

# HEALTH CARE FINANCIALIZATION

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## *Abstract*\*\*\*

*When a private equity-backed hospital cannot afford basic medical supplies, and patients die as a result, the problem is not merely mismanagement but health care financialization—a shift from caring for patients and communities to extracting wealth for investors and executives. Arising in both for-profit and nonprofit institutions, financialization manifests in three ways: governance moves from clinicians and community stakeholders to financial actors; profits derive from financial engineering and labor suppression rather than value creation; and accountability is obscured through consolidation, delocalization, and intricate corporate structures. These dynamics are evident in private equity’s leveraged buyouts and asset-stripping of providers, and in Medicare Advantage insurers’ vertically integrated delivery systems. In both, financialization drives higher spending, degraded care, and clinician demoralization—particularly troubling in a system funded largely by taxpayers. Recognizing that health care still relies on private capital, the Article outlines a policy framework to foster productive investment while constraining extraction, and calls for governance that centers patients, communities, and clinicians rather than financial imperatives.*

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## INTRODUCTION

In August 2023, 39-year-old Sungida Rashid and her husband, Nabil, moved to Boston with a child on the way.<sup>1</sup> As Sungida's expected delivery neared, the couple selected a nearby hospital, St. Elizabeth's Medical Center in Boston, owned by Steward Health Care.<sup>2</sup> Sungida was admitted to the Steward hospital on a Sunday in October and went into labor.<sup>3</sup> By early Tuesday morning, she gave birth to her daughter.<sup>4</sup>

But as Sungida and her husband celebrated their newborn, the hospital was in dire straits. Cerberus, a private equity firm, purchased the nonprofit Caritas Christi Health Care system in Massachusetts in 2010 and rebranded it as the for-profit system called Steward Health Care.<sup>5</sup> Driven by profit, Steward cut corners, understaffed its hospitals, and failed to pay vendors for important supplies.<sup>6</sup>

Barely a day after Sungida gave birth, her abdomen filled with blood.<sup>7</sup> She was rushed into surgery.<sup>8</sup> Doctors said they needed an embolism coil to block the bleeding, a device expected to be available at a Level IV maternal care center.<sup>9</sup> However, because the hospital had not paid its bills, the coils had been repossessed by the supplier, meaning they could not properly treat Sungida.<sup>10</sup>

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1. Jessica Bartlett, *Steward's Medical Devices Were Repossessed. Weeks Later, a New Mother Died.*, BOS. GLOBE (Jan. 25, 2024), <https://www.bostonglobe.com/2024/01/25/business/steward-health-care-mother-death/> [https://perma.cc/CJ7W-8TFY].

2. See *id.* (noting that Sungida had chosen St. Elizabeth's for its proximity, accessibility, and her good relationship with staff).

3. *Id.*

4. *Id.*

5. Maya Brownstein, *Private Equity's Appetite for Hospitals May Put Patients at Risk*, HARV. T.H. CHAN SCH. PUB. HEALTH (Dec. 18, 2024), <https://hsph.harvard.edu/news/private-equitys-appetite-for-hospitals-may-put-patients-at-risk/> [https://perma.cc/79F8-MWLH].

6. See Michael Kaplan, Jon LaPook & Sheena Samu, *A New Mom Died After Giving Birth at a Boston Hospital. Was Corporate Greed to Blame?*, CBS NEWS (Feb. 28, 2024), <https://www.cbsnews.com/news/a-new-mom-died-after-giving-birth-at-a-boston-hospital-was-corporate-greed-to-blame/> [https://perma.cc/Y9ER-WWD7] (describing that while representatives from Steward attributed the health system's financial turmoil to the pandemic, low reimbursement rates from Medicare and Medicaid, and an underfunded pension fund, the company's financial decisions told a different story, including the CEO's purchase of a \$40 million yacht and millions in dividends distributed shareholders).

7. Bartlett, *supra* note 1.

8. See *id.*

9. See *id.* (noting that while an embolism coil is not the type of equipment available in every hospital, St. Elizabeth defines itself as a Level IV maternal care center on its website, "the highest designation available from the American College of Obstetricians and Gynecologists"—a designation that requires the hospital have the capacity for embolization).

10. See *id.* (detailing that while there are multiple ways to treat internal bleeds, these bleeds are urgent and require quick treatment, and the lack of access to the embolism coil prevented doctors from quickly carrying out their plan to stop Sungida's bleeding).

In a last-ditch effort, the medical team transferred her to the nearby Boston Medical Center, but it was too late.<sup>11</sup> Without timely treatment at St. Elizabeth's, Sungida died an hour into surgery.<sup>12</sup>

Sungida is one of many patients to suffer as a result of an increasingly financialized U.S. health care system.<sup>13</sup>

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Health care financialization refers to the shift in the primary ends of health care institutions from the production of patient and community health to the extractive production of wealth for equity owners and management.<sup>14</sup> Arising in both for-profit and nonprofit institutions,<sup>15</sup> health care financialization is characterized by three features. First, financialization transfers governance and decision-making authority from community stakeholders and health care producers to financial investors and executives.<sup>16</sup> Second, financialization's emphasis on short-term profit generation encourages extractive strategies of financial engineering and labor suppression, rather than value creation.<sup>17</sup> And

11. *Id.*

12. *Id.*

13. See, e.g., Kana Ruhalter & Arun Rath, *The Devastating Human Toll Caused by Steward's Financial Failure*, GBH NEWS (Sep. 10, 2024), <https://www.wgbh.org/news/national/2024-09-10/the-devastating-human-toll-caused-by-stewards-financial-failure> [<https://perma.cc/AJY5-Y2J8>] (describing the patient harms of the Steward hospital collapse); Yasmin Rafiei, *When Private Equity Takes Over a Nursing Home*, THE NEW YORKER (Aug. 25, 2022), <https://www.newyorker.com/news/dispatch/when-private-equity-takes-over-a-nursing-home> [<https://perma.cc/Z2F9-NLTK>] (describing the worsening patient care in private equity-acquired nursing homes); David Armstrong, Patrick Rucker & Maya Miller, *UnitedHealthcare Tried to Deny Coverage to a Chronically Ill Patient. He Fought Back, Exposing the Insurer's Inner Workings.*, PROPUBLICA (Feb. 2, 2023), <https://www.propublica.org/article/unitedhealth-healthcare-insurance-denial-ulcerative-colitis> [<https://perma.cc/7KBE-JPLG>] (describing UnitedHealthcare's coverage denials to a young man with ulcerative colitis).

14. See, e.g., GERALD A. EPSTEIN, *FINANCIALIZATION AND THE WORLD ECONOMY* 3 (2005) (defining financialization as "the increasing role of financial motives, financial markets, financial actors[,] and financial institutions in the operation of the domestic and international economies.")

15. *Id.* at 1.

16. See Joseph Dov Bruch, Victor Roy & Colleen M. Grogan, *The Financialization of Health in the United States*, 390 NEJM 178, 178, 180 (2024) (identifying increased prioritization on shareholder interests in the health care sector and the phenomenon of "value shifting," where value is taken from members of society and transferred to "the owners of capital."); PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE: THE RISE OF A SOVEREIGN PROFESSION AND THE MAKING OF A VAST INDUSTRY* 429 (2d ed. 2017) (describing how hospital consolidation shifts "the locus of control from community boards to regional and national health care corporations.").

17. We understand "value creation" here to refer as the creation of health outcomes through the delivery of health care goods and services. This concept of value derives both from the health care literature and the financialization literature. In health care, "value" is often framed as the ratio of health outcomes to cost. See, e.g., Michael E. Porter, *What Is Value in Health Care?*, 363 NEJM 2477, 2477 (2010) (defining "value" in healthcare as dependent on patient outcomes and efficiency, not the volume of services delivered); Susan N. Landon, Jane Padikkala & Leora I. Horwitz, *Defining Value in Health Care: A Scoping Review of the Literature*, 33 INT. J. QUALITY HEALTH CARE 1, 6–7 (2021) (concluding that while definitions of "value" in health care vary, "addressing costs alongside quality and outcomes"

third, financialization enables accountability avoidance through mechanisms like delocalization, consolidation, and sophisticated corporate governance.<sup>18</sup>

This account of U.S. health care financialization is illustrated by two principal cases: rising private equity ownership and asset extraction from health care providers<sup>19</sup> and the incursion of Medicare Advantage insurance companies into care delivery via vertical integration.<sup>20</sup> In both instances, financialization carries significant risks of harm in the form of: (1) increased spending from market consolidation and financial engineering, without generating value; (2) reduced health care quality and access for patients; and (3) moral injury and exit by the clinical workforce.<sup>21</sup> More broadly, a financialized health care system functions primarily to accumulate wealth for private investors and corporate executives and not to benefit patients, communities, or the clinical providers of health care.<sup>22</sup>

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remains critical). In the financialization literature more broadly, “value” refers to the production of new goods and services. “Value creation” uses human and physical resources to produce new goods and services, whereas “value extraction” entails activities that move around existing resources and generate disproportionate gain from trade. See MARIANA MAZZUCATO, *THE VALUE OF EVERYTHING: MAKING AND TAKING IN THE GLOBAL ECONOMY* 6, 16, 133, 174–75 (2018) (explaining how financialization is characterized by value-extraction and short-termism).

