition/deadweight-loss> (last visited Mar. 13, 2018).

233. Roin, *supra* note 43, at 1023.

234. Roin, *supra* note 43, at 1023.

235. Roin, *supra* note 43, at 1018.

236. Roin, *supra* note 43, at 1019.

237. Shavell & Ypersele, *supra* note 204, at 528 (citing Wright, *supra* note 213).

238. Roin, *supra* note 43, at 1018.

239. Roin, *supra* note 43, at 1008–09.

system for protecting patients and deterring unlicensed practice violations. The new system required should incentivize individuals to report unlicensed practice and in turn, deter violators, thus protecting patients. First, this section will challenge other options to deterring unlicensed practice and explain their downfalls. Next, this analysis will explore whether qui tam actions are a viable option for incentivizing private individuals to report unlicensed practice. Finally, this section will explore why a prize scheme would likely be the best system to incentivize private individuals to report unlicensed practice and to deter unlicensed practice.

A. *Medical Malpractice Is Not an Option*

Medical malpractice is an important consolation for patients that have been injured by physicians. However, complaints to the IDFPR are more omnipresent; some states report that the number of claims brought by the respective licensing board are four times greater than the number of malpractice claims.²⁴⁰ Additionally, “a complaint to the board is . . . potentially more dangerous than a malpractice filing.”²⁴¹ Medical malpractice claims are difficult to file, expensive to try, expose the complainant to the defendant, promote unfair settlement, and—most importantly—require a patient to first be injured.²⁴² Thus, many plaintiffs are swayed from filing a malpractice claim.²⁴³

An *ex ante* deterrence is preferable to an *ex post* medical malpractice claim. It is much easier for private citizens to report to the IDFPR rather than to file a medical malpractice claim.²⁴⁴ To report a claim with the IDFPR, individuals simply have to fill out a form online; whereas malpractice claims require individuals to hire a lawyer, pay the massive costs of gathering evidence and assembling experts, and endure trial.²⁴⁵ Even finding a lawyer to agree to prosecute a malpractice claim can be difficult.²⁴⁶ Additionally, when an individual chooses

240. Leigh Page, *The Black Cloud of a Medical Board Investigation*, MEDSCAPE, https://www.medscape.com/viewarticle/853911_2 (last visited Mar. 13, 2018).

241. *Id.*

242. *Id.*

243. *Id.*

244. *See id.*

245. *See id.*

246. Marshal Allen & Olga Pierce, *Ten Patient Stories: When Attorneys Refused My Medical Malpractice Case*, PROPUBLICA, <https://www.propublica.org/article/ten-patient-stories-when-attorneys-refused-my-medical-malpractice-case> (last visited Mar. 13, 2018). This proved all too true for Jeanine Thomas. *Id.* Ms. Thomas had surgery on her ankle and contracted a deadly bacterial infection that required several more operations and almost five more years of recovery. *Id.* Ms. Thomas was unable to find a malpractice attorney willing to file her claim due to the lack of profitability for the attorney. *Id.* Ms. Thomas’s story demonstrates how expensive these claims

to report a complaint with the IDFPR, the defendant will not know who the complainant is; whereas when filing a malpractice claim, the complainant must be prepared to face the defendant.²⁴⁷ Moreover, defendants that have claims brought against them by the IDFPR often settle the charges to prevent a trial.²⁴⁸ Even more so, filing a valid claim with the IDFPR does not require an injury, whereas a patient will not have a valid malpractice claim without first being injured.²⁴⁹ Private citizens can report to the IDFPR when a physician has committed unlicensed practice by performing any of the following acts: exceeding the scope of their license, delegating duties improperly, or practicing corporate medicine.²⁵⁰ However, medical malpractice shines in its ability to compensate for the injury, as compared to reports filed under the MPA where the complainant receives no monetary reward.²⁵¹ Introducing the *qui tam* action or the prize system would provide a monetary reward for catching the unlicensed practice and protecting patients. Medical malpractice claims may provide some deterrence, however, this Note argues for preventing unlicensed practice before a patient is injured. Put another way, the continuance of patients getting injured by unlicensed practice suggests that malpractice claims are not a deterrence at all.

B. Stricter Fines and More Funding are Not Viable Options

Implementing stricter fines on violators or enhancing the current governmental resources would not effectively deter unlicensed practice; thus, neither of these options would keep patients safe. Violators will not fear higher fines for practicing without a license because unlicensed practice remains prevalent even when threatened with the FCA fines, which can be in the hundreds of thousands of dollars.²⁵² Additionally, if the IDFPR received more funding to be allocated towards enhanced resources for catching unlicensed practice, it would not prevent unlicensed practice. Both a continuation of the current

are to prosecute and the difficulty in finding representation—a common problem in malpractice claims. *Id.*

247. Page, *supra* note 240. This is an added disadvantage to medical malpractice because sometimes the violator to whom the individual is reporting will be their employer. *See* Page, *supra* note 240.

248. Page, *supra* note 240.

249. Page, *supra* note 240.

250. *See supra* Part II.B.

251. Page, *supra* note 240; *see also* 225 ILL. COMP. STAT. 60/22(A) (2018) (“Any funds collected from such fines [assessed for violating the MPA] shall be deposited in the Illinois State Medical Disciplinary Fund,” rather than paid to a complaining patient).

252. WHISTLEBLOWERS INT’L, *supra* note 25. Under the FCA authorities have paid average reward payouts of approximately \$1.5 million. WHISTLEBLOWERS INT’L, *supra* note 25.

resources and a potential expansion of funding towards those same resources are inferior, compared to the private information that individuals obtain through their role as patients.²⁵³ Enhancing the same, inferior resources will not improve the system. The government needs to tap into new resources in order to prevent unlicensed practice. Patients have better access to information on violators than the government, and adding more personnel will likely not change this.²⁵⁴

The IDFPR's current funding for prosecuting unlicensed practice is appropriated through the fees collected from issuing medical licenses.²⁵⁵ If within any year, the fees and fines generated by the medical profession are insufficient to finance any necessary costs of regulating the profession, the remainder of those costs will be financed from appropriations from sources "other than fees and fines."²⁵⁶ Thus, the board²⁵⁷ is only permitted to receive additional funding if the current funds are not enough to cover the costs of regulating the profession. The board lacks budgetary authority to allocate funds for itself towards fining unlicensed practice.²⁵⁸ The board is not independently authorized to budget for itself.²⁵⁹ The board neither drafts its own budget nor approves of its own budget.²⁶⁰ The board is not even authorized to advise on determining the budget.²⁶¹ Moreover, the budget is not reviewed annually.²⁶² It is unlikely that the Illinois legislature will expend more money towards the board to be used for preventing unlicensed practice.²⁶³ This is even more unlikely when

253. See Roin, *supra* note 43, at 1008–10, 1027 (finding private citizens have superior information than the government).

