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ARTICLE

Capital Markets and Medical Care: How Wall Street Invented Physician Management Companies in the 1990s

Barbara Bridgman Perkins

Investment banks collaborated with health care entrepreneurs and managers in the 1990s to add a costly layer of investor-owned corporations to the US medical delivery system. In capitalizing and consolidating physician practices, publicly traded Physician Practice Management Companies (PPMCs) incorporated elements of the broader capitalist economy. Companies such as PhyCor, MedPartners, and FPA Medical Management turned to the equity and debt markets to generate shareholder profits and capital for acquisitions. Contemporary theories of financial economics reinforced their activities. PPMCs collapsed after shareholder lawsuits accused them of reporting false figures to the SEC and banks withdrew their credit. Physicians were both accomplices and victims in the process that made the medical delivery system less equitable, less effective, and more expensive. Although this experiment in medical capitalism failed, it widened the door for Wall Street to build new ways to profit from health care.

Keywords: capital markets; medicine; finance; accounting

Introduction: The Finance Industry Builds Physician Management Companies

Investment bank Salomon Smith Barney raised several billion dollars in the 1990s to invent a new kind of medical enterprise. Physician practice management companies (PPMCs) were financial intermediaries that offered new ways for investors to profit from medical care by merging medical providers and linking them to capital providers. In the same year his bank became part of the Citigroup behemoth, Salomon manager Larry Marsh celebrated the organizational innovation as a "management and business consultant, a bank, and a buyer, all wrapped into one."[1] Without mentioning cost, quality, or patient care, Marsh identified PPMCs' primary goal as profiting shareholders.

In investigating how bankers collaborated with health care managers and entrepreneurs to build PPMCs, this article explores a chapter in an ongoing story of how US medical care incorporated elements of the capitalist economy. Earlier episodes saw the construction of

E-mail: bdbperkins68@yahoo.com

1. Marsh, "Doctor's Bottom Line," 75.

corporate hospital chains in the 1970s and the conversion of health insurance and hospitals to for-profit status. Their conversion repudiated the *not-for-profit* alternative to investor (often physician) ownership of proprietary hospitals earlier in the century. The 1980s witnessed massive consolidation of smaller hospitals into regional oligopolies and the spread of large, often academic high-tech medical centers profiting from revenue-generating specialty services—even as many legally retained their tax-exempt, not-for-profit status.

Financial firms organized PPMCs in the 1990s by capitalizing and consolidating private doctors' practices. The new companies purchased portions of doctors' contractual revenues from Medicare and private health insurance[2] and channeled them into the capital markets. Accounting and credit rating standards as well as newly developed theories in finance economics accommodated their practice of selling equity and debt to generate capital for acquisitions and shareholder profits. PPMCs based on asset price appreciation failed when the stock markets fell. Major shareholders, with finance companies holding the largest portions, sued the companies for fraudulently inflating the price of their stocks by reporting false figures to the US Securities and Exchange Commission (SEC), and major creditors forced them into bankruptcy.

It all started when the finance industry perceived the (then) $200 billion American physician services market—plus doctors' influence over an additional $800 billion in health care expenditures—as a huge unexploited opportunity for investors to profit from medical delivery.[3] Physician management companies covered less than 5 percent of US doctors in the mid-1990s, the industry estimated. A flood of capital from private equity (mostly venture capital), public equity (stocks), publicly traded debt (bonds), and private bank loans drove PPMC growth. The companies flourished in the absence of empirical studies measuring their impact on health care costs, effectiveness, or quality.[4] Whether or not PPMCs increased medical care efficiency as widely touted, financial analysts appreciated that the industry increased the total wealth invested in medical care as well as its costs by adding another expense-generating layer of organization to the medical delivery business.[5] Querying whether meeting capital needs was consistent with meeting social and health needs, a management professor criticized that speculation was building costly managerial firms and luxury medical facilities that did not provide better medical care.[6] Nonetheless, PPMCs took advantage of the economic tenor of the time. New histories would identify it as the second era of finance capitalism.

Histories of Capitalism and the Business History of Medicine

When her professional cohort came of age in the 1990s and 2000s, capitalism historian Julia Ott noted, it witnessed "mounting inequality, skyrocketing asset prices, soaring debt levels, [and] stagnating standards of living—even as both political parties assured us that capitalist markets would save us all."[7] Like the 1920s, Ott further specified, the two decades prior to the

2. Cohen, "PPMCs: A Perspective," 495–502.
3. Wood, "Risky Business," 327–328.
4. Conrad, Koos, Harney, and Haase, "Prospects and Performance," 320–322.
5. Reinhardt, "Rise and Fall," 52.
6. Silvers, "Capital Markets in Restructuring," in *Kenneth Arrow*, 163.
7. Ott, comment in "Interchange: The History of Capitalism," 506.

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crisis of 2008 saw rising stock market prices fueled by unsustainable debt and reinforced by beliefs in efficient capital markets.[8]

The present paper has benefitted from and is in dialog with contemporary histories of capitalism and its finance. Scholars have identified market systems of exchange, the use of capital to accumulate more capital, and dependence on credit as hallmarks of capitalist economies.[9] PPMCs built each of these elements into their economies. In capitalizing doctors' practices, PPMCs transformed medical services into businesses generating capital. They continuously issued equity and debt and relied on high stock prices to support their loans and yield capital gains.[10] Historian Jonathan Levy called this practice "capitalism of asset price appreciation,"[11] which will be discussed further in the section on Major PPMCs. In applying market- and capital-centered strategies, PPMCs continued a long-standing—if only partly acknowledged—tradition of fitting business organization to medical delivery.

Few American histories of medicine have directly examined capitalism; however, a key exception was the 2020 paper on "What Historians of Medicine Can Learn from Historians of Capitalism" together with the invited responses to it. In the paper, Christy Ford Chapin defined capitalism in terms of competition and portrayed the medical profession's restriction of physician supply with licensing and board certification in the early twentieth century as part of its "program against medical capitalism."[12] Beatrix Hoffman responded that in view of the monopoly capitalism emerging at the time, "organized medicine seems not anticapitalist but fully in step with other dominant economic actors."[13] Restricting competition with entry control is a time-honored market tactic, conducted in this case in the name of professionalism. My publications on the business history of medicine have explicitly discussed ways in which medical care developed forms of organization in step with the wider economy.[14]

Other historical studies exploring business influences on medical care have also prepared the ground for studying its capitalist developments.[15] To various degrees, the cited works going back to physician-historian George Rosen in the 1940s describe how business organization and methods have permeated medical care. Their approach contrasts with a more conventional view that medical care is exceptional—that it has been driven almost purely by science, technology, and professional goals—and is thereby different from market economies. Concepts of *profession* have traditionally been used to argue that medicine (or law or accounting) is not capitalist because—irrespective of its economic activities—it has

8. Ott, "What Was the Great Bull Market?" in *American Capitalism*, 63.

9. Wallerstein, *Historical Capitalism*, 13–14; Heilbroner, *The Nature and Logic of Capitalism*, 33–37; McCraw, "Introduction," in *Creating Modern Capitalism*, 3–4.

10. Kocka and van der Linden, *Capitalism*, 5; Cook, *The Pricing of Progress*, 5–6.

11. Levy, *Ages of American Capitalism*, xxvii–xxviii, 589–593.

12. Chapin, "What Historians of Medicine Can Learn," 319–367.

13. Hoffman, "Comment: What Historians of Medicine Can Learn," 368–373.

14. Perkins, "Shaping Institution-Based Specialism," 419–435; Perkins, "Economic Organization of Medicine," 1721–1726; Perkins, *The Medical Delivery Business*; Perkins, *Cancer, Radiation Therapy, and the Market*; Perkins, "How U.S. Health Policy Embraced Markets," 587–618.

15. Rosen, *The Specialization of Medicine*; Stevens, *American Medicine and the Public Interest*; Vogel, *The Invention of the Modern Hospital*; Rosner, *A Once Charitable Enterprise*; Starr, *The Social Transformation of American Medicine*, Stevens, *In Sickness and In Wealth*; Ameringer, *The Health Care Revolution*; Schafer, *The Business of Private Medical Practice*; Tomes, *Remaking the American Patient*; Donzé and Fernández Pérez, *The Business of Health*; This list focuses on medical care organization and excludes important studies on the insurance and pharmaceutical industries.