18. Eileen Appelbaum & Rosemary Batt, *Financialization in Health Care: The Transformation of US Hospital Systems* 1, 57 (Sep. 9, 2021) (working paper) (on file with the Center for Economic and Policy Research) [hereinafter Appelbaum & Batt, *Financialization in Health Care*].

19. Eileen Appelbaum & Rosemary Batt, *Private Equity Buyouts in Healthcare: Who Wins, Who Loses?* 5 (Ctr. for Econ. & Pol’y Rsch., Working Paper No. 118, 2020), <https://cepr.net/publications/private-equity-buyouts-in-healthcare-who-wins-who-loses/> [<https://perma.cc/F5LD-54TX>] [hereinafter Appelbaum & Batt, *Private Equity Buyouts*].

20. EILEEN APPELBAUM, ROSEMARY BATT & EMMA CURCHIN, *PROFITING AT THE EXPENSE OF SENIORS: THE FINANCIALIZATION OF HOME HEALTH CARE* 25 (2023) [hereinafter Appelbaum, Batt & Curchin, *Profiting at the Expense of Seniors*].

21. See Erin C. Fuse Brown & Mark A. Hall, *Private Equity and the Corporatization of Health Care*, 76 STAN. L. REV. 527, 543–46 (2024) (describing these risks with respect to private equity investment) [hereinafter Fuse Brown & Hall, *Private Equity*, STAN L. REV.]; Hayden Rooke-Ley, *Medicare Advantage and Vertical Consolidation in Health Care*, AM. ECON. LIBERTIES PROJECT 24, 26–27, 38 (Apr. 2024), <https://www.economicliberties.us/wp-content/uploads/2024/04/Medicare-Advantage-AELP.pdf> [<https://perma.cc/SND9-ME8K>] (describing these risks with respect to Medicare Advantage).

22. See Benjamin M. Hunter & Susan F. Murray, *Deconstructing the Financialization of Healthcare*, 50 DEV. AND CHANGE 1263, 1276 (2019) (“a private investment-fueled expansion of these healthcare provision models raises important questions about the decline of healthcare systems as social institutions and the implications for equity. The expansion of privately financed projects is primarily a commercial venture to which population health is a secondary, indeed sometimes a contradictory, consideration.”); Jessica L. Andersen, *Impact of Private Capital and Financialization on Health Equity: A Response to Enekeuchi*, HEALTH AFFS. FOREFRONT (Jan. 3, 2024), <https://www.healthaffairs.org/content/forefront/impact-private-capital-and-financialization-health-equity-response-enekeuchi> [<https://perma.cc/6MWX-MCTW>] (emphasizing that financialization of the health care industry shifts hospital operational strategies to favor shareholders “above all else” to the detriment of patient care quality and health care costs, and identifying the “aggressive use of mergers and acquisitions to increase market power” and engaging in “fraudulent billing practices such as upcoding” as examples of these strategies).

Developing an understanding of financialization helps to explore questions about the role of private-sector investment and ownership in health care. U.S. health care is predominantly taxpayer financed, so returns on private-sector capital are especially “public.”<sup>23</sup> Thus, the question is less *whether* public policy ought to play an affirmative role in shaping these investments, but *how*. Our account of financialization illuminates that health care services, when treated as a market commodity, are highly vulnerable to financialization, so unfettered private-sector investment in health care risks the extraction of health care assets from communities and society as a whole.<sup>24</sup>

Despite these concerns, however, we resist the wholesale condemnation of private enterprise in health care to augment public investment. Forms of private-sector investment and ownership vary widely and have long persisted in health care.<sup>25</sup> And practically speaking, health care providers of all kinds—from large health systems to nursing homes to physician practices—increasingly rely on private-sector capital to survive in the face of massive industry consolidation; rising administrative, data, and technological costs; and the imperatives to bear financial risk under the value-based payment revolution.<sup>26</sup>

Health care financialization thus presents a policy conundrum. What framework for law and policy can enable capital investment without financialization? What sorts of payment policies, rules of commerce, and governance structures can guard against the transfer of power and assets, financial engineering and labor exploitation, and evasion of accountability? Where should we be more reliant on public investment and even public ownership? We have written elsewhere about specific policy responses to the concerns of private equity involvement and Medicare Advantage’s vertical consolidation of the health care system.<sup>27</sup> But if health care financialization

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23. See Adam Gaffney, Steffie Woolhandler & David U. Himmelstein, *Century-Long Trends in the Financing and Ownership of American Health Care*, 101 MILBANK Q. 325, 341 (2023) (noting the proportion of health care spending funded by taxpayer financing has “soared from 9% in 1923 to 69% in 2020[,]” where taxpayer subsidies for private insurance now account for nearly a third of these public expenditures).

24. Andersen, *supra* note 22.

25. See Fuse Brown & Hall, *Private Equity*, STAN. L. REV., *supra* note 21, at 527, 542 (noting that “private equity is the latest manifestation of a long trend toward the corporatization and financialization of medicine,” and describing prior forms of private investment in health care, including the physician practice management company (PPMC) bubble from the 1990s).

26. See *infra* Section II.C.

27. See Fuse Brown & Hall, *Private Equity*, STAN. L. REV., *supra* note 21, at 578–583 (asserting the legislature and regulatory agencies have tools to force PE investors to “make their operations more transparent and to close the payment loopholes” that they exploit); Erin C. Fuse Brown et al., *Legislative and Regulatory Options for Improving Medicare Advantage*, 48 J. HEALTH POL., POL’Y & L. 919–50 (2023) [hereinafter Fuse Brown et al., *Legislative and Regulatory Options for Improving Medicare Advantage*]; (describing the problematic design features of the Medicare Advantage payment policy and providing potential legislative and regulatory strategies that can address these issues); Erin C. Fuse Brown et al., *The Rise of Health Care Consolidation and What to Do About It*, HEALTH AFFS. FOREFRONT (Sep.

represents a sector-wide development—one central to, or even synonymous with, our new Gilded Age of Medicine<sup>28</sup>—then a commensurate response is in order: an updated policy framework for governing U.S. health care.

Here we offer the broad contours of such a framework, oriented around three broad policy categories: reforming payment policy, shaping health care markets, and building and allocating supply. This policy agenda would depart from managed care and value-based payment and instead emphasize direct regulation through pricing policy; it would deploy market shaping rules such as structural separations and antitrust reform, access requirements, nondiscrimination, and ownership and governance rules; and it would pursue a muscular approach to building and allocating health care supply with targeted workforce development, channeling of private-sector capital, public investment and ownership, and entry and exit restrictions.

These concepts depart from prevailing approaches to health policy, but they are beginning to take hold at the state level—a sign that a new governing framework may be emerging.<sup>29</sup> Close observers will also note the framework’s parallels to other sectors more commonly associated with the “regulated industries” or “public utility” tradition. Indeed, many of these proposed legal and policy tools were pioneered by Progressive Era and New Deal reformers in response to a Gilded Age economy that exhibited many of the same features of financialization now manifesting in health care.<sup>30</sup>

Fundamentally, the aim of this article is to define the phenomenon of financialization and to drive a research and policy agenda to protect against its worst effects and to reorient the health care system for all of us who depend upon it.

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9, 2024) [hereinafter Fuse Brown et al., *The Rise of Health Care Consolidation*], <https://www.healthaffairs.org/content/forefront/rise-health-care-consolidation-and-do> [<https://perma.cc/22DK-S2TF>] (highlighting the negative impact of private equity’s consolidation in the health care sector, and offering policy options to combat these issues, such as increasing funding for antitrust enforcement and amending legal standards to make it easier to block anticompetitive mergers, establishment of centralized databases to increase ownership transparency, and increased enforcement of fraud and abuse laws to deter fraudulent billing, upcoding, self-referrals and kickback schemes); Hayden Rooke-Ley, Soleil Shah & Erin C. Fuse Brown, *Medicare Advantage and Consolidation’s New Frontier — The Danger of UnitedHealthcare for All*, 391 NEJM 99 (2024) [hereinafter Rooke-Ley, Shah & Fuse Brown, *Medicare Advantage*] (proposing policies to address vertical consolidation by Medicare Advantage insurers, including directing more resources to support increased antitrust scrutiny and enforcement, prohibiting insurers from owning medical practices, and limiting corporate control of physician practices, and more).