254. *Id.*; see also *supra* notes 68–69 (discussing that the government agency has investigatory resources). However, government resources will never be superior to private citizen resources in low visibility crimes. See *infra* note 297; see also *infra* note 371 and accompanying text.

255. See 20 ILL. COMP. STAT. 2105/2105-300 (2017). "Appropriations for the direct and allocable indirect costs of licensing and regulating each regulated profession . . . are intended to be payable from the fees and fines that are assessed and collected from that profession." *Id.*

256. *Id.*

257. "'Board' means the board of persons designated for a profession, trade, or occupation under the provisions of any Act now or hereafter in force whereby the jurisdiction of that profession, trade, or occupation is devolved on the Department [of Professional Regulation]." 20 ILL. COMP. STAT. 2105/2105-5 (2017).

258. FED'N OF STATE MED. BDS., *supra* note 11.

259. FED'N OF STATE MED. BDS., *supra* note 11.

260. FED'N OF STATE MED. BDS., *supra* note 11.

261. See FED'N OF STATE MED. BDS., *supra* note 11.

262. See FED'N OF STATE MED. BDS., *supra* note 11.

263. The Illinois legislature has struggled to pass a budget since 2015. See Kim Geiger & Monique Garcia, *Illinois lawmakers get closer to avoiding another long showdown as Senate advances budget*, CHI. TRIBUNE, <http://www.chicagotribune.com/news/local/politics/ct-met-illinois-legislature-budget-votes-20180530-story.html> (last visited Oct. 4, 2018).

considering the government's hesitance towards implementing the qui tam action due to the lack of financial incentive.²⁶⁴

The government has an interest in patients receiving proper health-care; however, it is unlikely to allocate funds toward deterring unlicensed practice because the government is not financially harmed by unlicensed practice.²⁶⁵ Without a significant harm, the government is not likely to appropriate funds towards current enforcement.²⁶⁶ What is more, settling on a budgetary agreement is already complicated enough without the additional goal of preventing unlicensed practice.²⁶⁷ Without incentivizing private individuals to report unlicensed practice, the government will not otherwise have access to such private information on this low-visibility violation.²⁶⁸ Implementing a new system of incentives can be funded by carving such incentives out of the current fines imposed on violators. This will not require the government to pass a new budget and will not require the board to implement a new policy. They are permitted to use the current fines for regulating the medical profession, which includes preventing unlicensed practice.

Harsher fines will not provide the government with private individual information on this low-visibility crime.²⁶⁹ Violators in the health-care system are not currently deterred by any level of fine, evidenced by the fact that they are still committing these violations. Additional state funding for additional resources will not provide an effective deterrence to unlicensed practice because the government will still not have the advantage of private citizen information. The incentive system will not have the downfalls present in the alternative option of imposing harsher fines and providing additional state funding. The incentive system requires no passage of legislation and no additional funding. The board has the authority to use already allocated funds towards medical license violations. Therefore, the board can choose to carve out a portion of such funds for individuals sharing their private information.

264. See *supra* notes 317–20 and accompanying text.

265. See WHISTLEBLOWERS INT'L, *supra* note 25.

266. See WHISTLEBLOWERS INT'L, *supra* note 25.

267. See *Illinois House approves state budget, ends historic impasse*, ABC 7 EYEWITNESS NEWS, <http://abc7chicago.com/politics/illinois-house-approves-state-budget-ends-historic-impasse/2187933/> (last visited Mar. 13, 2018).

268. Garrett, *supra* note 34, at 785 (“Despite this inherent difficulty [to detect low-visibility crimes], qui tam provisions have proven themselves undeniably successful in uncovering and prosecuting fraud.”).

269. Garrett, *supra* note 34, at 784 (“[A] qui tam provision is an excellent regulatory tool for detecting and prosecuting low-visibility crimes”).

C. *Qui Tam Suits for Unlicensed Practice*

This section discusses whether adding an FCA-like qui tam enforcement provision to the Illinois MPA would help incentivize individuals to report unlicensed practice and hence, deter it. While the FCA is a crucial tool in fighting fraud in healthcare,²⁷⁰ unlicensed practice continues to fly under its radar until the violator submits a sufficient number of false claims to catch the government's attention. This analysis considers whether adding a qui tam provision to the Illinois MPA to incentivize the reporting of unlicensed practice would mirror the success the FCA has in reporting fraudulent billing. This section goes on to discuss why other areas of law are moving towards implementing qui tam actions and explains the concerns of implementation. Finally, this section explores whether unlicensed practice is harmful enough to the government to justify adding a qui tam provision to the Illinois MPA.

Qui tam suits in the MPA would proactively prevent harm to patients. The deterrence would provide a proactive solution to preventing harm to patients by enforcing the MPA before patients are injured. By providing an incentive for private individuals to report unlicensed practice, violators are deterred from unlicensed practice out of fear of being reported by patients.²⁷¹ Qui tam suits allow reporting individuals to obtain up to 25% of proceeds the government collects from the lawsuit.²⁷² Hence, the incentive to report would originate from the possibility of obtaining a portion of those proceeds. When the FCA adopted the qui tam provision, individuals were motivated to come forward because the government rewarded those individuals with a percentage of the financial earnings of the suit.²⁷³ Since the implementation of the qui tam provision, the amount of claims the government has prosecuted under the FCA has substantially increased.²⁷⁴ In utilizing qui tam actions under the MPA, private individuals would be incentivized to come forward and report unlicensed practice with the potential of receiving a hefty portion of the pro-

270. See generally John T. Boese, *Use of the False Claims Act to Enforce Federal Regulations: Necessary Limits on False Certification Cases Brought Under the Civil False Claims Act*, ENVRTL., MASS TORTS & PRODS. LIAB. LITIG. COMMS.' JOINT CLE SEMINAR, https://www.americanbar.org/content/dam/aba/administrative/litigation/materials/2015-joint-cle/written_materials/02_what_you_don%27t_know_could_hurt_you_an_examination.authcheckdam.pdf (last viewed Dec. 1, 2017); *Universal Health Servs., Inc. v. United States*, 136 S.Ct. 1989 (2016).