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formulated a set of values that portray its professionals as immune (at least partially) to financial incentives. More recently, economists have used the argument that medicine is not different to advocate applying capitalist market mechanisms to it.[16]

Capital Markets and PPMC Development

Like other business consolidators of the time,[17] PPMCs were not products of markets for goods and services. They were products of capital markets, and Wall Street institutions actively drove their development. This section discusses how investment banks and other financial firms developed PPMCs, bought and sold their stocks, and designed their business modes of operation. Salomon Smith Barney and other banks constructed PPMCs as vehicles for creating investor profits from physician revenues. They spun upwards of 20 percent of physicians' contractual revenues into investor gold by growing it in the capital markets. Financial consultants entered the scene to teach doctors how to write business plans that would appeal to PPMC purchasers and increase value for shareholder-owners.[18] Investment banking gained (and lost) the most from the creative accounting methods and shareholder primacy policies employed by PPMCs such as PhyCor, MedPartners, and FPA Medical Management (FPA).

PPMCs offered a variety of purchase agreements to physicians. Some bought doctors' practices outright and made the physicians their employees. These companies generally paid $250,000-$500,000 per doctor to buy their real estate, equipment, and all other practice-based assets.[19] Other physicians exchanged ownership of their practices for equity ownership in the management companies, thus becoming PPMC shareholders. The companies pledged to physicians accepting stock as payment that much higher payouts would later materialize from taking the company public or selling it to a larger private equity company. Alternatively, many medical groups contracted with PPMCs solely to provide managerial services to their independent practice associations (IPAs). In all cases, physicians not employed by PPMCs continued to be employed by their own for-profit, limited-liability professional corporations (PCs).

PPMC management agreements typically mandated 20- to 40-year contracts. Managers assured physicians that they would retain control of clinical decision-making while the companies handled "tedious" administrative and financial details. In exchange for 15–20 percent (and sometimes more) of the groups' annual operating incomes plus a portion of their ancillary service revenues, PPMCs promised to maintain financial records, negotiate contracts with insurance companies, and loan their groups low-interest-rate capital to purchase costly clinical and information technologies. The very latest high-tech information system, PricewaterhouseCoopers accounting firm counseled managers, could enhance physician

16. Robinson, "The End of Asymmetric Information,"181.
17. Buder, *Capitalizing on Change*, 159.
18. Messinger and Stevenson, "Practice Financing Strategies," 72.
19. *Wall Street Journal*, "PhyCor Tries to Mesh Doctor Practices, Finds It 'Like Herding Cats,'" May 4, 1998, A1, A10.

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productivity, generate value for shareholders, and give each PPMC a competitive advantage over other PPMCs (which were also using technology to gain competitive advantage).[20]

Many PPMCs further organized separate management service organizations (MSOs) to administer the business operations of their clinics.[21] In attending solely to the financial process, MSOs were pure capitalist entities responsible only for turning physician cash flows into investor capital. The MSOs—or equivalent PPMC offices—contracted with insurance plans paying a fixed amount per patient for providing a fixed range of services to a defined population. From the pool of money their companies allotted them, PCs generally paid their member physicians by salary plus a productivity bonus.[22]

In bundling doctors' groups and building PPMCs and MSOs, their managers and bankers put into practice Chicago school precepts of markets and theories of finance capitalism.

Shareholder Value and Chicago School Finance Capitalism

Wall Street "shaped the world in its own image," business historian Per Hansen noted, "by spreading the narrative of efficient markets, meritocracy, and shareholder value."[23]

Following *Capitalism and Freedom*, which staked his 1962 claim on redefining capitalism (and freedom), University of Chicago economist Milton Friedman issued a provocative yet initially neglected challenge. He argued in the *New York Times Magazine* that "The Social Responsibility of Business Is to Increase Its Profits."[24] The 1970 article was an early shot in the battle to reinstitute shareholder value ideology for the popular idea that the government had a social responsibility to mitigate the inequalities and instabilities of capitalism. It signaled a return to the shareholder rights values prevalent earlier in the century and a denial of the more socially inclusive *stakeholder* concept that had risen out of disruptions of the Depression.[25] The new shareholder movement gained traction, according to economic historian Mary O'Sullivan, when corporations foundered and stock values fell in the turbulent 1970s.[26]

Shareholder value was also a key tactic in a campaign to extend the power of the financial industry. University of Chicago-trained business school economist Michael Jensen studied investment bank practices with the aim of reorganizing the industry and elevating its role in the national economy.[27] *The Financiers*, Jensen's book written for a popular audience, celebrated the glamour, wealth, and daring of the banks and bankers he investigated. At the same time, he designed reforms for what he identified as flaws in the industry.[28] Jensen and colleagues held that business managers needed to act as agents for investors' interests

20. Blair, Hahn, and Sarra, "Recent Trends," 21–27.
21. Robinson, "Consolidation of Medical Groups," 144–149.
22. Robinson and Casalino, "The Growth of Medical Groups," 1684–1687
23. Hansen, "From Finance Capitalism to Financialization," 630–631.
24. *New York Times*, "A Friedman Doctrine—The Social Responsibility of Business Is to Increase Its Profits," September 13, 1970, SM 17.
25. Whitman, *New World, New Rules*, 75, 91–92, 106.
26. O'Sullivan, *Contests for Corporate Control*, 7.
27. Lemann, *Transaction Man*, 100, 119.
28. Jensen, *The Financiers*, 203.

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instead of using profits to expand corporate empires or personal portfolios. They also encouraged leveraged buyouts (LBOs) and other mergers and acquisitions (M&As) on the grounds that they raised shareholder value and strengthened the power of investment banks.[29]

Friedman, Jensen, and other economists connected in various ways to the University of Chicago became known as the Chicago school. Identified as *conservative* or *neoliberal*, its theories became the theoretical foundation for the new field of finance economics.[30] *Markets* took on new meanings when economists shifted their attention from markets for goods and services to markets for capital. The Efficient (Capital) Market Hypothesis (EMH), developed by University of Chicago economist Eugene Fama and colleagues, offered a rationale for reorienting companies to shareholder value.[31] Particular markets are defined as *efficient* when the value of a business is equivalent to the amount of capital invested in it.[32] Fama held that the prices of stocks and other securities traded in the capital markets rapidly and accurately—in terms of companies' earning power—adjusted to all available information.[33] This hypothesis bolstered the whole stock market economy. Market "forces" in action became the powerful activities of financial firms and conservative think tanks that financed and disseminated the new market theories.[34] As Hansen noted, Wall Street firms broadcast the ethos of shareholder value and efficient markets to the world.

The work of the Chicago school reoriented corporate America to investor capitalism.[35] Investment bankers, portfolio managers, and research analysts interviewed in the late 1990s unanimously informed anthropologist and former investment bank staff Karen Ho that creating shareholder value by raising stock prices was the primary mission of Wall Street firms. Ho observed, however, that the bankers' quotidian work was often inconsistent with their stated values and tended to relate more directly to enhancing the power of their companies.[36]

Regardless of the extent to which it was actually practiced, the Chicago school's shareholder value ideology became PPMC corporate policy and a major tool in Wall Street's project to make medical care a capitalist business. The shareholder value movement boosted PPMCs' goals of returning profits to investors by selling equities and debts rather than goods and services. When the price of their stocks collapsed, PPMC shareholders based their lawsuits on efficient market theory, as discussed below in the section on fraud. Shareholder primacy became case law—albeit not statutory law—as courts legitimized it, integrated it into legal decision-making, and imposed it as a corporate obligation.[37] But first, PPMCs had to enter the stock market economy—and most of them did not succeed.

29. Fama and Jensen, "Separation of Ownership and Control," 304–305; Jensen and Meckling, "Agency Costs and Ownership Structure," 312–313; Lemann, *Transaction Man*, 112–117, 129; O'Sullivan, *Contests for Corporate Control*, 7, 43, 289; Baker and Smith, *The New Financial Capitalists*, 37–39.
30. Mirowski, *Never Let a Serious Crisis*, 268.
31. Davis, *Managed by the Markets*, 49–50.
32. Baskin and Miranti, *A History of Corporate Finance*, 180.
33. Brine and Poovey, *Finance in America*, 311–314; Fama, "Efficient Capital Markets," 383.
34. Burgin, *The Great Persuasion*, 171–174; Oreskes and Conway, *The Big Myth*, 148, 161, 280–281.
35. Baskin and Miranti, *A History of Corporate Finance*, 231.
36. Ho, *Liquidated*, 117, 22–25, 130, 153.
37. Rhee, "A Legal Theory," 2008–2016.