28. See generally Dhruv Khullar, *The Gilded Age of Medicine Is Here*, THE NEW YORKER (Dec. 12, 2024), <https://www.newyorker.com/culture/2024-in-review/the-gilded-age-of-medicine-is-here> [<https://perma.cc/Z7L6-ZR6N>] (describing the current era as a “Gilded Age” of medicine, marked by increasingly consolidated corporate and for-profit control of health care, where “[i]ncreasingly, health insurers, private hospitals, and even nonprofits are behaving as though they aim first to extract revenue, and only second to care for people.”).

29. See *infra* Part IV (discussing state legislation).

30. See *infra* Part IV (discussing public utility governance).

This article proceeds in four parts. Part I provides a framework for understanding health care financialization, including a definition of health care financialization, the means by which financialization is accomplished, and key behaviors that characterize financialization.<sup>31</sup> Part I also builds on recent efforts to define financialization, distinguishes it from related terms of “privatization” and “corporatization,” and considers some of the forces driving demand for private-sector capital in health care.<sup>32</sup> Part II discusses two case studies of health care financialization—private equity investment and vertical consolidation by Medicare Advantage insurance companies—and explains how both financialize the health care system.<sup>33</sup> Part III explores the tradeoffs between the risks of health care financialization to health care spending, patient care, and the clinical workforce, balanced against the demand for private-sector capital by health care entities.<sup>34</sup> This section calls for a nuanced approach to the policy conundrum that avoids both dichotomous bans on private-sector capital in health care and its unfettered entry.<sup>35</sup> Part IV sketches a policy framework for addressing financialization, with legal and policy tools organized into a three-part framework to guide research and policy development.<sup>36</sup>

## I. CONCEPTUAL FRAMEWORK FOR HEALTH CARE FINANCIALIZATION

### *A. Defining Financialization in Health Care*

Financialization occurs when the primary objective of health care entities transforms from the production of health care for patients and the community to the extractive production of wealth for financial firms and corporate managers.<sup>37</sup> Health care financialization elevates profit and shareholder maximization over patient and community health, such that conflicts between maximizing profit and patient welfare are resolved in favor of profits.<sup>38</sup> Financialization in health care is extractive, mining health care assets, such as insurer or government payments or real property, to generate returns for investors at the expense of patient care or community health.

Three key characteristics follow from financialization in health care. The first is a relocation of power: financialization occurs via a transfer of governance

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31. See *infra* Part I.

32. See *infra* Part I.

33. See *infra* Part II.

34. See *infra* Part III.

35. See *infra* Part III.

36. See *infra* Part IV.

37. Appelbaum & Batt, Financialization in Health Care, *supra* note 18, at 17–18.

38. See Bruch, Roy, & Grogan, *supra* note 16, at 178 (linking the rise of financialization to the concept of shareholder primacy that “prioritizes the interests of shareholders over other potential stakeholders, such as workers or local communities.”).



and decision-making authority from the producers of goods and services to the financiers and executives.<sup>39</sup> For example, financialization of physician practices occurs when a management services organization (MSO)—a separate, lay-owned corporate entity—uses financial incentives and sophisticated contracting arrangements to assume *de facto* control of the medical practice; the MSO can thereby influence physicians' clinical decisions, such as patients' prescriptions, length of visits, referrals, or diagnoses, in order to maximize profit.<sup>40</sup>

Second, financialization's emphasis on profits as a means of prioritizing short-term financial returns and growth over social goals and business sustainability incentivizes financial engineering and labor suppression.<sup>41</sup> Financial engineering refers to business maneuvers and gaming strategies that increase short-term revenue and profitability without improving the quality, value, or availability of care.<sup>42</sup> Examples of financial engineering include the exploitation of payment loopholes,<sup>43</sup> multiple arbitrage through add-on

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39. See Bruch, Roy & Grogan, *supra* note 16, at 178.

40. Jane M. Zhu, Hayden Rooke-Ley & Erin Fuse Brown, *A Doctrine in Name Only — Strengthening Prohibitions against the Corporate Practice of Medicine*, 389 NEJM 965 (2023), <http://www.nejm.org/doi/10.1056/NEJMp2306904> [<https://perma.cc/95JV-SNGH>]; Am. Acad. of Emergency Med. The Corporate Practice of Medicine: Protecting Patient Care and Physician Autonomy, <https://www.aaem.org/the-corporate-practice-of-medicine-protecting-patient-care-and-physician-autonomy/> [<https://perma.cc/7VZU-2YTH>] (last accessed July 6, 2025); HAYDEN ROOKE-LEY ET AL., THE CORPORATE BACKDOOR TO MEDICINE: HOW MSOs ARE RESHAPING PHYSICIAN PRACTICES 4 (2025).

41. Christopher Cai & Zirui Song, *A Policy Framework for the Growing Influence of Private Equity in Health Care Delivery*, 329 JAMA 1545, 1545 (2023) [hereinafter Cai & Song, *A Policy Framework*].

42. See Mark Hall & Erin C. Fuse Brown, *Private Equity and the Corporatization of Health Care*, HARV. L. SCH. F. ON CORP. GOVERNANCE (Apr. 19, 2023) [hereinafter Hall & Fuse Brown, *Private Equity*, HARV. L. SCH.], <https://corpgov.law.harvard.edu/2023/04/19/private-equity-and-the-corporatization-of-health-care/> [<https://perma.cc/22FE-WFXE>] (noting that private equity investors are drawn to sectors where they can reap “very significant profit rewards over a relatively short term,” especially now in health services, where they are able to employ strategies to “exploit market dysfunctions or regulatory ‘loopholes’” to generate fast and substantial revenue. The drive for fast generation of revenue “threatens to increase costs and lower quality” due to “consolidation, overutilization and upcoding, constraints on physicians’ clinical autonomy, and compromises in patient care.”).

43. See, e.g., Erin Fuse Brown et al., *Private Equity Investment as a Divining Rod for Market Failure: Policy Responses to Harmful Physician Practice Acquisitions*, USC-BROOKINGS SCHAEFFER INITIATIVE FOR HEALTH POLICY 17–18 (Oct. 2021) [hereinafter FUSE BROWN, ET AL, *PRIVATE EQUITY INVESTMENT*], <http://www.brookings.edu/wp-content/uploads/2021/10/Private-Equity-Investment-As-A-Divining-Rod-For-Market-Failure-14.pdf> [<https://perma.cc/E5XT-VDDQ>] (describing examples of payment loopholes exploited by private equity investors, including out-of-network surprise medical bills, Medicare Part B payments for physician-administered drugs, and diagnostic upcoding to increase risk adjusted payments in Medicare Advantage).

acquisitions,<sup>44</sup> real estate sale-leaseback arrangements,<sup>45</sup> or funneling surpluses into investment funds rather than health care capacity,<sup>46</sup> that provide no benefits to patient care. Due to the labor-intensive nature of health care, labor suppression is central to the cost-cutting dimension of driving profitability. Productivity gains through operational efficiencies are notoriously difficult to consistently achieve.<sup>47</sup> Generating margins—particularly in hospitals, nursing homes, home health care, and medical practices—therefore requires anti-labor tactics that often jeopardize care quality: reductions in staffing levels, resisting union formation, workplace fissuring, wage suppression, and substitution with lower-cost clinicians.<sup>48</sup>

Third, financialization enables the financial investors to evade reputational, legal, and market accountability. Financialization relies on delocalization and consolidation to shield the locus of decision-making and power from reputational harm, legal liability, and competition.<sup>49</sup> Delocalization refers to the removal of health care assets and governance from the community in which the health care entity operates.<sup>50</sup> In a health system with locally accountable governance, there is grave reputational harm from taking actions in pursuit of profits at the expense

44. See, e.g., Sherry Glied & Thomas D'Aunno, *Efficiency and Arbitrage in Health Services Innovation*, 3 JAMA HEALTH F., Mar. 3, 2022, at 1 (asserting private equity firms gain from and exploit arbitrage opportunities, where firms generate money from buying an asset in one market and selling it to another market at a higher price); Lawrence P. Casalino et al., *Private Equity Acquisition of Physician Practices*, 171 ANN. INTERN. MED. 114 (2019) (describing how private equity firms can increase valuation of smaller physician practices by merging them into larger practices, which presents “a major arbitrage opportunity.”).