271. David, *supra* note 168; Division of Professional Regulation, ILL. DEP'T OF FIN. & PROF'L REGULATION, <https://www.idfpr.com/Admin/Complaints.asp>, (last visited Dec. 1, 2017).

272. See Vogel, *supra* note 27.

273. Melker, *supra* note 168; David, *supra* note 168.

274. WHISTLEBLOWERS INT'L, *supra* note 25.

ceeds. More people will want the opportunity to reap the benefits of a winning lawsuit, hence, the number of unlicensed practice claims will increase, as seen in fraud claims under the FCA.²⁷⁵ As more claims are brought, more violators will be caught, and violators will finally be deterred from unlicensed practice out of fear of being prosecuted. The FCA implemented the qui tam suit as one of the biggest steps toward combatting fraud in healthcare.²⁷⁶ By adopting the same scheme, the MPA could transform the current, insufficient protections against the unlicensed practice of medicine. Qui tam claims under the MPA could fix the lack of incentives under the MPA and permit the IDFPR to finally deter unlicensed practice.

Additionally, the MPA could prevent the time lag of the FCA qui tam claims. The FCA occasionally, and derivatively, catches unlicensed practice in investigating fraudulent billing; however, it takes a longer period to do so and thus results in more patients being injured.²⁷⁷ The MPA's adoption of a qui tam provision would share many commonalities with the FCA qui tam provision. Yet, the current differences between the two Acts are glaring. The current MPA does not provide a financial incentive for private individuals to give the IDFPR their private information on the violator, while the FCA qui tam action does provide such an incentive.²⁷⁸ The MPA discovers unlicensed practice sooner because of its focus on licenses, while the FCA qui tam action can take up to twenty years.²⁷⁹ Implementing a qui tam action under the MPA could catch unlicensed practice sooner than under the FCA and thus better protect patients.

In *Reddy v. Department of Professional Regulation*, IDFPR prosecuted the violator under the MPA after five years of his unlawful practice.²⁸⁰ Whereas, in *United States v. New York Society for the Relief of the Ruptured and Crippled*, the United States prosecuted the violators under the FCA after twenty-one years of practicing.²⁸¹ If the qui tam action in *New York Society* would have been brought by a state agency, the unlicensed practice could have been caught sooner like in *Reddy*. The government presumably could have avoided sixteen years

275. See WHISTLEBLOWERS INT'L, *supra* note 25.

276. Melker, *supra* note 168.

277. See, e.g., *Universal Health Servs., Inc. v. United States*, 136 S. Ct. 1989 (2016); *United States ex rel. Putnam v. E. Idaho Reg'l Med. Ctr.*, 696 F.Supp.2d 1190 (D. Idaho 2010); *United States v. N.Y. Soc'y for the Relief of the Ruptured & Crippled, Maintaining the Hosp. for Special Surgery*, No. 07 Civ. 292 (PKC), 2014 WL 3905742 (S.D.N.Y. Aug. 7, 2014).

278. 31 U.S.C. § 3729(a)(1) (2012).

279. *N.Y. Soc'y*, 2014 WL 3905742 (showing an example of a FCA qui tam action taking twenty years to catch unlicensed practice).

280. *Reddy v. Dep't of Prof'l Regulation*, 336 Ill. App. 3d 350, 352 (2002).

281. See *N. Y. Soc'y*, 2014 WL 3905742, at *2.

of risk to patient safety. The MPA has a more concentrated framework than the FCA, allowing the IDFPR to research, investigate, and prosecute unlicensed practice quicker than the FCA can, thus protecting more patients. Adding a qui tam provision to the MPA would avoid the time lag experienced in FCA prosecution and incentivize private individuals to report unlicensed practice.²⁸² Thus, deterring violators and keeping patients safe.

The implementation of qui tam actions is expanding into other areas of law for similar reasons, including (1) providing government with private information not otherwise available and (2) obtaining such information faster. For example, qui tam actions have been considered under the Fair Housing Act (FHA).²⁸³ In *United States ex rel. Anti-Discrimination Center of Metro New York v. Westchester County*, citizens claimed the Affirmatively Furthering Fair Housing (AFFH) group reported false FHA claims to the government about the status of Westchester's housing market in order to receive more government funds.²⁸⁴ Westchester implemented the FHA to prevent housing market discrimination by local and national government authorities.²⁸⁵ The AFFH group was employed to further prevent discrimination; however, after the group's enforcement was called into question, scholars started to wonder if the FCA would provide a viable alternative for enforcing fair housing.²⁸⁶ The discriminated citizens did not have the ability to bring direct suits against the AFFH officers for violating their duty to promote fair housing, so the citizens brought an FCA qui tam action against the AFFH for the false claims about the fair housing market the group submitted to the government.²⁸⁷ The plaintiffs won \$62.5 million in settlement.²⁸⁸ The qui tam action was the chosen litigation route because it would help deter future officers in the AFFH from violating their duty out of fear of being reported by the citizens and facing similar liability.²⁸⁹

282. Garrett, *supra* note 34, at 767.

283. Matthew J. Termine, *Promoting Residential Integration through the Fair Housing Act: Are Qui Tam Actions a Viable Method of Enforcing Affirmatively Furthering Fair Housing Violations*, 49 *FORDHAM L. REV.* 1367 (2010).