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Initial Public Offerings (IPOs), Accounting Rules, and Rating Criteria

G*oing public* in initial public offerings (IPOs) by registering company shares with the SEC, listing them on (private) stock exchanges, and selling them to investors was the gold standard for capitalist business in the 1990s. Investment banks profited handsomely from the processes they developed. They charged large fees to shepherd IPOs, set the price of the first issue, purchased the stocks at a discount (generally around 7 percent), and sold them to favored clients for another commission.[38] Financial analysts buoyed high prices by writing glowing reports about stocks their institutions owned or managed. The analysts informed investors that they could profitably inject many more billions of dollars into physician groups. On the medical side, analysts instructed practice management companies that they needed to conduct their business in the public equity marketplace in order to raise sufficient capital to successfully compete, and that so doing itself required large amounts of capital.

Other Wall Street companies also ensured that PPMCs followed the rules of the wider economy. Accounting firms certified their financial reports according to capitalist accounting principles. Ratings companies defined operational criteria. To attain an investment-grade rating, for example, Fitch Investors Service required PPMCs to demonstrate high debt service capacity, high projected profits, high patient volumes, and productivity-linked physician compensation. Standard & Poor's mandated a debt as a percent of capitalization (leverage) ratio of less than 75 percent and a minimum of 100 full-time revenue-producing physicians in each clinic.[39] Operational criteria like these sought to maintain elevated stock prices.

And indeed, PPMC stocks sizzled at the time. The analyst who chose FPA in 1996 won *Forbes* magazine's annual forecasting contest when the price of its stock skyrocketed 242 percent.[40] McKinsey company advisors taught their influential business clients that "winners" in the health care marketplace were companies that delivered the highest value to shareholders.[41] Physician management companies promised to do just that.

Major Publicly Traded PPMCs

PhyCor, MedPartners, and FPA did succeed in entering the stock markets. Initiated by hospital managers, auxiliary health care professionals, and physician entrepreneurs, respectively, they each applied capitalist tactics of relying on capital markets and asset appreciation for growth, seeking medical practices serving more affluent patients, and building revenue-generating specialty services.

Venture capital (VC) firms deploying wealth accumulated by institutional investors jumpstarted PPMCs by investing billions of dollars in exchange for managerial control and (usually) ownership privileges.[42] When ProMedCo founders asked VC funders for $5 million in seed money, for example, the VC administrators informed them that their offer was $25–30 million

38. Campbell, *Going Public*, 2–3.
39. Coddington, Moore, and Clarke, *Capitalizing Medical Groups*, 101–104.
40. *Forbes*, "Pick Only One," 261–263.
41. Goh and Pritula, "New Value Creators," 193.
42. American Medical Association, *Physician Practice Management Companies*, 13.

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in exchange for 65 percent ownership.[43] The VC firms recruited administrators and physicians with business training to develop PPMCs according to the principles of modern finance.

As one of the first multispecialty physician consolidators to list its shares on the stock exchange, PhyCor paved the road for how publicly traded PPMCs worked. Four former executives of the Hospital Corporation of America (HCA) hospital chain joined forces with Anthem Capital Management and other VC firms to inaugurate PhyCor in Nashville, TN, in 1988. Unlike many PPMCs to follow, however, PhyCor did not purchase controlling interests in its physician groups—a factor that may have disadvantaged company growth. The new company offered management contracts to selected doctors' groups and assembled others into more loosely knit IPAs. Applying corporate management methods he had used at HCA, CEO Joseph Hutts recruited established medical groups with good local reputations and high market shares.[44] The company appreciated that each practice purchase instantly added revenues to its own balance sheets. Moreover, every $300,000 physician cash flow purchase could be leveraged into a $1 million credit line to use for more acquisitions.[45]

Listing its shares on the stock market in 1992 considerably enhanced PhyCor's ability to grow. Like the publicly traded PPMCs that followed, PhyCor based its growth on asset price appreciation tactics that businesses, particularly those in finance and real estate, had developed in the 1980s. This method, according to Levy, enabled companies to use stocks they owned as collateral to borrow money in the credit markets and to generate capital gains by selling stocks that had risen in price.[46] PhyCor raised capital by synergistically selling shares on the stock markets and borrowing money in the credit markets. In general, companies seeking to grow by acquisition issued debt to purchase other companies and then issued cheaper, longer-term debt against the acquired assets to pay back the earlier debt.[47] In summary, high stock prices improved access to debt capital that supported more cash flow acquisitions that further boosted stock prices … and so on in an escalating loop. The asset price-debt capital loop was the PPMC way for capital to make more capital. In basing their business model on leveraged asset appreciation, PhyCor, and other PPMCs wove threads of capitalism into the fabric of medical care.

PhyCor planned for acquisition expenditures to exceed operational revenues regularly and for the company to issue new securities to cover the difference. In so doing, the company netted over $345 million in secondary stock issues in 1995–1997 and $194 million in bond sales in 1996.[48] Some of the stock offerings went directly into repaying bank loans.[49] The powerful growth engine of combining stock plus debt generated over $1 billion for PhyCor acquisitions between 1995 and 1997. Five percent of PhyCor's total purchases in 1997 were paid in stock and convertible notes, 30 percent in assumed liabilities, and 65 percent in loans from the company's bank credit facility plus an unidentified amount of cash derived from operations. The following year the company's banking consortium extended its credit facility

43. Lutz, "The Bar is Raised," 282.
44. PhyCor, *Annual Report 1997*, 3.
45. Lutz and Hanlon, "Raising Private Capital," 233.
46. Levy, *Ages of American Capitalism*, 589–593, 608, 612, 620–621, 675.
47. Hyman, "Rethinking," in *What's Good for Business*, 195–211.
48. PhyCor, Inc., *Annual Report 1997*, 38, 49.
49. PhyCor, Inc., *Annual Report 1997*, 23.

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to $400 million for "acquisitions, working capital, capital expenditures and general corporate purposes."[50] Such a broad scope illustrated PhyCor's dependence on continuous infusions from its banks to stay in business. It also suggested the extent to which banks expected to profit from doing business with companies that did not serve indigent populations.

The PPMC industry depended on the contractual insurance system that was blind to the existence of uninsured people and avoided contracting with Medicaid. PhyCor and other PPMCs avoided uninsured patients, their prospectuses assured investors, by defining themselves as organizations that contracted with insurance plans to provide services solely to their enrollees. The companies even avoided low-income people covered by state Medicaid programs, although they sought out private insurers offering supplemental Medicare plans to older middle-class adults. Whereas commercial insurance and Medicare each accounted for 49 percent of PhyCor's aggregate clinical revenues in 1997, Medicaid accounted for only 2 percent.[51] Competing companies using the same payment mechanism rapidly entered the market.

The major competitor vastly, if briefly, outran all the others. Richard Scrushy, founder of the HealthSouth rehabilitation and hospital chain and instigator of a variety of financial companies connected to health care, started up MedPartners as a pharmacy benefits management company in Birmingham, AL in 1993. The following year Scrushy collaborated with investment bank Smith Barney to inaugurate Capstone Capital Corporation—a real estate investment trust (REIT). REITs, which received reduced tax status, enabled companies to sell their facilities and then lease them back, thereby converting nonliquid real estate assets into cash for reinvestment. Capstone primarily purchased properties that Scrushy and his other companies owned.[52]

Funded initially with $1 million from HealthSouth, MedPartners attracted $20 million from venture capital companies New Enterprise Associates, Venrock & Associates, and 1st Century Partners.[53] Scrushy served on the board of directors of the company designed to help his HealthSouth rehabilitation services maximize reimbursements from the US Department of Labor's well-funded Workers' Compensation Program. He branched MedPartners into physician practice management almost immediately and hired fellow HealthSouth respiratory therapist Larry House as CEO. House followed HealthSouth practices of hiring managers from financial firms to build the profit-driven provider chain. MedPartners aimed to attain a competitive advantage over hospital-owned doctors' groups as well as independent physicians in the country's less-regulated, higher-income local markets.[54]

MedPartners intensively managed the money flowing in from its physician practices. After purchasing controlling interests in doctors' professional corporations, MedPartners collected all practice revenues and doled them back according to its determination of each PC's profitability. The company offered its less remunerative PCs fee-for-service payments ranging

50. PhyCor, Inc., *Annual Report 1997*, 24.

51. PhyCor, Inc., *Annual Report 2001*, 18.

52. HealthSouth Rehabilitation Corp, Capstone Capital Corp, "Common Stock Prospectus," June 24, 1994; Milt Freudenheim and Reed Abelson, "Market Place; Growing Concerns on the Health of HealthSouth," *New York Times*, September 19, 2002, C1.