45. See, e.g., SENATE BUDGET COMMITTEE BIPARTISAN STAFF REPORT, PROFITS OVER PATIENTS: THE HARMFUL EFFECTS OF PRIVATE EQUITY ON THE U.S. HEALTH CARE SYSTEM iii (Jan. 2025), [https://www.budget.senate.gov/imo/media/doc/profits\\_over\\_patients\\_the\\_harmful\\_effects\\_of\\_private\\_equity\\_on\\_the\\_ushealthcaresystem1.pdf](https://www.budget.senate.gov/imo/media/doc/profits_over_patients_the_harmful_effects_of_private_equity_on_the_ushealthcaresystem1.pdf) [<https://perma.cc/7Y5N-Y5T5>] (describing how private equity investors used sale-leaseback arrangements to extract wealth for shareholders while leaving the Lifepoint and Prospect Medical hospitals in financial distress).

46. See, e.g., Martha C. White, *Hospitals Made \$21B on Wall Street Last Year, But Are Patients Seeing Those Profits?*, NBC NEWS (Feb. 7, 2018), <https://www.nbcnews.com/business/business-news/hospitals-made-21b-wall-street-last-year-are-patients-seeing-n845176> [<https://perma.cc/LEU6-9F6K>] (identifying how large hospital systems invest their funds into investment funds, generating substantial amounts of investment revenue far exceeding profits from patient care, yet do not use these profits to give patients lower prices).

47. GABRIEL WINANT, *THE NEXT SHIFT: THE FALL OF INDUSTRY AND THE RISE OF HEALTH CARE IN RUST BELT AMERICA* 2 (2021).

48. *Id.* at 2–5.

49. See STARR, *supra* note 16, at 429 (describing how hospital consolidation shifts the “locus of control” from communities to national corporations).

50. MARYANN P. FELDMAN & MARTIN F. KENNEY, *PRIVATE EQUITY AND THE DEMISE OF THE LOCAL: THE LOSS OF COMMUNITY ECONOMIC POWER AND AUTONOMY* 36 (Arie Y. Lewin & Till Talaulicar eds., 2024) (describing how private equity consolidations at local hospitals remove key actors from the community causing patients to travel for care).

of patients or communities.<sup>51</sup> Consolidated health systems whose governing bodies and assets are removed from communities to financial firms and corporate managers face few reputational consequences.<sup>52</sup> In similar ways, a private-equity firm that rolls up physician practices is shielded by layers of corporate structure and market power from both competitive constraints and liability from price spikes and labor cuts that sacrifice patient care quality.<sup>53</sup>

### *B. Financialization – Conceptions and Distinctions*

The concept of financialization has been emerging in the literature for five decades and is neither unique to health care nor the U.S.<sup>54</sup> In Gerald Epstein's seminal formulation, financialization refers to the increasing role of financial motives, financial markets, financial actors, and financial institutions in the operation of the domestic and international economies.<sup>55</sup> As a form of capitalist development, the term describes a systemic shift in the primary driver of profit accumulation from the production of goods and services to financial activities.<sup>56</sup> This concept was reflected by Greta Krippner, who defined financialization as

51. See Jonathan Weil, *How a Private-Equity Payday Drained a Hospital Chain of Cash*, WALL ST. J. (Sep. 11, 2024), <https://www.wsj.com/finance/how-a-private-equity-payday-drained-a-hospital-chain-of-cash-35a5cb35> [<https://perma.cc/9TZG-XU7X>] (discussing the fall in patient care and staffing and equipment after a hospital experienced a large loss and was forced to file for bankruptcy).

52. See *id.* (discussing how a hospital failed to file financial disclosures with the court on multiple occasions and did not face legal consequences and failed to make a dividend payment despite having the sufficient financial capital).

53. See, e.g., Memorandum Op. & Ord. at 1, *FTC v. U.S. Anesthesia Partners Inc.*, No. 4:23-CV-03560, 2024 WL 2137649 (S.D. Tex. May 13, 2024), appeal dismissed, No. 24-20270, 2024 WL 5003580 (5th Cir. Aug. 15, 2024) (dismissing private equity fund, Welsh Carson, as a defendant in the case by the FTC alleging the monopolization of anesthesiology markets in Texas); See also Brendan Ballou, *Private Equity is Gutting America—and Getting Away With It*, N.Y. TIMES (April 28, 2023), <https://www.nytimes.com/2023/04/28/opinion/private-equity.html> [<https://perma.cc/4WYR-BVUE>] (describing how private equity fund Carlyle Group evaded liability for staffing cuts and patient deaths at bankrupted nursing home chain, HCR Manorcare).

54. See, e.g., EPSTEIN, *supra* note 14, at 3 (2005) (defining financialization as “the increasing role of financial motives, financial markets, financial actors[,] and financial institutions in the operation of the domestic and international economies.”); Malcom Sawyer, *What is Financialization?*, 42 INT’L J. POL. ECON. 5, 7–8 (2014) (characterizing financialization as “not merely the expansion and proliferation of financial instruments and markets that are striking but also the penetration of such financing into a widening range of both economic and social reproduction—housing, pensions, health, and so on.”); MIKE KONCZAL & NELL ABERNATHY, *DEFINING FINANCIALIZATION* 4 (2015) (defining financialization as “the growth of the financial sector, its increased power over the real economy, the explosion in the power of wealth, and the reduction of all of society to the realm of finance.”).

55. EPSTEIN, *supra* note 14, at 5.

56. Greta R. Krippner, *The Financialization of the American Economy*, 3 SOCIO-ECON. REV. 173, 174 (2005); Donald Tomaskovic-Devey & Ken-Hou Lin, *Financialization: Causes, Inequality Consequences, and Policy Implications*, 18 N.C. BANKING INST. 167 (2013); Gerald F. Davis & Suntae Kim, *Financialization of the US Economy*, EMERGING TRENDS SOC. AND BEHAV. SCIS (2015), <https://emergingtrends.stanford.edu/s/emergingtrends/item/12580> [<https://perma.cc/ZAZ9-PV6T>]; Costas Lapavistas, *The Financialization of Capitalism: ‘Profiting without Producing,’* 17 CITY 792 (2013); Bruch, Roy & Grogan, *supra* note 16, at 178.

“a pattern of accumulation in which profits accrue primarily through financial channels rather than through trade and commodity production.”<sup>57</sup> This signifies a fundamental shift where economic attention has moved away from tangible, productive investment and toward the pursuit of gains through financial instruments, asset trading, and capital market manipulation—from productive capital to financial capital.<sup>58</sup> These forms of “financial capital” include investment from banks, insurance companies, private equity and venture capital firms, bond investors, and rating agencies.<sup>59</sup>

Much of the economic sociology and political economy literature explores financialization’s impact on corporate governance—how financial logics, strategies, and attitudes have permeated the “real” economy to produce profits for financial investors.<sup>60</sup> Such financialization stems in large part from the rise of shareholder primacy, the concept famously popularized by Milton Friedman that the primary duty of the corporation is to maximize profits for shareholders, rather than to promote social welfare more broadly.<sup>61</sup> Under the earlier regime of managerialism, corporate governance emphasized the autonomy of professional managers who balanced the interests of multiple stakeholders, such as employees, consumers, and communities, while pursuing long-term organizational growth and sustainability.<sup>62</sup> However, starting in the 1980s, this managerial logic gave way to the new orientation centered on financial performance, increasingly prioritizing stock prices, dividends, and return to shareholders over productive investment or sustainable value creation.<sup>63</sup> While financialization originated in the reorientation of corporate priorities and

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57. See Krippner, *supra* note 56, at 174.

58. See Krippner, *supra* note 56, at 154.

59. See EPSTEIN, *supra* note 14, at 5 (describing financialization as the “increasing role of financial motives, financial markets, financial actors and financial institutions in the operation of the domestic and international economies.”).

60. Laura Horn, *The Financialization of the Corporation*, in *THE CORPORATION: A CRITICAL, MULTI-DISCIPLINARY HANDBOOK* 282 (Grietje Baars & Andre Spicer, eds. 2017) (describing post-Keynesian accounts emphasizing the “growing role of the financial vis-à-vis the productive sector” and the how the financialization literature shows that aggregate investment in the “real economy” declines as financial investments have higher returns); MAZZUCATO, *supra* note 17, at 16 (describing financialization as “the growth of the financial sector and the spread of financial practices and attitudes into the real economy.”).