284. Termine, *supra* note 283, at 1370–71 (citing *United States ex rel. Anti-Discrimination Ctr. of Metro N.Y. v. Westchester Cty.*, No. 06 Civ. 02860 (DLC), 2009 U.S. Dist. LEXIS 35041 (S.D.N.Y. Apr. 24, 2009)). The government would obtain more funds if it could show it was following the anti-discrimination laws. *Id.*

285. Termine, *supra* note 283, at 1404.

286. Termine, *supra* note 283, at 1371.

287. Termine, *supra* note 283, at 1371.

288. Termine, *supra* note 283, at 1369.

289. Termine, *supra* note 283, at 1426.

Like violations of the AFFH, the MPA does not currently provide citizens with the ability of bringing a private action. More so, the AFFH does not provide a deterrence for individuals breaking the fair housing rules, and the MPA also does not provide a deterrence for individuals breaking the licensure rules. The qui tam suit brought to enforce the AFFH provided private individuals with the ability to bring claims against violators for not promoting fair housing.²⁹⁰ Likewise, adding the qui tam suit to the MPA will provide private individuals with the ability to bring claims for unlicensed practice. Just as the qui tam suit was a solution for the citizens in *Anti-Discrimination Center*, qui tam suits could be a solution for citizens under the MPA.²⁹¹

Unlicensed practice cannot be rightfully prosecuted under the FCA qui tam, therefore the MPA needs to implement its own qui tam action. The FCA is significantly lacking in its early detection of unlicensed practice, while the IDFPR is best positioned to detect and deter the wrongdoing they specifically preside over.²⁹² The IDFPR has the duty and experience of prosecuting unlicensed practice and with a more concentrated framework than the FCA, qui tams under the Illinois MPA will allow violators to be caught within five years, rather than twenty-one.²⁹³

Qui tam actions have also been considered in the financial realm. The Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank) implemented whistleblower provisions following the 2008 financial collapse.²⁹⁴ Scholars have suggested the addition of a qui tam provision to Dodd-Frank to more effectively enforce the Foreign Corrupt Practices Act (FCPA).²⁹⁵ Under Dodd-Frank, the whistleblower provision is currently the only mechanism available where private individuals can get involved in preventing bribery.²⁹⁶ Scholars who explored the possibility of adding the qui tam provision to Dodd-Frank stated that doing so would allow private citizens to

290. Termine, *supra* note 283, at 1426.

291. Termine, *supra* note 283, at 1370.

292. See *Fixing the False Claims Act*, U.S. CHAMBER INST. FOR LEGAL REFORM, https://www.wilmerhale.com/uploadedFiles/WilmerHale_Shared_Content/Files/PDFs/IRL-Fixing-The-FCA.pdf (last visited Mar. 13, 2018). See also *supra* text accompanying notes 276–80.

293. See *Fixing the False Claims Act*, *supra* note 292; see also *supra* text accompanying notes 276–80.

294. Garrett, *supra* note 34, at 766–67. The Dodd-Frank is a large statute containing a whistleblower program. Garrett, *supra* note 34, at 766. The Dodd-Frank's whistleblower enforcement applies to all its sub-parts judicial or administrative actions, including the FCPA. Garrett, *supra* note 34, at 768.

295. Garrett, *supra* note 34, at 767.

296. Garrett, *supra* note 34, at 767.

remain involved in the law suit, rather than remain “mere informants” like private individuals are in whistleblower actions.²⁹⁷ Scholars have pushed Dodd-Frank to implement qui tam actions because the actions are excellent regulatory tools for detecting and prosecuting low-visibility crimes.²⁹⁸ Fraud in general is difficult to detect, yet qui tam actions have undeniably proven to be successful in detecting and prosecuting fraud.²⁹⁹

To draw an analogy, the MPA currently does not provide incentives for private individuals to report violations and not be a “mere informant.”³⁰⁰ The MPA needs to implement a qui tam in order to incentivize a private citizen to report. Additionally, the MPA cannot rely on the FCA qui tam action because the FCA does not have the same experience that the IDFPF has in prosecuting low-visibility crimes like unlicensed practice.³⁰¹ Adding the qui tam to the MPA would provide an incentive to report and that report would be given to officials who have the experience necessary for prosecuting low-visibility crimes.

Implementing qui tam suits in Dodd-Frank to effectively enforce the FCPA would involve statutory impediments not present in the MPA. Under the Dodd-Frank, the SEC is required to have a separate enforcement action prior to any payout for a whistleblower.³⁰² This requirement has been discussed as a downfall to adding the qui tam to the Dodd-Frank because the SEC lacks jurisdiction to hear enforce-

297. Garrett, *supra* note 34, at 767. Whistleblowers and qui tam actions are different in that, under a qui tam action, the private individual brings the suit and, in a whistleblower action, the government brings the suit. See generally Garrett, *supra* note 34.

Whistleblowers are not a part of the litigation but are merely a piece of the evidence if their tip goes that far. The whistleblower does not have a stake in the matter beyond the potential award that may arise from a successful SEC action. The whistleblower is reliant on the resources and determination of the SEC to bring a claim, litigate, and vociferously battle to vindicate wrongs.

Garrett, *supra* note 34, at 781. “For whistleblowers, the inability to bring a claim themselves means that their tip or information may be lost when it gets to the SEC.” Garrett, *supra* note 34, at 781.

The inability to bring a claim may also mean no claim is ever brought, or even if a claim is brought the whistleblowers might have to fight the government to ensure that they get their fair share. In short, the whistleblower’s inability to bring the claim is a significant disincentive to the whistleblower.

Garrett, *supra* note 34, at 781.

298. Garrett, *supra* note 34, at 785. Low-visibility crimes are crimes that are purposefully concealed from the government, therefore detection is difficult. Garrett, *supra* note 34, at 785.

299. See WHISTLEBLOWERS INT’L, *supra* note 25.

300. See Garrett *supra* note 34, at 767.

301. See Garrett *supra* note 34, at 767.

302. Garrett *supra* note 34, at 775.

ment actions for the FCPA.³⁰³ Thus, the qui tam actions that produce a payout would never be eligible for the award because the SEC would lack jurisdiction to hear the required, separate enforcement action.³⁰⁴ Therefore, the payout could not be distributed, rendering the financial incentives futile for relators to come forward and report violations.³⁰⁵ The MPA would not be jurisdictionally limited in hearing claims of unlicensed practice like the SEC is in hearing claims under the FCPA, because the MPA provides broad powers to IDFPR to prosecute unlicensed practice.³⁰⁶ Additionally, there is no other government agency required to hear the MPA case prior to enforcement.³⁰⁷ IDFPR is authorized to hear all claims involving licenses to practice medicine.³⁰⁸