53. Coddington, Moore, and Clarke, *Capitalizing Medical Groups*, 219.

54. Jaklevic, "Design and Conquer," 43.

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from 40–70 percent of their net revenues. Its more profitable physician groups received salaries, bonuses, and profit-sharing arrangements.[55] The company also sought to gain from profitable ancillary services.

Managers of multispecialty PPMCs searched for physician practices willing to scale up in size and technological capacity. ProMedCo recruited medical groups with only a few ancillary services so it could dramatically boost their incomes (and its own) by loaning them money to construct new ones.[56] PhyCor also gained by adding specialty services. When the company's assortment of such services accounted for 27 percent of its gross clinical revenues in 1997,[57] financial advisors suggested that the figure should be much higher. PPMCs would come to offer costly specialty centers in rehabilitation, imaging, renal dialysis, ambulatory surgery, sports medicine, weight management, heart disease, and cosmetic surgery, among others. As internal markets providing capital, PPMCs could offer their clinics lower interest rates available to large companies and retain a cut for themselves.[58] Like many other clinics, they opened and closed specialty centers according to profits rather than patient health needs.

MedPartners further strove to purchase doctors' groups in the more lucrative specialties. Orthopedic surgery was one of the company's prime targets, as the specialty could integrate vertically with rehabilitation services, link up with the field of sports medicine, and build popular health spas. In 1994, MedPartners purchased the physical assets and accounts receivable of the Fowler Sports Medicine and Orthopaedics clinic in Tuscaloosa. MedPartners' agreement with Fowler stipulated that the clinic would directly deposit all of its revenues into a MedPartners' BankSouth account and that MedPartners would return to the clinic 78 percent of its net revenues. Building on the Fowler practice, MedPartners and HealthSouth together planned to construct a new facility that combined the sports medicine clinic with a HealthSouth rehab clinic under the HealthSouth corporate umbrella.[59]

In choosing its medical groups, MedPartners strove to control 10–15 percent or more of every regional market it entered. To accomplish this goal, MedPartners acquired rival PPMCs in addition to individual practice groups. In 1995, the same year it went public, MedPartners purchased Mullikin Medical Enterprises, another large PPMC, in a $360 million stock swap—an acquisition method discussed in a later section.[60] The price of MedPartners stock leaped as the company proclaimed itself the biggest PPMC in the nation.

Nineteen ninety-six was a banner year for MedPartners' acquisitions supported by the multiplier effect of asset price appreciation plus debt. The company netted $194 million in a secondary offering of common stock in March and used part of the proceeds to pay off loans coming due.[61] The payoff enabled MedPartners to attain a $1 billion unsecured credit facility in September to fund further acquisitions and provide the capital needed to operate its clinics. The covenants of the credit facility conferred substantial power on the banks when they required MedPartners to maintain stipulated financial ratios and to obtain bank consent for

55. MedPartners, *Annual Report 1997*, 43.
56. Lowes, "Physician Practice Management Companies… Going…Going…,"
57. PhyCor, Inc., *Annual Report 1997*, 7.
58. Robinson, "Financial Capital," 66; Robinson, *Corporate Practice*, 156.
59. Alabama Supreme Court, *HealthSouth v. MedPartners*, 818–819.
60. *New York Times*, "Physician Management Merger Deal," August 16, 1995, D1.
61. MedPartners, Inc., *Annual Report 1997*, 32–33.

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acquisitions costing more than $75 million when more than half would be paid in (debt-supplied) cash. Also in September, MedPartners completed its purchase of pharmaceutical service and practice management company Caremark International in a $2.5 billion stock swap accounted for as a pooling of interest—an accounting tactic also discussed in the later section.[62] Wall Street once more voted its approval, and the stock prices of both companies soared. Selling a $450 million senior note offering in October, MedPartners boasted that it was the only PPMC to attain an investment-grade rating for its debt that year. Other PPMCs, it seemed, had to rely on the speculative grade, or "junk" bonds that were stimulating M&A activity throughout the economy. Ernst & Young, MedPartners' as well as HealthSouth's auditor, conferred on Larry House a regional Entrepreneur of the Year award, and MedPartners made the *Fortune 500* list for the first time. In 1997 the company announced net revenues of $6.3 billion (a figure that shareholders would later contest).

FPA as well as MedPartners and PhyCor used alternating currents of equity and debt to pay for its acquisitions. FPA issued $87.7 million in common stock and $169.8 million in notes for its physician purchases in 1996–1997.[63] Some PPMC mergers took on aspects of the leveraged buyout (LBO) movement of the time.[64] Although they were not "hostile" takeovers, PPMC buyouts, like those in the larger economy, sought businesses with high fixed incomes, bought them with debt secured by the income, and paid the interest on the debt with their annual cut.

By 1998, 40 of approximately 120 US PPMCs had debuted on the stock market; the remaining two-thirds continued as private equity companies. Selling stocks and bonds in the capital markets and having a fling with dot-com companies generated big money for PPMC investors.

Major PPMC Shareholders

Shareholder privilege policies benefitted stock-owning physicians and managers as well as the institutional investors who were controlling increasing portions of the nation's stocks and bonds. Those investors included banks as well as pension funds and large endowments. In fact, seven of the top eight institutional investors holding the largest number of publicly traded stocks in the early 1990s were investment banks and other financial services corporations.[65] Their extensive holdings indicated that financial institutions were themselves the shareholders that Wall Street wished to benefit.[66] Financial companies also came to control growing portions of health care stock; some of them became major PPMC owners.

Key corporations gaining from stock ownership in PhyCor included private venture capital company E.M. Warburg, Pincus, which in 1999 held 9.8 percent of PhyCor's stocks "beneficially owned" (which generally included voting rights). Investment management firm Legg Mason owned 7.4 percent of PhyCor that year, and the Prudential Insurance Company of America owned 5.5 percent.[67] Major financial firms benefitting from MedPartners ownership

62. MedPartners, Inc., *Amendment no. 2*, 21.
63. FPA Medical Management, Inc., *Annual Report 1997*, 35.
64. Baker and Smith, *The New Financial Capitalists*, 50.
65. Useem, *Investor Capitalism*, 176.
66. Fligstein, *The Architecture of Markets*, 156, 166–167.
67. PhyCor, Inc., *Proxy Statement 1999*, 11.

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in 1999 included Manning & Napier Advisors, which owned 8.6 percent of MedPartners stock; FMR Corporation, owning 6.4 percent; Wellington Management, 5.7 percent; and Wachovia Bank, 4.4 percent.[68] Although FPA's proxy report did not identify institutional investors, newspapers reported that at various times, mutual fund company AIM Management Group held 6.7 percent of the company's stock, George D. Bjurman Associates, 5.3 percent, and MFS Emerging Growth fund 1.7 percent.[69]

On average, the top institutional investors—all finance companies—controlled one-fifth to one-fourth of the stocks issued by the three major PPMCs. Some of the same companies were simultaneously pouring money into hospital chains. The Wellington Management Company, for example, owned 9.5 percent, and the FMR Corporation and its major owners Edward and Abigail Johnson owned 8.0 percent, of Columbia/HCA Healthcare Corporation's outstanding common stock in 1999.[70] In the same year, FMR also held 10.1 percent of the Humana hospital chain, and finance companies in total owned 30 percent of Humana.[71] The finance investor-owners likely kept a close watch on the management of their PPMCs and hospital chains.