61. See Horn, *supra* note 60, at 283; Michael C. Jensen & William H. Meckling, *Theory of the Firm: Managerial Behavior, Agency Costs and Ownership Structure*, 3 J. FIN. ECON. 305 (1976); Milton Friedman, *A Friedman Doctrine-- The Social Responsibility of Business is to Increase its Profits*, N.Y. TIMES (Sep. 13, 1970), <https://www.nytimes.com/1970/09/13/archives/a-friedman-doctrine-the-social-responsibility-of-business-is-to.html> [<https://perma.cc/5FD6-RXG8>].

62. Brian R. Cheffins, *The Past, Present and Future of Corporate Purpose* 20–22 (University of Cambridge and ECGI, Working Paper no. 713, 2023), <https://papers.ssrn.com/abstract=4420800> [<https://perma.cc/Y7FA-N4KG>].

63. *Id.* at 26.

accumulation strategies, its effects soon spread throughout the economy as part of a broader shift toward a financialized corporate ethos and governance.<sup>64</sup>

The normative implication of financialization is decidedly negative. Scholars have characterized financialization as producing extraction rather than value-creation.<sup>65</sup> According to Kean Birch and Callum Ward, financialization, or “financialized capital,” is “extractive,” where the returns on asset ownership exceed returns on labor, and “parasitical” because it “kill[s] the host of production.”

It is from this strain of the literature—financialization’s modes of governance and its extractive effects—that we draw our definition and apply it to health care<sup>66</sup>: the primacy of short-term profit extraction for financial firms and corporate managers over the production of health for patients and the community. From there, we apply the literature’s engagement with practices, behaviors, and attitudes of financialized institutions to capture the underlying motivation and ethos of financialization in health care. That is, we specify the modes of governance and operational traits that characterize, or flow from, a financialized health care entity: the transfer of governance power from producers of health care goods and services to financiers and executives, governance that prioritizes financial engineering and labor suppression to achieve short-term profits, and mechanisms of accountability avoidance. This definition of health care financialization establishes a framework for assessing when financialization is occurring and, more importantly, for developing a research and policy agenda to confront it. Though health care financialization may correlate with private, for-profit ownership and investment structures—such as a financial firm owning of a medical clinic—it can span ownership and organizational form, ranging from private equity and publicly traded companies to nonprofit hospital systems.<sup>67</sup>

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64. Paddy Ireland, *Financialization and Corporate Governance*, 60 N. IR. LEGAL Q. 1, 2 (2009) (describing the spread of the “shareholder value” model of the corporation and corporate governance, where the sole object of corporate governance is to maximize shareholder value).

65. See MAZZUCATO, *supra* note 17, at 133, 174–75 (explaining how financialization is characterized by value-extraction and short-termism).

66. See Bruch, Roy & Grogan, *supra* note 16, at 178 (describing financialization as “involv[ing] the transformation of public, private, and corporate health care entities into salable and tradable assets from which the financial sector may accumulate capital. Financialization captures the new forms of financial-sector ownership and control in the U.S. health care system, as well as the demands of financial markets for short-term profit growth and the distribution of this growth to financial actors that are external to health care entities and U.S. households.”).

67. Appelbaum & Batt, *Financialization in Health Care*, *supra* note 18, at 1. Appelbaum and Batt note the following:

[H]ealthcare financialization has occurred along two parallel tracks: from ‘the inside out’ – as nonprofit hospitals increasingly adopt non-healthcare-related financial strategies to survive; and from ‘the outside in’ – as financial actors have moved into healthcare because they view it as a lucrative investment. Nonprofit, for-profit, and private equity owned hospitals have

Epstein's oft-cited definition highlights the *who* of financialization—the influence or involvement of the financial sector and its motives in the operation and governance of the economy.<sup>68</sup> And in the health care context, the growing role of financial actors and institutions explains how health care assets are extracted from health care institutions and converted or collateralized into market commodities.<sup>69</sup> However, to understand how financialization in health care both differs from and is broader than the mere presence of financial institutions and private-sector capital financing, which have been part of U.S. health care for decades, the key distinction lies in the primary *ends* of a financialized health care entity: the supremacy of profit over patient care or community health.<sup>70</sup> This also helps us identify the set of operational and governance strategies that characterize financialized institutions—whether or not formally involved with traditional markers of the financial sector.

Our definition is more capacious than those that focus on the involvement of financial firms in a previously non-financial sector.<sup>71</sup> We acknowledge that our broader definition may entail some tradeoffs, including a departure from the literature on financialization in non-health sectors, in order to more broadly conceptualize policies to address health care financialization that go beyond financial regulations toward a reimagined industrial organization of health care.<sup>72</sup> However, health care is somewhat distinct because the traditional producers of health care services—physicians and nonprofit health care entities—owe fiduciary, ethical, and charitable duties to their patients and communities.<sup>73</sup> Thus, when these health care providers become financialized, the subordination of their duties to prioritize patient and community health in favor of profit maximization for shareholders and managers exacts a rupture to the fundamental nature of and social contract upon which the sector was built.

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contributed in different ways to the process of financialization in healthcare – in which the logic of financial calculations often overshadows the logic of human care giving.

*Id.*

68. EPSTEIN, *supra* note 14, at 5.

69. Hunter & Murray, *supra* note 22, at 1270–71.

70. See Applebaum & Batt, Financialization in Health Care, *supra* note 18, at 1 (describing financialization in health care as the process “in which the logic of financial calculations often overshadows the logic of human care giving.”).

71. See, e.g., MAZZUCATO, *supra* note 17, at 16 (describing financialization as “the growth of the financial sector and the spread of financial practices and attitudes into the real economy.”).

72. See *infra* Part IV (setting forth a policy and research agenda to reimagine the industrial organization of health care in response to financialization).

73. See BRIETTA CLARK ET AL., HEALTH LAW: CASES, MATERIALS, AND PROBLEMS 121, 753 (9th ed., 2022) (discussing physicians and entities’ duties to patients and communities); Maxwell J. Mehlman, *Why Physicians are Fiduciaries For Their Patients*, 12 IND. HEALTH L. REV. 1, 2 (2015) (describing the physician-patient relationship as a fiduciary one).

Financialization can be distinguished from the related concept of “privatization.”<sup>74</sup> Privatization refers to the private ownership or control of a firm or assets, in contrast to public ownership.<sup>75</sup> While significant public funding in the form of taxpayer dollars flows through the Medicare and Medicaid programs, in the U.S., the vast majority of the health care system is owned, governed, and operated by private entities.<sup>76</sup> Even nonprofit corporations, with their requirements for charitable or public purposes, are private entities.<sup>77</sup> Thus, privatization is not synonymous with financialization.<sup>78</sup> A health care system that is privately owned can be pursued primarily toward the ends of improving health for the benefit of the community, rather than for the profit of its private owners.<sup>79</sup> This may be a fair (although not uniformly accurate) characterization of how the U.S. health care system operated for much of its history, centering the primacy of community benefit through the nonprofit status of health care facilities and the professional fiduciary and ethical duties of for-profit physicians.<sup>80</sup> As such, while privatization can facilitate financialization—particularly if it encourages certain ownership and business models more prone to value extraction—it is possible to have privately owned and delivered health care entities that do not pursue profit margin and wealth accumulation as the primary aim.<sup>81</sup>

Compared to privatization, the term “corporatization” is conceptually closer to financialization.<sup>82</sup> In prior writing with Mark Hall on private equity in health care, the terms corporatization and financialization are used

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74. Bruch, Roy & Grogan, *supra* note 16, at 178.

75. *Id.*

76. Nancy De Lew, George Greenberg & Kraig Kinchen, *A Layman's Guide to the U.S. Health Care System*, 14 HEALTH CARE FIN. REV. 151, 152–54 (1992).

77. Bruch, Roy & Grogan, *supra* note 16, at 178–79.

78. *See id.* (drawing a distinction between privatization and financialization as financialization requires a transformation of public, private, and corporate health entities).

79. *See* Jill R. Horwitz, *Making Profits and Providing Care: Comparing Nonprofit, For-Profit, and Government Hospitals*, 24 HEALTH AFFS. 790, 794 (2005) (discussing how private nonprofit hospitals are more likely than for-profit hospitals to provide less profitable services such as psychiatric emergency care).