Another statutory impediment to Dodd-Frank's implementation of the qui tam action is whether the incentive would be great enough. Under the whistleblower provision in the Dodd-Frank Act, there is a statutory requirement that the action must be claiming at least \$1 million.³⁰⁹ This minimum is to ensure the government is catching the "worst of the worst" offenders.³¹⁰ However, the FCPA prohibits all types of bribery, big and small, and presides over actions claiming varying amounts.³¹¹ Thus, under the FCPA, the smaller claims would not benefit from the qui tam action being implemented into Dodd Frank because there would be little incentive for individuals to report nominal claims, since there would be minimal qui tam rewards.³¹²

Private citizens would rather not investigate claims for \$1,000 because they would not receive as much compensation when compared to investigating a \$10,000 claim. To draw a contrast, Dodd Frank would require a statutorily-imposed minimum in order to bring a claim. Under a state's MPA, there is no monetary requirement on the amount that the claim must be in order to be brought.³¹³ To explain, complaints of unlicensed practice only need to claim that an individual is practicing without a license or exceeding the scope of their license, but bribery crimes require a certain amount of money to be involved

303. Garrett *supra* note 34, at 775.

304. Garrett *supra* note 34, at 775.

305. Garrett *supra* note 34, at 767.

306. See 225 ILL. COMP. STAT. 60/37 (2018).

307. See *supra* text accompanying notes 142–44 (describing the enforcement process as mandated by the Illinois MPA).

308. See 225 ILL. COMP. STAT. 60/36 (2018).

309. Garrett *supra* note 34, at 768.

310. Garrett *supra* note 34, at 776.

311. Garrett, *supra* note 34, at 776.

312. Garrett, *supra* note 34, at 777.

313. Compare 15 U.S.C. § 78u-6(b)(1) (2012) with 225 ILL. COMP. STAT. 60/1 et seq. (2018).

in the transaction for a claim to be brought.³¹⁴ Even without a statutorily-required minimum, one scholar points out, “[w]ould a whistleblower want to risk so much and fall short of any compensation?”³¹⁵ Under the MPA, each claim imposes a fine of \$10,000, while bribery claims under the FCA can be as low as five dollars.³¹⁶ Therefore, the concern of falling short on compensation for reporting unlicensed practice would not be present in the MPA.

The qui tam provides a viable option for an incentive system to deter unlicensed practice and protect patients. Nevertheless, the harm required to justify the addition of the qui tam, may not be considered great enough in unlicensed practice. The reason for creating the qui tam action was centered around the harm that the violation imposed on the government.³¹⁷ The government was being financially harmed by individuals filing fraudulent claims and thus, taking the government’s money.³¹⁸ In implementing the qui tam action for unlicensed practice, some may ask—What is the harm being done to the government that justifies implementing qui tam actions?

The government harm in unlicensed practice is a derivative harm. As noted in *Universal Health Services*, the violator first harmed the patient by hiring unlicensed care providers, while secondly, the violator harmed the government when it requested reimbursement for the treatment performed by the unlicensed providers.³¹⁹ Yet, this derivative financial harm may not be great enough to justify implementing the qui tam. Under the FCA, the government harm from fraudulent billing can be penalized by the qui tam in the millions, while unlicensed practice will likely only be penalized in the thousands.³²⁰ Unlicensed practice does not generate significant funds; however, the government still has an interest in preventing harm to patients. If the harm is not considered great enough to justify qui tam implementation, Illinois needs an alternative system to protect patients from unlicensed practice that will provide private citizens an incentive to report and thus deter unlicensed practice.

314. See Garrett, *supra* note 34, at 776 (describing the \$1 million dollar statutory minimum under the Dodd Frank Act, 15 U.S.C. § 78u-6(b)(1)).

315. Garrett, *supra* note 34, at 777–78.

316. Compare 225 Ill. Comp. Stat. 60/3.5 (2018) with Garrett, *supra* note 34, at 777.

317. See WHISTLEBLOWERS INT’L, *supra* note 25.

318. WHISTLEBLOWERS INT’L, *supra* note 25.

319. See *Universal Health Servs. v. United States*, 136 S. Ct. 1989 (2016).

320. FCA claims can be up to \$100 million, whereas the maximum penalty for unlicensed practice claims is ten thousand dollars. Compare WHISTLEBLOWERS INT’L, *supra* note 25 with 225 Ill. Comp. Stat. 60/3.5 (2018).

D. Prizes for Reporting Unlicensed Practice

The use of incentives schemes has been explored in various areas of law, including the prize system for patents. Prizes are defined as “payment[s] funded out of general revenue that is made to a[n] [individual] conditional on delivering a specified” action.³²¹ Without the requirement of government harm to justify implementing the prize system, this system may be the needed incentive to deter unlicensed practice. First, this section will briefly recap the prize system in the context of patents. Next, this section will apply the prize system to unlicensed practice to determine whether the system will provide the necessary incentives to deter unlicensed practice. Afterwards, this section will explore the impediments to applying the prize system to unlicensed practice, but this section will argue that the prize system is superior to other incentive systems and can overcome such impediments. Finally, this section will explain how the prize system will be financed.

Under the prize system, the incentive to share the innovation with the government is “due entirely to the reward.”³²² Providing individuals with incentives to innovate and share the innovation is for the good of all, including the government. For patents, the prize system greater incentivizes individuals to research innovations that the government views as important. Under the prize system, the government “gives a reward to the innovator if he [the innovator] succeeds with an innovation,” then, unlike the intellectual property system, the innovation is made available to the public.³²³ Hence, the incentive to innovate is “due entirely to the reward.”³²⁴ The reward has to be great enough to recoup research costs and low enough to still benefit the government, so setting the reward at the perfect price is of concern.³²⁵ However, setting the perfect price is not impossible due to various data that provide the government with insight on what levels of incentives motivate private individuals to act.³²⁶ Implementing the prize system to deter unlicensed practice is a valid approach to counteracting unlicensed practice. The system would motivate private individu-

321. Gallini & Scotchmer, *supra* note 46, at 53.

322. Shavell & Ypersele, *supra* note 204, at 534.

323. Shavell & Ypersele, *supra* note 204, at 534.

324. Shavell & Ypersele, *supra* note 204, at 534.

325. Shavell & Ypersele, *supra* note 204, at 534.

326. Shavell & Ypersele, *supra* note 204, at 541–42 (discussing the government’s ability to set rewards based on sales data, demand curves, and customer surveys and how these bases remain inferior to innovators information because they are inherently *ex post* rather than *ex ante*). Further supporting the idea that the government has inferior information, some scholars have noted that the “market-based process for valuing goods works only in the presence of scarcity . . . and since inventions are intangible ideas, they are not scarce goods.” Roin, *supra* note 43, at 1035.

als to report information on unlicensed practice by providing individuals with a “prize” for their provided information. Brian Wright suggested that under the prize system, a private individual’s information is very valuable to the government.³²⁷ Therefore, tapping into the private individual’s information and incentivizing them to report is essential for the prize system to deter unlicensed practice and protect patients.