Regarding individual PPMC owners, six of the top eight holders of FPA stock beneficially owned in 1997 were company officers or directors. That group, most of whom were doctors of osteopathic medicine, collectively owned 13.8 percent of the company.[72] Much of FPA's annual report that year—like those of other PPMCs—focused on further expanding executive stock options. In 1999, twelve of PhyCor directors and officers owned 8.3 percent of the company's outstanding shares.[73] Two years later, when PhyCor folded, directors and officers as a group owned only 3.6 percent, indicating that some had already cashed out.[74] MedPartners also designated committees for expanding stock options. Its Strategic Planning Committee searched for new ways to create shareholder value, and its Compensation Committee offered below-market stock options to managers and physicians. In 1999, Richard Scrushy owned 1.4 percent of MedPartners stock, Larry House (by then former CEO), owned 2.7 percent, and Edwin Crawford (new CEO and Chairman) owned 1.9 percent. Combined, its executive officers and directors owned 8.5 percent.[75]

Exercising options in a booming stock market led to massive personal fortunes for many corporate executives.[76] Scrushy's MedPartners stock—including options—was worth $29 million in 1999, and House's was worth $72 million.[77] MedPartners' stock represented just a fraction of the corporate wealth that contributed to Scrushy's sumptuous lifestyle. (He did not always use his capital to create more capital.) At one point, Scrushy owned four estates,

68. MedPartners, Inc., *Annual Meeting of Stockholders, 1999*, 2–3.
69. Korman, "Is Recovery in Store for FPA Shares?" *New York Times*, May 4, 1997, Sect. 3, 4.
70. Columbia/HCA Healthcare Corporation, *Annual Meeting of Stockholders, 1999*, 3.
71. Humana Inc., *Annual Meeting of Stockholders, 1999*, 9.
72. FPA Medical Management, Inc., Annual Meeting of Stockholders, 1997, 8.
73. PhyCor, Inc., *Proxy Statement 1999*, 11.
74. PhyCor, Inc., *Annual Report, 2001*, 70.
75. MedPartners, Inc., *Annual Meeting of Stockholders 1999*, 2–3.
76. Englander and Kaufman, "The End of Managerial Ideology," 438–439.
77. Elkind, "Vulgarians," 132–136, 138, 143–145.

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two airplanes, thirty automobiles, ten yachts (one of which was named "Monopoly"), and artworks by Picasso, Renoir, and Miro.[78]

Much of the physician management company's growth and accumulated wealth arose from gaming an advantageous accounting method.

Stock-for-Stock Acquisitions and the Pooling-of-Interest Accounting Dispute

Companies often paid for their acquisitions in stock during times of rising stock markets.[79] In so doing, the purchasing company issued sufficient new stock to use as currency to buy all of the selling company's outstanding shares. Wholly stock-for-stock acquisitions qualified with the Internal Revenue Service (IRS) as corporate reorganizations not subject to federal taxes because they entailed no exchange of money. Financial accounting practices as well as IRS policies facilitated the stock-for-stock trades.

The accounting industry had developed formal professional standards when the use of common stock rose earlier in the century. Academic experts in finance later claimed that many of the standards were oriented toward equity owners.[80] When the stock markets expanded again in the 1960s, the Accounting Principles Board (APB) of the private American Institute of Certified Public Accountants—tasked to write generally accepted accounting principles (GAAPs) for the SEC—sought to strengthen the standards. As part of that effort, the APB issued two rules detailing acceptable methods of accounting for corporate mergers. One rule delineated a standard purchase method; the other developed criteria for a pooling-of-interest method. Neither rule detailed the circumstances under which it was to be used, however—which turned out to be problematic.[81]

Acquiring companies promoted pooling because it permitted them simply to merge two companies' current balance sheets, which meant recording previously acquired assets at historical costs rather than current market valuations. In times of rising markets, this accounting practice inflated projected rates of return.[82] Pooling also escaped amortizing *goodwill*—the excess value attained when a purchasing company pays more than the seller's net asset value. Estimated at around 50 percent for medical practices, goodwill includes reputation, intellectual property, brand recognition, and the glamour of medicine. Since PPMCs sought to profit from these properties when purchasing medical practices, not having to amortize goodwill against future earnings was a gift to acquiring companies. It offered another means of elevating projected profits, in this case by ignoring potential deterioration in the value of the purchased goodwill.[83]

78. Namrata Tripathi, "Trial By Media: HealthSouth CEO Richard Scrushy Took up Televangelism to Manipulate Jury Pool in Fraud Case," Media Entertainment Arts World Wide, May 12, 2020. https://meaww.com/netflix-trial-by-media-health-south-ceo-televangelist-richard-scrushy-manipulate-jury-financial-fraud

79. Baker and Smith, *The New Financial Capitalists*, 16.

80. Baskin and Miranti, *A History of Corporate Finance*, 226.

81. Rayburn and Powers, "History of Pooling," 175–178.

82. Baskin and Miranti, *A History of Corporate Finance*, 276, 281.

83. *Financial Times*, "The Pool is Closed, Part 2," March 11, 2014, unpaginated. https://www.ft.com/content/51c87b0f-2070-3adc-a661-e39e50ac5202

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Although many academicians strongly criticized pooling accounting,[84] the method supported numerous corporate mergers over the next two decades—including many in health care. Five of FPA's seven mergers in 1997 were stock-for-stock trades accounted for as pooling of interest.[85] MedPartners' stock swap acquisitions mirrored HealthSouth stock swaps with pooling accounting as well as the $5.7 billion tax-free Columbia/HCA hospital chain pooling of interest merger that instantly raised the value of the combined company's stock by $2 billion.[86] While pooling represented only 8 percent of the total number of PPMC acquisitions from 1991 to 1997, it accounted for 56 percent of their total dollar value—a figure that mirrored M&As across the economy.[87]

Pooling had long been contentious within industry as well as academia, however in 1997 the industry-funded Financial Accounting Standards Board (FASB), which had replaced the APB, commissioned an Emerging Issues Task Force (EITF) specifically to study pooling accounting in health care. Representing accounting companies, law firms, PPMCs, and the SEC, the EITF concluded that physician practice company mergers did not meet the ownership continuity criteria required for pooling accounting. By implication, they had never qualified to use the accounting mechanism that facilitated so much PPMC development. Individual PPMCs and the industry as a whole, it seemed, could not have grown to the extent they did without the accounting method that artificially elevated projected profits. The FASB acted to prohibit the pooling of interest accounting for all physician acquisition transactions entered after November 20, 1997.[88]

The FASB continued to investigate pooling in other industries while corporate interests lobbied to retain it. The title of a Merrill Lynch study maintained that eliminating pooling would *Inhibit Economically Sound Mergers and Hinder the Efficiency and Innovation of US Business.* However, other interests—particularly in the high-tech industries—were willing to give up pooling as a trade-off for the FASB giving in on goodwill amortization and substituting a more lenient impairment testing process.[89] Perhaps also shaken by Citigroup's giant 1998 pooling merger that permitted it to project an extra $52 billion in earnings,[90] the FASB prohibited pooling and required purchase accounting for all business combinations initiated after June 30, 2001. Reflecting contemporary shareholder value priorities, the FACB chairman called the rule change a way to provide investors with more accurate information about actual M&A costs.[91] After the ban went into effect, corporations managed to conduct many stock-for-stock mergers without pooling.

Pooling accounting had not just reported financial transactions, academic accountants later concluded, it had promoted mergers inconsistent with sound business practices.[92] PPMCs'

84. Baskin and Miranti, *A History of Corporate Finance*, 280–281.
85. FPA Medical Management, Inc., *Annual Report 1997, 5*.
86. "Columbia Healthcare-HCA Merger is Completed," *New York Times*, February 11, 1994, D3.
87. American Medical Association, *Physician Practice Management Companies*, 34–35.
88. Accounting Standards Board, Emerging Issues Task Force, "Application of FASB Statement No. 94," 14–16.
89. Ketz, "Critical Look," 61–64.
90. *Wall Street Journal*, "FASB May Change M&A Accounting," April 27, 1998, A3, A24.
91. Tie, "Battle Over Pooling," 14–16.
92. Rockness, Rockness, and Ivancevich, "M&A Game Changes," 22.

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hectic M&A activity based on capital growth from asset price appreciation, stock-for-stock trades, and high leverage—and sustained by accommodating financial analysts, accounting rules, and rating standards—hyperinflated PPMC share values and helped set the companies up for financial disaster.