80. *See* Connie J. Evashwick & Penrose Jackson, *The Evolution of Community Benefit: Perspective on Progress Toward Purpose*, FRONTIERS IN PUB. HEALTH, Mar. 1, 2020, at 1–2 (describing the history of the community benefit requirement for tax-exempt nonprofit hospitals); Maxwell J. Mehlman, *supra* note 73, at 2, 8 (analyzing the role of physicians' fiduciary obligations to their patients, including the obligation to resolve financial conflicts of interest in favor of the patient's interests).

81. *See generally* Sharyn J. Potter, *A Longitudinal Analysis of the Distinction Between For-Profit and Not-for-Profit Hospitals in America*, 42 J. HEALTH AND SOC. BEHAV. 17, 39 (2001) (finding that from 1980 to 1995 while not-for-profit and for-profit hospitals were converging in terms of efficiency, there was “evidence that not-for-profit hospitals are simultaneously pursuing efficiency and community service. . . and not-for-profit hospitals are giving back to their communities.”).

82. Erin C. Fuse Brown, *Defining Health Care “Corporatization”*, 393 NEJM 1, 2 (2025) (defining “corporatization” as “the general trend throughout the health care industry toward higher levels of integrated control by consolidated profit-seeking enterprises” and noting the alignment of the terms “financialization” and “corporatization” in the health care context).

interchangeably.<sup>83</sup> Both corporatization and financialization include the concept of shareholder primacy.<sup>84</sup> That said, professional corporations and community-based nonprofit corporations are still corporations, yet these corporate forms have long participated in the health care system and were perceived to be less “corporate” or financialized (at least by today’s standards), perhaps because of their professional ethical obligation, smaller size, and proximity to their communities.<sup>85</sup> Size, more than organizational form, appears to underlie the concept of corporatization.<sup>86</sup> Indeed, large corporate acquisitions of locally owned medical practices are sometimes referred to as “going corporate.”<sup>87</sup> Nurses and clinicians at expanding, multi-state, nonprofit hospital systems often describe how the institution has become “corporate.”<sup>88</sup> Our distinction between corporatization and financialization concerns the latter’s emphasis on wealth extraction from communities, workers, and patient-consumers in the form of profit for financial investors and corporate executives who are insulated from reputational or legal liability.<sup>89</sup>

These features of size and reputation also explain how a large nonprofit organization can be financialized. Nearly every city or state has a dominant health system with dozens of hospitals, an academic medical center, thousands of physicians, an insurance arm, a revenue cycle management subsidiary, and a for-profit financial investment fund.<sup>90</sup> Notwithstanding their nonprofit status, these large health systems can engage in rampant profit-seeking at the expense of patients and communities through aggressive consolidation,<sup>91</sup> financial

83. Fuse Brown & Hall, *Private Equity*, STAN. L. REV., *supra* note 21, at 533.

84. See Friedman, *supra* note 61 (arguing that a corporation has only one social responsibility, “to use its resources and engage in activities designed to increase its profits so long as it stays within the rules of the game, which is to say, engages in open and free competition without deception or fraud.”).

85. See Horwitz, *supra* note 63, at 790–98 (discussing how for-profit and nonprofit hospitals alike participate in profit making).

86. Starr, *supra* note 16, at 429.

87. See Marion Mass, *American Healthcare: Increasingly Corporate and Rapacious*, MEDPAGE TODAY (Feb. 10, 2020), <https://www.medpagetoday.com/publichealthpolicy/healthpolicy/84795> [<https://perma.cc/LD2B-PBAB>] (discussing the decrease in independent private practices as large corporations are acquiring private practices).

88. See, e.g., Fred de Sam Lazaro & Simeon Lancaster *Doctors Unionize as Healthcare Services are Consolidated Into Corporate Systems*, PBS NEWS HOURS (Jan. 1, 2024), <https://www.pbs.org/newshour/show/doctors-unionize-as-healthcare-services-are-consolidated-into-corporate-systems> [<https://perma.cc/D4SV-73FA>] (providing clinicians’ perceptions on how their daily lives have changed since being acquired by large corporate owners).

89. See Bruch, Roy & Grogan, *supra* note 16, at 178 (characterizing “financialization” by its focus on “shareholder primacy[:] a corporate governance strategy that prioritizes the interest of shareholders over other potential stakeholders, such as workers or local communities”).

90. DAVID DRANOVE & LAWTON R. BURNS, *BIG MED: MEGAPROVIDERS AND THE HIGH COST OF HEALTH CARE IN AMERICA* 2, 3 (2021).

91. See Glenn Melnick, Emmett Keeler & Jack Zwanziger, *Market Power and Hospital Pricing: Are Nonprofits Different?*, 18 HEALTH AFFS. 167, 167 (1999) (discussing how nonprofit hospitals may increase prices when merging with another hospital as a means of exploiting their market power).



engineering tactics such as billing unnecessary facility fees for acquired physicians' services,<sup>92</sup> raising prices beyond reach for their communities,<sup>93</sup> leaving insurers' provider networks,<sup>94</sup> and suing their low-income patients for unpaid medical debts.<sup>95</sup> Moreover, due to their market power, they can engage in labor market suppression through layoffs, staffing cuts, and lower wages.<sup>96</sup> But their market dominance and status with payers as a "must-have" in provider networks insulate large health systems from reputational or market discipline.<sup>97</sup> Finally, nonprofit hospitals can become financialized through their reliance on bonds (a form of debt) to finance capital expenses, which encourages prioritizing profitable services and locales (and subordinating the organization's charitable mission) to secure favorable credit ratings and to satisfy debtholder covenants.<sup>98</sup>

Finally, our definitional emphasis on extractive modes of corporate governance means that not all forms of private-sector investment—even from classically financial actors—necessarily drive health care financialization. For instance, some policies paint venture capital firms with the same financialized brush as private equity.<sup>99</sup> Generally, however, venture capital invests in early-stage companies or innovations, does not take a majority or controlling position in the company, and holds the investment for longer periods of time; thus,

92. See Melanie Evans, *Hospitals Are Adding Billions in 'Facility' Fees for Routine Care*, WALL ST. J. (Mar. 25, 2024), <https://www.wsj.com/health/healthcare/hidden-hospital-fees-cost-patients-hundreds-of-dollars-0024cd95> [<https://perma.cc/V3F7-6HPJ>] (discussing how hospitals are adding facility fees to medical bills for routine outpatient medical care including colonoscopies, mammograms, and heart screenings).

93. See Jessica Y. Chang & Kathryn Martin, *Commercial Inpatient Hospital Price Growth Driven by System Affiliation and Nonprofit-status Hospitals*, HEALTH AFFS. SCHOLAR, Nov. 1, 2024, at 1, 4 (finding that between 2012 and 2021 "inpatient prices among nonprofit hospitals were consistently higher and grew faster than for-profit hospitals.").

94. Suzanne Blake, *Hospitals Leave Medicare Advantage Networks as Problems Plague Coverage*, NEWSWEEK (Jul. 24, 2024), <https://www.newsweek.com/hospitals-leave-medicare-advantage-networks-problems-coverage-1929855> [<https://perma.cc/2N6X-CKX4>] (discussing how certain Medicare Advantage insurance companies are leaving certain areas after hospitals dropped out of their networks due to payments that were lower, delayed, or denied).

95. Emily Gee & Thomas Waldrop, *Policies to Hold Nonprofit Hospitals Accountable*, CTR. FOR AM. PROGRESS (Oct. 18, 2022), <https://www.americanprogress.org/article/policies-to-hold-nonprofit-hospitals-accountable/> [<https://perma.cc/879L-QCZ7>].

96. See Kiley Kosciński, *Justice Department Supports UPMC Workers in Lawsuit Alleging Health Care Monopoly*, 90.5 WESA (Oct. 3, 2024), <https://www.wesa.fm/health-science-tech/2024-10-03/justice-department-upmc-lawsuit-health-care-monopoly> [<https://perma.cc/BV8E-4DKB>] (examining how concentrated market conditions can result in lower health care employee wages and bad working conditions).

97. See Gee & Waldrop, *supra* note 85 (explaining how hospitals with regional monopoly power or a strong reputation can demand higher payment rates from payers, creating financial protections for the hospitals from having to operate efficiently).

98. Elizabeth King, *The Charitable Costs of Debt* 11–13 (unpublished manuscript) (2025) (on file with author).

99. See, e.g., Health Over Wealth Act, S. 4804, 118th Cong. (2024) (defining a "private equity fund" to include a "venture capital fund").

venture capital may not have the same incentives for financial engineering and short-term profits as does private equity.<sup>100</sup> These distinctions further underscore the importance of a more precise definition of health care financialization, both for identifying the forms of financial investment that are most vulnerable to abuse and to not overzealously choke off all forms of private-sector capital investment that may be socially or economically beneficial.