However, the government would need the ability to set the perfect price. To set the perfect price, the government must quantify both how important the unlicensed practice information is to the government and the social value of stopping the unlicensed practice.³²⁸ First, to determine the social value, the government will have to look at how much harm the violator has caused. Second, to determine how important the information is to the government, it will have to consider how likely it is the government would have caught the violator without the private individual’s information. As stated, the challenge of setting the perfect price also involves the moral hazard of the government undervaluing the information about the unlicensed individual.³²⁹ Setting the reward at the perfect price is essential in making the prize system work. If the price is perfect, then the individual would be willing to put the best investment into researching the unlicensed practice, and the government would achieve the best outcome (catching more unlicensed practice).³³⁰ However, as shown, setting the perfect price that will incentivize individuals, recoup research losses, and still benefit the government is difficult.³³¹

Academics have determined that it is too difficult to set the perfect price for patents. To draw a contrast, setting the perfect price for unlicensed practice, would not “prove insurmountable.”³³² The prize system is better able to value the innovation rather than the intellectual property system because it values the innovation after it is on the market and the innovation’s social value is objectively determinable through surmising data.³³³ The intellectual property system, however, determines the value of the innovation before it is on the market.³³⁴ The argument that it is difficult to set the perfect price is even less robust in the context of preventing unlicensed practice. The perfect

327. Wright, *supra* note 213, at 703.

328. Shavell & Ypersele, *supra* note 204, at 541; Roin, *supra* note 43, at 1036–37.

329. Wright, *supra* note 213, at 703.

330. Shavell & Ypersele, *supra* note 204, at 534, 536.

331. Shavell & Ypersele, *supra* note 204, at 534, 536.

332. Shavell & Ypersele, *supra* note 204, at 528.

333. Shavell & Ypersele, *supra* note 204, at 528.

334. Shavell & Ypersele, *supra* note 204, at 528.

price can be determined by considering the current data that reflects how prevalent unlicensed practice is under the MPA and what threshold of reward will incentivize private individuals to report under the FCA.³³⁵ The government already has the data to determine what reward amount is considered the perfect price because they have data on how prevalent unlicensed practice is and data on how much money motivates an individual to share their information with the government under the FCA. Thus, the state can surmise how prevalent unlicensed practice is and combine the FCA payout data with an estimate of the information on how useful prosecuting these violators is to patients. The fear of setting the perfect price would be circumvented and state agencies will be able to set a well-informed, calculated reward amount for reporting unlicensed practice.

Academics have also stated that the existence of “superiority of information” provided by private individuals is fictitious.³³⁶ A private individual’s information is arguably “imperfect *ex ante*” information. The information from private individuals can be considered imperfect because the discovery of the information is during the time when the private individual decides on “research investment.”³³⁷ Thus, the individual may be biased and falsely report.³³⁸ The information about unlicensed practice could be considered imperfect due to the existence of any bias that may be clouding the private individual’s judgment throughout her research. This exemplifies that valid and objective research on the violator may be impossible to discern. Objectivity is important in reporting unlicensed practice to prevent frivolous accusations and careless tarnishing of reputations.³³⁹ Objectivity is important in reporting unlicensed practice; however, the likelihood of frivolous claims being prosecuted is low because the IDFPR thoroughly researches the alleged violator before deciding to prosecute.³⁴⁰ The noted concern of bias would not swallow the benefit in a prize system for reporting unlicensed practice. Patients inherently have better access to information on unlicensed practice than the government will ever have because it is a low-visibility crime. The government will never have this information without disguisedly stepping into the pa-

335. Roin, *supra* note 43, at 1036 (proposing the idea that the government can link prize payouts to the volume of sales and then surmise the innovations social value by combining this data with an estimate of the innovations utility to consumers).

336. Shavell & Ypersele, *supra* note 204, at 542.

337. Shavell & Ypersele, *supra* note 204, at 542.

338. Shavell & Ypersele, *supra* note 204, at 542.

339. See Sandvick, *supra*, note 56, at 69.

340. See 225 ILL. COMP. STAT. 60/36 (2018) (stating the investigation procedures).

tient's shoes, physically visiting the violator, and witnessing the violator practicing without a license or exceeding the scope of their license.

The prize system has also been considered within the healthcare field for drug patents. Replacing the drug patents with prizes was contemplated in order to lower the monopolized costs of the drugs.³⁴¹ In a prize system for drug patents, the government would determine the reward amount, and then the reward was financed through taxes.³⁴² Imposing additional taxes always carries a sting. However, it was determined that citizens overall would end up paying less for their prescription drugs due to the drugs not being set at such a high monopolized cost.³⁴³ In the drug patent context, it was assumed that the government had enough information about the social value of the drugs; therefore, the government could offer prizes that would provide an incentive to make new drugs and thus, new drugs would be on the market at a lower cost.³⁴⁴ To emphasize, publicizing the patents increased drug innovation and improved the output within the pharmaceutical industry as a whole.³⁴⁵

Imposing additional taxes to help finance the prize for reporting unlicensed practice certainly carries an even heftier sting for Illinois residents. Thus, in the alternative of adding a tax, the prize amount could be funded by the fines currently imposed on violators of the MPA. Violators are currently fined up to ten thousand dollars per offense for practicing without a license.³⁴⁶ Once a violator has been fined ten thousand dollars, or more, the board³⁴⁷ can carve into that amount and allocate part of it to be used for the prize given to the individual who reported the violation. With more violators being reported and prosecuted, these fines will accumulate, and thus provide consistently increasing fund amounts for prizes to award to private individuals who report. Similar to the pharmaceuticals industry, patients would end up “paying less” overall due to the increase in prosecution.³⁴⁸ Prosecuting more unlicensed practice would “decrease costs” for patients because it will deter violators out of fear of prose-

341. Roin, *supra* note 43, at 1017.

342. Roin, *supra* note 43, at 1017.

343. Roin, *supra* note 43, at 1017.

344. Shavell & Ypersele, *supra* note 204, at 541–42.

345. Shavell & Ypersele, *supra* note 204, at 545.

346. 255 ILL. COMP. STAT. 60/22 (2018).