PPMCs Collapse

Asset price appreciation helped support the growth of the US physician management industry and asset price depreciation helped bring it down. When their stock prices plummeted, PPMCs could no longer access credit to maintain operations, let alone make new acquisitions. Led by institutional investors owning PPMC stocks, shareholder lawsuits accused the companies of fraudulently elevating the price of their stock by reporting false earnings figures to the SEC. Physicians were both accomplices and victims in the rise and fall of the PPMC industry. Its fall bankrupted individual medical groups newly burdened with high debt levels, disrupted long-standing practice groups, abandoned patients the companies had contracted to serve, and plunged their service areas into chaos.

In 1996, the aggregate wealth shareholders had invested in PPMCs was worth $14 billion (the total capitalization of their stocks). When concerns began to arise that PPMC stocks might be overvalued, bankers demanded exceptionally high earnings reports from the companies to merit Wall Street approbation. Morgan Stanley banker Lee Stettner, for example, suggested that his PPMC clients project 25–35 percent revenue growth per year in order to convince investors that they added to medical practice profits.[93] Such instructions put considerable pressure on companies to report satisfactory figures to the SEC. In 1998, shareholders were suddenly horrified to learn that $9 billion in the value of their stocks had vaporized.[94] The shareholders filed lawsuits accusing PPMCs of fraud.

The trigger for the fall might have seemed innocuous—another merger. PhyCor had announced in October 1997 that it would acquire MedPartners in a $7 billion stock swap accounted for as a pooling of interest plus an assumption of $1.2 billion in MedPartners' debt.[95] Wall Street was stunned, however, partly because PhyCor was so much smaller than MedPartners and partly because it had always refrained from using pooling accounting. In addition, MedPartners' fourth-quarter financial report to the SEC recorded a $647 million nonrecurring asset revaluation charge against future earnings to cover "restructuring and impairment" costs.[96] Plainly put, it lost revenues when it had closed clinics and dismissed staff. The accounting maneuver permitted large financial losses to be recorded as one-time operating expenses, a common ploy that inappropriately elevated projected future profits. PhyCor also disclosed asset impairment charges that quarter, having disposed of what it called insufficiently profitable clinics. Media reporters as well as bank analysts knew that such earnings write-offs conveyed serious financial troubles.

93. Coddington, Moore, and Clarke, *Capitalizing Medical Groups*, 198–199.
94. Lutz and Garbrecht, "Push to Consolidate," 1.
95. *New York Times*, "PhyCor to Buy a Competitor," October 30, 1997, D1.
96. MedPartners, Inc., *Annual Report 1997*, 2–3.

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Three months later, MedPartners and PhyCor announced that they had called off their planned merger. Their stock prices plummeted as merger failure theories ricocheted off the walls of Wall Street. Some pundits credited PhyCor's due diligence with uncovering overstated MedPartners' earnings; others hinted that both companies had entered merger negotiations to cover up financial difficulties. As a final blow, PhyCor acknowledged that it did not have sufficient operating control of its PCs to qualify for pooling of interest accounting.[97]

HealthSouth's Richard Scrushy took over as MedPartners' Chairman and acting CEO during the turmoil. *The Wall Street Journal* reassured shareholders that the new CEO would boost investor confidence as well as the price of MedPartners' stock.[98] Scrushy told *Fortune* magazine that he had no idea how bad things had gotten. Perhaps he should have followed the advice of his company's ethics compliance officer, who had warned executives not to play "the ostrich game."[99] While pooling-of-interest accounting had permitted companies to exaggerate projected profits legally, institutional shareholders accused MedPartners and other PPMCs of illegally inflating figures reported to the SEC.

Shareholders Accuse PPMCs of Fraud

Investment banks gained from PPMC growth by preparing, buying, and selling their securities. When PPMCs failed, they sought to reduce their losses by joining shareholders' lawsuits. As in the wider economy, the banks' multiple roles invited conflicts of interest between fiduciary responsibilities to clients and their own financial interests as they did business on both the buy and sell sides of the market. As Jensen's *Financiers* had cautioned, "If millions of dollars are at stake, don't expect to be politely ushered by friendly investment bankers to the front of the line."[100] PricewaterhouseCoopers accounting firm warned of "manipulation and distortion" in reported PPMC earnings.[101] Banks joined other investors as lead plaintiffs accusing PPMCs of reporting false figures to the SEC in order to hold up their stock prices—even as some of the banks engaged in the same activity. Shareholders alleged in a lawsuit that Salomon Bank had reported to the SEC false information that artificially inflated the market price of the Salomon securities they had purchased.[102]

Claims of PPMC fraud were strikingly similar to the allegations against Salomon. Investors accused the companies of using accounting methods that maintained the appearance of profitability when actual financial conditions were ominous. Class-action lawsuits against FPA, for example, charged that the company's "aggressive" accounting practices had vastly overstated its revenues, which had led investors to purchase stocks at inflated prices.

97. PhyCor, Inc., *Annual Report 1997*, 19; Accounting Standards Board, Emerging Issues Task Force, "Application of FASB Statement No. 94," 14–16.
98. *Wall Street Journal*, "MedPartners Loss," March 19, 1998, A3.
99. Lutz and Jany, "Fraud and Compliance," 141.
100. Jensen, *The Financiers*, 205.
101. Lutz, "The Bar is Raised," 279.
102. Salomon Smith Barney Holdings, *Quarterly report, period ended June 30, 1999*, 3–4.

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Shareholders further accused the company and some of its senior officers of misrepresenting operational revenues, securities fraud, and insider trading.[103]

Although the judicial system often merely slapped the wrists of perpetrators of white-collar crimes, it singled out a few exceptions. FPA's former Chief Financial Officer Steven Mark Lash was sentenced to four years in prison and ordered to pay $36 million in 2004 for falsifying company financial reports. The inflated revenue reports had smoothed the way for $340 million more in bank loans for FPA to continue operations. It was the Bank of Boston that initially questioned the firm's accounting practices, although FPA's auditors, Deloitte & Touche, had signed off on all its reports.[104]

Lawsuits similarly took issue with MedPartners' boast that the $3 billion in net revenues its physician practice division had reported to the SEC in 1997 had outperformed all other PPMCs in the country. When shareholders accused the company of reporting false information and violating federal securities laws, the company loftily parried that such legal actions arose "in the ordinary course of business."[105] MedPartners' own physicians filed some of the suits against their company's business practices. A 300-doctor California IPA accused MedPartners of fraud, breach of fiduciary duty, and withholding business records.[106] In a different suit, physicians at Talbert Medical Management alleged that MedPartners had paid its senior doctors a $4 million bribe to accept the company's initial purchase offer.[107]

MedPartners' investors sought $750 million in damages after the value of their stocks plunged upon news of the PhyCor merger failure. Institutional investors, including Birmingham's own Retirement and Relief System as well as banks, accused the company of materially misrepresenting its true financial condition. When MedPartners and its insurance company, AIG, claimed that the company was on the brink of insolvency and that $56 million exhausted its insurance coverage, shareholders settled for the $56 million. MedPartners neglected to mention, however, that it had previously purchased an unlimited excess coverage policy from AIG that would have paid what the shareholders demanded (and more). When MedPartners shareholders finally learned of that policy, they filed a new lawsuit accusing AIG and MedPartners of fraudulently not disclosing it. An Alabama court eventually approved a settlement of the later $3.2 billion suit for $310 million.[108] Perhaps MedPartners had thought it was also covered ethically when it assured investors that its insurance coverage meant that lawsuits were not likely to result in awards that would have an adverse effect on the company's financial status.[109] In general, shareholder settlements recovered small fractions of lost investments, and SEC fraud charges covered small fractions of falsely inflated revenues. The lawsuits often ended in settlements in which defendants conceded—without acknowledging "wrongdoing"—that they had knowingly reported wrong figures. Such a situation not only cheated shareholders, it leaves scholars in a quandary about using corporate reports that may include intentional misinformation.

103. Stanford Law School, "FPA Medical Management;" Serwer, "Code Blue," 186, 188.
104. *San Diego Business Journal*, "Fall of High-Flying Firm," March 22, 2004, 3, 30.
105. MedPartners, Inc., *Annual Report 1997*, 61.
106. Jaklevic, "MedPartners Sued," 12.
107. Stanford Law School, "Case Summary: MedPartners," unpaginated.
108. Morse, "CVS Caremark, AIG Pay," unpaginated.
109. MedPartners, Inc., *Annual Report 1998*, 14.