The ethos of health care financialization is well stated by a hospitalist in Portland, Oregon, who works at Providence, a not-for-profit system with hospitals across the West and in Texas:

I think that we're getting into a situation now where medicine and business are butting heads ... I feel that frontline care providers are focused on providing high-quality, compassionate care, but I feel that the business community has gotten to a point where they look at it as optimizing a profit margin where the more people you see, the more the business makes.<sup>101</sup>

This statement sums up the experience of trying to deliver health care in a financialized health system. It also begs the question of why the health care system, particularly community-based institutional health care providers and professionals, would willingly accept financial capital.

### *C. Demand for Health Care Capital Drives Financialization*

The practical reality is that the technological and administrative complexity of providing health care today creates a need for private-sector capital by health care providers and suppliers. The chief public sources of health care finance, Medicare and Medicaid, may be inadequate to support capital upgrades and to respond to the technological and administrative complexity required by public and private payers today.<sup>102</sup>

There is merit to this account of health care providers' growing demand for more resources to provide health care in the current system.<sup>103</sup> For example,

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100. Umar Ikram, Khin-Kyemon Aung & Zirui Song, *Private Equity and Primary Care: Lessons from the Field*, NEJM CATALYST, Nov. 19, 2024, at 3.

101. Kristine De Leon, *Providence Faces Potential Strike of Nearly 5,000 Health Workers Across Oregon*, OREGONIAN (Dec. 4, 2024), <https://www.oregonlive.com/health/2024/12/providence-faces-potential-strike-of-nearly-5000-health-workers-across-oregon.html> [<https://perma.cc/GH6P-H52K>].

102. See Matthew Fiedler, *Matthew Fiedler's Testimony on Administrative Burden in Health Care*, BROOKINGS (July 26, 2023), <https://www.brookings.edu/articles/matthew-fiedlers-testimony-on-administrative-burden-in-health-care/> [<https://perma.cc/HZS6-H2JE>] (discussing methods to reduce administrative costs for physicians and healthcare facilities).

103. See CAROL K. KANE, AM. MED. ASS'N, POLICY RESEARCH PERSPECTIVES 13 (2025) (reporting survey results for why physicians sold their practices and indicating that more than half of physicians reported a significant motivation as improving access to costly resources, managing administrative requirements of payers, and participating in risk-based payment models).

independent primary care providers struggle to survive with comparatively low commercial reimbursement and value-based contracting that requires them to assume population health risk and to track a dizzying amount of quality and other metrics.<sup>104</sup> Indeed, the consequences of unregulated private insurance prices and the value-based ethos are the disappearance of independent primary care providers.<sup>105</sup> These providers need the bargaining power and resources of a large health system, private equity firm, or payer-backed entity to purchase the information technology and do what they need to get paid.<sup>106</sup> Private equity, hospital-based, or payer-based management companies offer to take the administrative burden off the plates of physicians.<sup>107</sup> However, for physicians, accepting this deal has become a Faustian bargain.<sup>108</sup> In exchange for shouldering this administrative burden, the financial investor takes the keys to the practice, and to many physicians, their professional souls.<sup>109</sup>

In other instances, a more banal factor drives physicians to sell their practices to private equity or insurance companies: money. Private equity firms and other large corporate investors offer physicians significant sums for their practice, more than is being offered by health systems or by new practitioners who may want to take over the practice.<sup>110</sup> However, the higher purchase price offered by private equity may come with additional debt, reduced future compensation, and other financial risks.<sup>111</sup> These lucrative up-front offers may

104. Intention to Treat: *The Plight of Primary Care, Part 1*, at 20:00-25:00 (NEJM, July 5, 2023), <http://www.nejm.org/doi/10.1056/NEJMp2303852> [<https://perma.cc/B3TJ-QUWW>].

105. Hayden Rooke-Ley, Zirui Song & Jane M. Zhu, *Value-Based Payment and Vanishing Small Independent Practices*, 332 JAMA 871, 871–72 (2024).

106. Soleil Shah, Hayden Rooke-Ley & Erin C. Fuse Brown, *Corporate Investors in Primary Care — Profits, Progress, and Pitfalls*, 388 NEJM 99, 99–101 (2023) [hereinafter *Corporate Investors in Primary Care*] (describing how physicians may partner with corporate investors to relieve their administrative burden of managing a practice).

107. Dhruv Khullar, Lawrence P. Casalino, Amelia Bond, *Vertical Integration and the Transformation of American Medicine*, 390 NEJM 965, 966 (2024) (describing how “value-based payment models have introduced substantial administrative burdens, which . . . have made it more attractive—or potentially necessary—for such practices to merge with a larger entity”); Rooke-Ley, Song & Zhu, *supra* note 105, at 871 (observing that corporate owners offer practices “capital, management, and scale. For example, insurers, retail chains, and private equity firms have rapidly acquired or affiliated with provider groups expressly to participate in value-based contracts.”).

108. Rooke-Ley, Shah & Brown, *Medicare Advantage*, *supra* note 27, at 97 (describing that corporate ownership may trade relief of the administrative burden for control over the practice of medicine, which can erode physician morale).

109. WENDY DEAN & SIMON TALBOT, *IF I BETRAY THESE WORDS: MORAL INJURY IN MEDICINE AND WHY IT’S SO HARD TO PUT PATIENTS FIRST* 16–20 (2024).

110. See Jarrod Barraza, *Comparison of Private Equity-Type Transactions versus Hospital-Type*, HORNE, <https://horne.com/comparison-of-private-equity-type-transactions-versus-hospital-type-transactions/> [<https://perma.cc/85D4-WQUK>] (last visited Nov. 3, 2025) (comparing benefits of private equity investment in physicians with hospital investment).

111. See Joe Aguilar & Natalie Bell, *Knock, Knock . . . Who’s there? Considerations for When Private Equity Comes for Physician Acquisitions*, MED. GRP. MGMT. ASS’N (Jan. 1, 2024), <https://www.mgma.com/articles/considerations-for-when-private-equity-comes-for-physician->

be particularly attractive to physicians who are nearing retirement or whose specialty type does not attract health system buyers.<sup>112</sup>

There is a similar demand for capital among institutional health care entities, such as hospitals or nursing homes.<sup>113</sup> Smaller, community hospitals—particularly those with a poor “payer mix” serving predominantly low-income Medicaid, Medicare, or uninsured patients—have neither the size nor scale to compete with giant health systems.<sup>114</sup> Struggling health care entities seek capital through selling their main assets to larger health systems, financial investors, or some combination to access the large entities’ market power, higher commercial prices, credit ratings, or debt financing opportunities.<sup>115</sup> In addition, the same forces from value-based payments pushing physicians to sell also apply to health facilities.<sup>116</sup>

Despite its promise of increased efficiencies and innovation, the influx of private-sector capital has not demonstrably produced these efficiencies, savings, or improvements in health care.<sup>117</sup> In certain cases, the inflow of private-sector capital has led to financialization in health care and encouraged the pursuit of strategies that maximize investor profit even if doing so harms patient care, reduces quality, or results in the bankruptcy or closure of key facilities or services.<sup>118</sup> Two concrete manifestations of health care financialization illustrate the tradeoffs (and dilemmas) when health care providers receive private-sector capital from private equity or Medicare Advantage insurers.

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acquisitions [<https://perma.cc/AT28-UV5U>] (discussing risks associated with “upfront financial incentives” generated by private equity investors).

112. *Id.*; FUSE BROWN ET AL, PRIVATE EQUITY INVESTMENT, *supra* note 43, at 6.

113. FUSE BROWN ET AL, PRIVATE EQUITY INVESTMENT, *supra* note 43, at 8.

114. David Dranove & Lawton R. Burns. Big Med: Megaproviders and the High Cost of Health Care in America 179 (2021).

115. “Financial Distress” is Driving Healthcare M&A Activity, ADVISORY BD. (Oct. 19, 2023), <https://www.advisory.com/daily-briefing/2023/10/19/health-system-transactions> [<https://perma.cc/SS67-RDXF>].

116. Rooke-Ley, Song, & Zhu, *supra* note 105, at 871; Khullar, Casalino, and Bond, *supra* note 107, at 966.

117. See Alexander Borsa et al., *Evaluating Trends in Private Equity Ownership and Impacts on Health Outcomes, Costs, and Quality: Systematic Review*, BMJ, July 19, 2023, at 10, 13 (finding in this systematic review that PE ownership markedly increased costs to patients and payers, and that the impact of PE ownership on quality was mixed, with greater evidence that PE ownership degrades quality than improves it).