347. 20 ILL. COMP. STAT. 2105/2105-5 (2017) (“‘Board’ means the board of persons designated for a profession, trade, or occupation under the provisions of any Act now or hereafter in force whereby the jurisdiction of that profession, trade, or occupation is devolved on the Department [of Professional Regulation]”).

348. Roin, *supra* note 43, at 1013 (discussing the prize system for pharmaceutical drugs and insurance companies; stating prizes would “de-link” the prices consumers have to pay for the

cution. Therefore, patients will not be taken advantage of by violators financially, physically, or emotionally. Patients will then receive adequate care when visiting a doctor and can have a fighting chance to prevent and cure illnesses.

IV. IMPACT

This Part explains the impact of adding the prize system to deter unlicensed practice under the Illinois MPA. First, this Part will discuss the advantages and disadvantages of adding the prize system to the Illinois MPA in order to prevent unlicensed practice. Second, it will discuss the likelihood of the addition of the prize system to the Illinois MPA.

First and foremost, patient safety is the main advantage of the prize system being implemented in the Illinois MPA. As discussed, the incentive from the prize system is the social value attained by the possible benefits of reporting unlicensed practice of medicine.³⁴⁹ The prize system would provide a monetary incentive for individuals to report unlicensed practice. The prize system has been said to prevent pointless innovation payouts and thus, provide “superior incentives for innovation.”³⁵⁰ Within the healthcare system, the prize system would prevent meritless claims. This could be accomplished by implementing private individuals in the process of bringing these claims. With the additional resource of first-hand knowledge and new incentives, private individuals will have superior incentives to report physicians. And with time, individuals will want to do so early on in order to receive the incentive before another private individual does. This impending knowledge of other individuals possibly bringing a claim will encourage earlier reporting, and ultimately protect more patients. Further, this will allow patients to report before they would have merits for a malpractice claim because the standard for unlicensed practice is lower than the standard for malpractice.³⁵¹ Patients do not have to wait to be injured before submitting a complaint for unlicensed practice as they would have to for a malpractice claim. Thus, the prize

drugs from the profits the innovators make off the drugs, thus de-linking the cost pressures from the price of the drugs and providing lower prices for all).

349. Roin, *supra* note 43, at 1002.

350. See Roin, *supra* note 43, at 1003. Roin explains that pointless payouts are prevented in the prize system because the ‘prize’ granted to the private individual for their innovation is quantified after the innovation is on the market and its social value is determined. Roin, *supra* note 43, at 1003. Whereas, the intellectual property system quantifies the innovation prior to releasing it on the market. Roin, *supra* note 43, at 1003.

351. See *supra* text accompanying notes 243–50 (discussing the respective merits of filing a complaint to the IDFPR and filing a medical malpractice suit).

system will allow patients to report the physician before the injury takes place and accordingly, patient injuries will go down. Physicians will become increasingly apprehensive about being reported and adjust their practice, exemplifying the deterrence effect of implementing a prize system.

The prize system allows the government to give a reward to the individual if she provides the government with information.³⁵² Providing an incentive to private individuals to report is advantageous for the government because individuals have better access to information on low-visibility crimes than the government. This better access is due to violators not knowing which private individuals are carefully watching their practice, compared to when the government is investigating a violator and provides them notice of the investigation; when the government issues notice, the alleged violators are in a better position to circumvent prosecution. The government can only benefit from tapping into a private individual's information and incentivizing these individuals to come forward with information on violators.³⁵³ Tapping into a private individual's information is essential for catching unlicensed practice more efficiently.

A lack of patent "races" in the prize system prevents research and development from being duplicated.³⁵⁴ Within the prize system, the lack of race to information would allow for collaboration in the discovery of unlicensed practice. Under the prize system, once the information is discovered, the innovation is made public, its value is quantified, and such value amount is then rewarded.³⁵⁵ This advantage creates the ability to provide innovation with zero dead weight loss.³⁵⁶ With zero dead weight loss, subsequent value can be added to the innovation by other private individuals. This rotating wheel of additional innovation will thus create a snowball effect for information on unlicensed practice.³⁵⁷ Individuals will be able to learn tactics on investigating and reporting unlicensed practice from others who have reported, which may lead to additional reports. Dead weight loss has been considered intellectual property's biggest drawback, whereas the prize system's ability to avoid the dead weight loss is one of its biggest advantages.³⁵⁸ With the ability to share resources, individuals would work together in the effort to discover sizeable unlicensed practice

352. Shavell & Ypersele, *supra* note 204, at 534.

353. WHISTLEBLOWERS INT'L, *supra* note 25.

354. Scotchmer, *supra* note 213, at 181.

355. Shavell & Ypersele, *supra* note 204, at 534.

356. Shavell & Ypersele, *supra* note 204, at 535.

357. Gallini & Scotchmer, *supra* note 46, at 55.

358. Roin, *supra* note 43, at 1023, 1025.

schemes and possibly split the reward. Splitting the reward would not be a disadvantage for the private individuals working together because the more pervasive the unlicensed practice that is prevented, the larger the social value will be in stopping it, therefore the larger the prize will be for individuals who report it.