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The extent to which MedPartners may have mirrored the concurrent reporting practices of its HealthSouth parent is undetermined. HealthSouth and Richard Scrushy would be indicted in 2003 and Michael Martin, its former Chief Financial Officer and simultaneous MedPartners and HealthSouth board member, would be imprisoned after testifying how he had helped company executives overstate HealthSouth's income by $3.1 billion between 1997 and 2003.[110] The fact that Scrushy had announced in 1998 that he was integrating MedPartners and HealthSouth operations may also suggest financial integration.[111] Scrushy himself escaped a prison sentence when a Birmingham jury acquitted him on grounds of religious conversion and repentance.[112]

PhyCor engaged in similar dubious activities, if not at such extravagant levels. PhyCor settled lawsuits alleging that the company and its top officers had falsified profits and misrepresented operating efficiencies. Plaintiffs charged that misrepresentations using inaccurate data had "artificially" inflated the price of PhyCor's stock by interfering with the efficient market mechanism. The artificial price inflation, the lawsuit further noted, had provided time for company executives to sell their personal holdings at high prices (as illustrated by the reductions in their holdings reported earlier) and reap millions of dollars at the expense of other shareholders.[113] Covered by the company's insurance policies, the settlement achieved "complete releases of all defendants and dismissal of the consolidated cases."[114]

Timely changes in judicial decision-making profited shareholders. The earlier case law-derived *business judgment rule* had deferred to the expertise of company managers. The business judgment rule implied that managers had no legal mandate to maximize shareholder value and that shareholders had no grounds for complaint against managerial decisions.[115] The replacement *fraud-on-the-market rule*, which courts developed in the 1970s and the US Supreme Court affirmed in 1988, based judicial decision-making on the Chicago school's efficient market hypothesis.[116] Courts supported the argument that if stock prices fully reflected all publicly available information, then intentional misinformation defrauded investors by distorting the prices at which they bought and sold stock.[117]

In consolidated cases seeking compensation for suffering losses from falling stock prices after paying high prices for HealthSouth stock when the company overstated its income by $3 billion, an Alabama district court explicitly grounded its rulings against the hospital chain on the efficient market hypothesis.[118] Once the data were demonstrated false, the defendants' only recourse in court, ironically, was to claim that the market in question was not efficient

110. Randall and Hill, "HealthSouth Derivative Litigation," 129.
111. Jaklevic and Japsen, "Scrushy's Synergies," unpaginated.
112. Namrata Tripathi, "Trial by Media: HealthSouth CEO Richard Scrushy Took up Televangelism to Manipulate Jury Pool in Fraud Case," May 12, 2020. https://meaww.com/netflix-trial-by-media-health-south-ceo-televangelist-richard-scrushy-manipulate-jury-financial-fraud
113. Stanford Law School, "PhyCor, Inc.," unpaginated.
114. PhyCor, Inc., *Annual Report 2001*, 13.
115. Stout, "Shareholder Value Myth," unpaginated.
116. Cornell Law School, "Fraud-on-the-market theory," 1.
117. Jovanovic, Andreadakis, and Schinckus, "Efficient Market Hypothesis," 177, 179.
118. United States District Court, "In re HealthSouth Corporation," 630–631, 634, 636, 639–640, 646.

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(which they knew from their own manipulations). Fraud-on-the-market has remained the basis of shareholder lawsuit adjudication.

The numerous accusations of fraud exposed PPMC practices of reporting inflated profits as a means of generating capital by raising stock prices. Court settlements made partial restitution to shareholders and illuminated false financial reports, false claims to insurance companies, and insider trading—otherwise called lying to the government, insurers, and investors. The PPMCs of the 1990s benefitted from widespread investor credence in markets where stock prices perfectly reflected available information—even as their executives fudged that information. Many shareholder claims terminated with bankruptcy filings that stayed all active litigation against the companies and their executives.

Bankruptcy

Contrary to investors' hopes—or illusions—PPMC asset prices did not rise forever. FPA stock prices plunged in 1998 after the media publicized the company's SEC report that it had missed a $2.6 million payment on its long-term debt.[119] Its debt capital pipeline consequently dried up, and FPA became the first publicly traded PPMC to file for bankruptcy relief from creditors. Banks became as heavily involved in administering FPA's exit as they had been in managing its entry into the market. BankBoston headed the lending consortium that turned FPA's credit tap back on long enough for the company to collect its last revenue streams and make selected payments to creditors.[120] Analysts feared that other PPMCs might be on the same financial trajectory.

MedPartners signaled big troubles the following year when it recorded a $1.2 billion impairment charge against future earnings.[121] The California Department of Corporations took over the company's large physician network in the state and placed it under Chapter 11 bankruptcy protection. MedPartners agreed to pay hospitals and doctors a portion of the $180 million in claims arrears via a new credit line plus sales of its California practices.[122] Merrill Lynch approved the agreement on the grounds that the company had arranged to meet its debt obligations—if not its obligations to doctors and patients. MedPartners forestalled further bankruptcy when it announced that it would divest its physician practice business in favor of its original pharmaceutical benefits business, and MedPartners became Caremark Rx.

Although some bank analysts stopped covering PPMCs after the FPA and MedPartners implosions, others envisioned further profits in physician practice consolidation. Credit Suisse First Boston was among the banks that put PhyCor on life support when it ran out of money. E.M. Warburg, Pincus also voted its confidence by increasing its holdings in PhyCor stock to 12.3 percent[123] and purchasing $200 million in subordinated notes.[124] Despite the

119. *Wall Street Journal*, "FPA Misses Deadline for Payment to Bondholders, Chairman Resigns," July 16, 1998, 2.

120. *New York Times*, "FPA Medical Files for Protection Under Bankruptcy Laws," July 21, 1998, D5.

121. MedPartners, Inc., *Annual Report 1998*, 4.

122. *Los Angeles Times*, "MedPartners Agrees to Pay Portion of Doctors' Claims," December 17, 1999, unpaginated. https://www.latimes.com/archives/la-xpm-1999-dec-17-fi-44763-story.html

123. PhyCor, Inc., *Annual Report 2001*, 70.

124. *Nashville Business Journal*, "PhyCor Modifies Warburg," August 24, 1999, unpaginated. https://www.bizjournals.com/nashville/stories/1999/08/23/daily5.html

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capital infusions, PhyCor lost more than $1 billion over the next two years.[125] In 2002, PhyCor and 47 of its subsidiaries filed for Chapter 11 with liabilities exceeding assets by $342 million.

Formal bankruptcy rules reversed the shareholder supremacy hierarchy by prioritizing creditors over stockholders. In conjunction with its lenders, PhyCor wrote a reorganization plan designed to "preserve the value of our remaining businesses for our creditors." The company proposed to pay creditors in shares of the reorganized company's common stock, and the creditors agreed to accept those payments as "full satisfaction" of their claims. The reorganization plan confirmed that holders of the company's common stock, options, and warrants would get nothing.[126]

PhyCor's bankruptcy declaration excluded its IPA management subsidiary, North American Medical Management (NAMM), which had become financially stable after closing down clinics in "underperforming" markets. NAMM reemerged as a subsidiary of a newly founded company, Aveta, Inc., a privately held risk management firm. By this time, eight of the ten largest publicly traded PPMs had filed in bankruptcy court, and the publicly traded, multispecialty PPMC model was nearly defunct.[127]

PPMCs had generated profits by selling new stock offerings and new debt—until they no longer could. They had relied on rolling over their loans, and they ran out of fuel when their bankers terminated the process. Economist Uwe Reinhardt concluded (albeit cautiously) that the PPMCs of the 1990s were Ponzi schemes.[128] PPMCs had additionally traced out the most dire path of *Ponzi finance*, which was what economist Hyman Minsky called the most extreme phase of his financial instability hypothesis. That was the point at which companies could pay neither the principle nor the interest on their outstanding debts after the price of the stock underlying their loans fell.[129] PhyCor acknowledged in its annual report that the company had filed for bankruptcy precisely when it reached that point.[130]

PPMCs' dependence on debt-propelled growth was inherently risky in medical care as in the rest of the economy. When reduced access to credit made the companies economically unsustainable, their executives falsified reports to the SEC. When their stock prices collapsed anyway, much paper (electronic) investor wealth went poof. As usual with stock market bubbles, a small number of people benefitted enormously, and enormous numbers of people suffered. Physicians, who played mixed roles in the PPMC story, fell into both categories.

Physicians: Accomplices and Victims

Many factors induced doctors and their practice groups to join management firms in the first place. They included increasing paperwork, changing payment structures, and escalating competition from the growth of hospital-owned physician groups. There were also mounting

125. Versel, "Dying Breath," 2.

126. PhyCor, Inc., *Annual Report 2001*, 24–27.

127. Neil Luria and Gregory Hagood, "Industry Voices—Private Equity May be Repeating Mistakes with Physician Practice Management Companies," December 10, 2019. https://www.fiercehealthcare.com/practices/industry-voices-private-equity-may-be-repeating-mistakes-physician-practice-management Accessed October 21, 2023.

128. Reinhardt, "Rise and Fall," 52.

129. Minsky, "Financial Instability Hypothesis," 7–8; Yellen, "Minsky Meltdown," 1–2.

130. PhyCor, Inc., *Annual Report 2001*, 18, 22, 24.

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pressures to borrow money to purchase costly information technology (IT) software and the latest clinical technologies. However, PPMC managers did not seem to know how to manage the situation any better than the doctors did. Nearly all of FPAs' medical groups, for example, suffered losses of millions of dollars between 1995 and 1997.[131]

Physicians who had monetized their practices by selling them to PPMCs for immediate cash reaped windfalls, as did those who sold their newly attained stock early in the game. Many PPMC doctors conceded that potentially lucrative stock options had enticed them into joining the companies.[132] However, the companies largely achieved consolidation economies by dismissing their least productive physicians and ancillary staff. Financial service experts advised PPMC managers that such staff reductions could generate up to 20 percent savings in total operational costs.[133] The remaining doctors often found significantly reduced take-home compensation after consigning 20 percent of their contractual revenues to the companies and incurring penalties for not maintaining mandated productivity levels. Some physicians complained of "relentless pressure to subordinate patients' interests to those of accountants and stockholders."[134]

Many participating doctors came to feel that the contracts their management companies drew up with insurance companies were not friendly to physicians and that PPMC incentives did not mesh with their own. Moreover, the capitation contracting system that made fixed payments for covering fixed numbers of patients transferred considerable financial risk to doctors as well as health risks to patients. Finally, physicians were blocked from extricating themselves by long-term contracts with noncompete clauses. The private equity-owned physician management companies of the 2010s and 20s may turn out to be more sustainable and fairer to physicians, but many issues remain about their quality and inequalities—a topic for another paper.

Having relinquished both financial and managerial control, PPMC doctors were no longer captains of their ships. MedPartners fired California physician-entrepreneur Albert Barnett, who had brought his forty-five-clinic Friendly Hills Medical Group into the company, for "defaming" MedPartners by stating publicly that the company's business practices were flawed.[135] Doctors at FPA's Tucson clinic found working for their company so onerous that they defied long-time professional norms distinguishing them from industrial workers by joining the Federation of Physicians and Dentists. When FPA management challenged the legitimacy of their action, the National Labor Relations Board recognized the doctors' union and found FPA guilty of unfair labor practices.[136] Unionization did not gain their members managerial power, however, or improve their finances.

Practice stability and patient care were seriously disrupted when PPMCs could no longer sell new equity and new debt to maintain operations. Physicians suddenly found themselves locked out of their own offices (literally) and their longstanding practice groups dissolved. Many groups never received full payment for the clinical services they had provided, and they

131. FPA Medical Management, *Annual Report 1997*, 35.
132. Mayer, "Regaining Control," 15–18.
133. Nemzoff, "Primer on Mergers," 221–226.
134. *New York Times*, "Doctors Organize," July 1, 1997, A12.
135. Schack, "Coverage for 'Disparagement,'" unpaginated.
136. Center for Studying Health System Change, "Thomas-Davis Medical Centers," unpaginated.

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found much of the stock they had accepted in payment for their practices to be worth nothing.[137] Even more humiliating, some groups found themselves deeply in debt to their PPMC creditors. Many newly unemployed doctors did not have enough money to buy back their own practices—although others bought theirs back for less than they had sold them. Involved physicians had been willing, if often naïve, collaborators in financializing their profession.

Conclusion: Health Care Financialization

PPMCs were part of the finance capitalism that Wall Street constructed and the Chicago school fortified during the latter part of the twentieth century. The Marxist-oriented *Monthly Review* named the financial industry's growth in wealth and power and its purposeful expansion of debt *financialization*.[138] In increasing the number and size of financial transactions, financial firms came to control growing portions of the nation's economy.[139] Backed by shareholder value policies,[140] companies focused on "making money from money more than on investment in new products and services," as business school professors Thomas McCraw and William Childs noted.[141] Financialization integrated a variety of economic activities into the capital markets.

As part of health care financialization, PPMCs entangled medical services with financial services and made investor profit their primary product. Implementing the elements of capitalist economies identified at the beginning of this article, PPMCs sold securities in the capital markets, used their returns to grow more capital, and employed debt to grow their businesses. The new enterprises were not so much in the business of buying and selling medical care as they were in the business of buying revenue streams and selling equities and debts.

Political and business endorsement of neoliberal ideas reinforced this business model. One neoliberal precept defined *freedom* as the right of capital to flow freely.[142] The free flow of capital into PPMCs profited investors and built inequality into the structure of medical delivery. PPMCs contracted to serve wealthier populations and excluded low-income people. They dismissed doctors and closed clinics with "negative demographics," by which they meant poor and racially diverse groups often experiencing high illness rates. Another neoliberal proposition—that inequality is a natural characteristic of market systems[143]—condoned this behavior. In brief, the free flow of capital into PPMCs made the medical delivery system more expensive and more inequitable.

Tied as they were to capital markets, PPMCs (and their doctors and patients) were in a way like canaries in a toxic coal mine. While optimistic—or opportunistic— financial forecasters had called the stock market boom of the 1990s a new economy of sustained economic growth, it was not. Within two years of the stock market's peak in 2000, America's publicly traded

137. Robinson, "Physician Organization in California," 81–96.

138. Cassidy, *How Markets Fail*, 215–216.

139. Krippner, *Capitalizing on Crisis*, 27–30; Hansen, "From Finance Capitalism to Financialization," 609, 626–627.

140. van der Zwan, "Making Sense of Financialization," 99.

141. McCraw and Childs. *American Business Since 1920*, 229, 240–241.

142. Mirowski, *Never Let a Serious Crisis*, 61–62.

143. Mirowski. *Never Let a Serious Crisis*, 63.

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companies had collectively lost $8.5 trillion in value.[144] PPMCs had been part of a classic bubble in which asset prices were unrelated to any notion of underlying value. In the end, they added very little economic value to investor portfolios or health value to patients and doctors. The major concern of this paper is not the rise and fall of PPMCs themselves, however, but the broader, longer, and potentially more damaging effects of the finance industry's ongoing transformation of society. Financiers continue to search for new ways to capture social and health monies and feed them into the capital markets.

The study of publicly traded PPMCs in the 1990s raises many questions about the social role of the finance industry. Should financial firms drive health care development? If not, what are the alternatives? What are the risks and benefits when providers double as financiers? Did settled fraud lawsuits identify bad apples, or did they reveal the modus operandi of the PPMC industry? When does creative accounting become fraudulent? Should the government delegate rulemaking to the private sector? Is it ethical for businesses to take risks with other peoples' money (or lives) so long as they have insurance? Should empirical measures of effectiveness and equality factor into capital investment in health care? If so, how? Should Medicare and other tax-funded health insurance plans continue to subsidize for-profit health care? Should (and could) Medicare and other Social Security benefits be insulated from the investor economy? Do corporations gaining from the legal assignment of the rights of personhood have social responsibilities beyond investor profit? Is tying social services to capital markets in an economic system that regularly experiences financial crises a fatal flaw? Can a health or other social welfare system function outside of the dominant economy? Should the nation support the current business-driven health care system as is?—or should government direct the flow of capital in the public interest?—or should the government finance it all (which is misleadingly called *socialized* medicine)? Alternatively, should the nation seek to develop a noncapitalist health care system (whatever that might look like)? Is protecting citizens' health and welfare a legitimate role of organized society? If so, how can we best implement it?

Historical investigation of the finance industry's impact on medical care development can illuminate the meaning of these questions and contribute new ideas on how to build financial and social systems better designed to realize an old value: the health and welfare of all people.

Barbara Bridgman Perkins, 849 Coast Blvd., Independent Scholar, San Diego, CA 92037 USA.

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