The difficulty of setting the reward at the perfect price is a possible disadvantage for the prize system; however, determining the reward is not impossible.³⁵⁹ In order for the prize system to work for unlicensed practice, the social value in reporting and preventing the violator from his or her practice would need to be quantified.³⁶⁰ Facing this challenge involves the problem of the government possibly undervaluing the information from the viewpoint of the private individual or purposely undervaluing the information in order to prevent having to pay a larger reward.³⁶¹ However, the likelihood of undervaluing the innovation is decreased due to the innovation's value being determined after it is on the market.³⁶² This allows for a more objective determination because the government can look at how many patients were seeing the violator and determine the sizeable contribution to society the public gains from the violator being prohibited from his or her practice. Still, quantifying this value will likely be a disadvantage to the prize system, even when in collaboration with data from the FCA. This disadvantage is due to the government and individuals having conflicting interests. The government would implement the prize system to keep patients safe, whereas individuals are reporting unlicensed practice in order to receive a reward. Therefore, the likelihood of private individuals viewing their discovery as undervalued is high. Consequently, the drawback with the prize system is the difficulty to set the perfect price without "knowledge of consumers' willingness to pay."³⁶³ The lack of consumer knowledge makes it difficult to set a reward amount without corruption or incompetence.³⁶⁴ However, the disadvantage of ensuring policies are executed under moral standards is present in much of the legislation passed in today. These disadvantages can be curtailed by regulations like the Freedom of Information Act (FOIA). FOIA was created for the purpose of enforcing agents to comply with the laws in place and provide transparency of govern-

359. See Shavell & Ypersele, *supra* note 204, at 528. See also Wright, *supra* note 213, at 703 (stating that private information can provide value to the government, however, suggests that quantifying this value is challenging).

360. Roin, *supra* note 43, at 1008.

361. Roin, *supra* note 43, at 1017.

362. Roin, *supra* note 43, at 1017–18.

363. Roin, *supra* note 43, at 1035–36 (emphasis omitted).

364. Roin, *supra* note 43, at 1018.

ment actions by empowering “citizenry as a check on the government.”³⁶⁵ FOIA will provide transparency when the government sets the reward amount at a certain price by allowing citizens to check the process behind determining the price.³⁶⁶ What is more, citizens will have the ability to discover the factors the government considers when setting an amount, thus providing a rubric for private citizens to follow in researching unlicensed practice. Therefore, the availability of regulations like FOIA will counteract the disadvantages of the prize system in unlicensed practice.

Another possible disadvantage of the prize system is the cost associated with enforcing and administering the system. Under the prize system, administrative costs would incur from the government determining the reward amounts and investigating the new influx of claims. It is argued that these administrative costs could outweigh the benefits of the prize system.³⁶⁷ However, with the availability of FCA data and the MPA data on the current presence of unlicensed practice, the administrative costs would not be as high as imagined.³⁶⁸ The IDFP has the resources to prosecute new claims of unlicensed practice and can estimate the number of claims that are likely to be brought. Administrative costs are much higher within the patent system than they would be for unlicensed practice because each patent has a different value in varying industries.³⁶⁹ This attribute of the patent system causes an increase in administrative costs. For example, the drug patent can vary in price depending on the innovator, the pharmaceutical companies, the state regulatory agencies, the drug insurance companies, and the Food and Drug Administration. Thus, there are many factors in deciding what the price of the drug should be. Comparatively, unlicensed practice is confined to one industry with a much smaller group of affected actors: the innovator, physician, and the board. Therefore, the administrative costs are less extensive and easier to outline. The board can set a fixed price and likely keep that price the same throughout all claims for unlicensed practice, with the exception of catching a sizable offender.

Over-enforcement costs are an additional pitfall. This concern stems from the likelihood of the social cost of finding a violator outweighing the social value of catching the violator. For example, when a “fine is

365. *History of FOIA*, ELEC. FRONTIER FOUND., <https://www.eff.org/issues/transparency/history-of-foia>, (last visited Mar. 13, 2018).

366. *Id.*

367. Roin, *supra* note 43, at 1018.

368. Roin, *supra* note 43, at 1018.

369. Roin, *supra* note 43, at 1018.

set higher than the social cost of the illegal activity, it encourages the private enforcer to expend more effort [in catching the illegal activity] because it is now more profitable for the individual enforcer to capture a share of the fine.”³⁷⁰ Fines are typically set at a certain amount that will still maintain deterrence, but decrease enforcement expenditures. Yet, the prize system will further lower the cost of enforcement for Illinois by “deputizing” individuals to gather information for cases on the government’s behalf.³⁷¹ Deputizing individuals will shift the costs of enforcement onto private individuals, and the imbalance of social costs and social value will not be imposed on the government. Individuals will also not be dissuaded by enforcement costs because private individuals are never willing to expend more energy than necessary to obtain a reward.³⁷² To provide another point, private individuals typically do not have to expend much energy on research relative to the government because individuals have easier access to information on low-visibility crimes.³⁷³ Therefore, the impact of implementing the prize system for the MPA would only include advantages for the government and, most importantly, for patients.

V. CONCLUSION

History shows that allowing private citizens to assist the government, and “not just provide a tip, leads to better enforcement of the law.”³⁷⁴ There is extensive history on the success of private individuals inserting themselves into enforcement of the law when the underlying crimes are difficult to detect, otherwise known as “low-visibility” crimes.³⁷⁵ With a lack of proper regulation, unlicensed practice will rampantly continue and patients will keep getting injured.³⁷⁶ Violators are not being reported or prosecuted due to the increasing avenues available for unlicensed practice and the lack of incentive to report. Illinois needs a new avenue for enforcing unlicensed practice violations within its own borders. Employing a prize system in the Illinois MPA would provide a backbone for Illinois in preventing unlicensed practice and protecting patients. The current MPA allows for individuals and physicians to report unlicensed practice, but falls short because

370. Ni Qian, *Necessary Evils: How to Stop Worrying and Love Qui Tam*, 2013 COLUM. BUS. L. REV. 594, 602.

371. *Cf. id.* at 601.

372. *Id.* at 602. *See* Roin, *supra* note 43, at 1028 (“Assuming that consumers do not pay more for innovations than their value to them . . .”).

373. Garrett, *supra* note 34, at 767.

374. Garrett, *supra* note 34, at 788.

375. Garrett, *supra* note 34, at 785.

376. Szostak, *supra* note 11.

it fails to incentivize individuals to report this low-visibility crime. Under the prize system, the government would give a reward to the private individual if she succeeds with obtaining valid information on a violator practicing without a license.³⁷⁷ Implementing the prize system for unlicensed practice is a valid approach to counteracting unlicensed practice because IDFPR would finally be able to provide an incentive for private individuals to report and thus, provide the government with access to private information. If the prize is right, private individuals will want to report unlicensed practice, violators will be deterred, and patients will be safe.

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377. Shavell & Ypersele, *supra* note 204, at 534.