118. See SEN. EDWARD J. MARKEY, THE STEWARD HEALTH CARE REPORT: HOW CORPORATE GREED HURT PATIENTS, HEALTH WORKERS, & COMMUNITIES 5–8 (Sep. 2024), [https://www.markey.senate.gov/imo/media/doc/the\\_steward\\_health\\_care\\_report.pdf](https://www.markey.senate.gov/imo/media/doc/the_steward_health_care_report.pdf) [<https://perma.cc/LEY9-7ZHU>] [(describing private equity investment strategies to maximize profits through real estate transactions and price increases and cut costs through staff reductions, which leads to worse patient care and risks of hospital bankruptcy or closure).

## II. CASE STUDIES IN FINANCIALIZATION: PRIVATE EQUITY AND MEDICARE ADVANTAGE

### *A. How Private Equity Financializes Health Care*

Over the past decade, private equity investment in health care has surged significantly.<sup>119</sup> According to industry reports, private equity investment in health care totaled nearly \$1 trillion between 2011 and 2021.<sup>120</sup> In 2021 alone, private equity firms invested approximately \$83 billion in health care, a record high for the sector.<sup>121</sup> A decade or two ago, private equity targeted hospitals and nursing facilities, but, in recent years, investment has shifted to physician practices, outpatient facilities, urgent care centers, behavioral health, digital health, and long-term and home-based care services.<sup>122</sup>

Private equity funds are collective investment vehicles that pool capital from large, institutional investors, such as pension funds, endowments, sovereign wealth funds, and high-net-worth individuals.<sup>123</sup> These funds are managed by private equity firms that deploy the aggregated capital to acquire controlling interests in companies.<sup>124</sup> The private equity firm uses its controlling stake to actively manage the portfolio companies to increase profit and operational efficiency and cut costs, with the goal of exiting these investments at a significant profit within three-to-seven years.<sup>125</sup>

119. See Suhas Gondi & Zirui Song, *Potential Implications of Private Equity Investments in Health Care Delivery*, 321 JAMA 1047, 1047 (2019) (“From 2010 to 2017, the value of private equity deals involving the acquisition of a health care–related company (most involving physician practices and hospitals) increased 187% and reached \$42.6 billion, while the number of health care deals increased by 48%.”).

120. See BAIN & COMPANY, *GLOBAL PRIVATE EQUITY REPORT 2022* 7 (2022) (visualizing the increase in global buyouts over the last two decades of private equity investment).

121. See CHRISTOPHER CAI & ZURI SONG, CAL. HEALTH CARE FOUND., *PRIVATE EQUITY IN HEALTHCARE: PREVALENCE, IMPACT, AND POLICY OPTIONS FOR CALIFORNIA AND THE U.S.* 3 (2024) [hereinafter CAL. HEALTH CARE FOUND.] (“At its most recent peak in 2021, [private equity] (PE) investment into health care totaled about \$83 billion nationally[.]”).

122. Appelbaum & Batt, *Private Equity Buyouts in Healthcare*, *supra* note 19, at 4; Sasha Zabelski, *Private Equity’s Move into Behavioral Health and What This Could Mean for Disparities in Access to Care*, ACADEMY HEALTH BLOG (Oct. 24, 2024), <https://academyhealth.org/blog/2024-10/private-equitys-move-behavioral-health-care-and-what-could-mean-disparities-access-care> [https://perma.cc/ER35-MVAZ].

123. *Id.* at 6.

124. See Borsa et al., *supra* note 117, at 1 (“PE firms use capital from institutional investors and individuals of high net worth in combination with large amounts of debt to acquire other companies.”).

125. Steven N. Kaplan & Per Strömberg, *Leveraged Buyouts and Private Equity*, 23 J. ECON. PERSPS. 121, 123 (2009); Umar Ikram, Khin-Kyemon Aung & Zirui Song, *Commentary, Private Equity and Primary Care: Lessons from the Field*, NEJM CATALYST, Nov. 19, 2021, at Tbl.1 (describing traditional private equity as taking a majority stake in the investment target and exiting within three to seven years); Casalino, *supra* note 44, at 78 (same).

Despite its name, the private equity investment model is financed with only about thirty-percent in equity, largely from institutional investors who are the limited partners.<sup>126</sup> The private equity fund's general partner makes the strategic decisions for the target companies and typically contributes two percent of its own equity.<sup>127</sup> The large majority of the investment (seventy-percent) is financed through debt, which is why these deals are often called leveraged buyouts (LBOs).<sup>128</sup> This burden of carrying and servicing the debt is placed on the acquired portfolio company—the hospital or physician practice—not the private equity firm.<sup>129</sup>

The private equity firm earns management fees, transaction fees for disposition of the target companies' assets, and it seeks to earn a 200-400% return on the initial investment upon exit from its investment within three-to-seven years.<sup>130</sup> Eighty percent of the profit goes to the limited partners and twenty-percent goes to the general partner for its comparatively small equity contribution—this return is called “carried interest,” taxed at favorable long-term capital gains rates, and is meant to reward the general partner's performance.<sup>131</sup>

The goal is to rapidly increase profits of portfolio companies and then sell the companies within a short time frame.<sup>132</sup> Several strategies are used to maximize the short-term value of the companies for sale: increase revenues, sell assets, grow the company through acquisitions, and cut operating costs.<sup>133</sup> The three main exit strategies include selling to another private equity firm, selling to another corporate buyer, or going public.<sup>134</sup> In many cases, the target goes bankrupt.<sup>135</sup> Across sectors, companies acquired through LBOs are ten-times

126. Appelbaum & Batt, *Private Equity Buyouts in Healthcare*, *supra* note 19, at 6.

127. *Id.*

128. *Id.* at 7–8.

129. Sajith Matthews & Renato Roxas, *Private Equity and its Effect on Patients: A Window into the Future*, 23 INT. J. HEALTH ECON. MANAG. 673, 674 (2023).

130. See Ikram et al. *supra* note 125, at 3 (describing traditional PE firms expectations for returns at “2-4x return per deal”).

131. MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: MEDICARE AND THE HEALTH CARE DELIVERY SYSTEM 80 (June 2021) [hereinafter MedPAC June 2021 Report to Congress] (describing the “2 and 20” PE model, in which PE firm general partner earn “carried interest” profits of about 20% of the sale proceeds of the fund portfolio); Mazzucato, *supra* note 17, at 157 (describing the carried interest model of compensation for PE fund general partners); *What is Carried Interest, and How Is It Taxed?* TAX POL'Y CTR. (Jan. 2024), <https://taxpolicycenter.org/briefing-book/what-carried-interest-and-should-it-be-taxed-capital-gain> [<https://perma.cc/U6UL-YA8J>] (describing how the general partner of a private equity fund typically receives 20% of the profits—called “carried interest”—and the limited partners receive 80%).

132. Ikram, Aung & Song, *supra* note 100, at 2–3.

133. FUSE BROWN, ET AL, PRIVATE EQUITY INVESTMENT, *supra* note 112, at 11–15.

134. Yashaswini Singh, Megha Reddy & Jane M Zhu, *Life Cycle of Private Equity Investments in Physician Practices: An Overview of Private Equity Exits*, HEALTH AFFS. SCHOLAR, April 2024, at 1.

135. See Valentina Dabos, Priv. Equity Stakeholder Project, Private Equity Bankruptcy Tracker (2025) (noting that private equity firms played a role in over 50% of large corporation bankruptcy filings in 2024).

more likely to declare bankruptcy than controls (similar companies without LBOs).<sup>136</sup> The combination of hefty management and transaction fees, high levels of debt, and carried interest payments upon exit offers private equity firms proportionally high returns on their initial investment, while shifting financial risk to the target companies.<sup>137</sup>

In many respects, private equity represents the latest iteration of for-profit, corporate health care.<sup>138</sup> However, three key characteristics set private equity apart from conventional corporate investment and characterize its involvement in health care as a form of financialization.<sup>139</sup>

First, private equity investments often involve a high level of leverage.<sup>140</sup> Unlike traditional corporate investments, private equity investors impose substantial debt obligations on the companies they acquire.<sup>141</sup> For example, when private equity firms invest in hospitals and nursing homes, such as Steward Healthcare or HCR ManorCare, they typically employ a strategy that involves selling the real estate assets to a real estate investment trust (REIT), which subsequently leases the facilities back to the operators at increasing lease rates.<sup>142</sup> Sale-leaseback arrangements resemble forms of leverage, such as a reverse mortgage, where the entity sells its real estate for a bolus of cash and pays monthly lease payments (instead of mortgage payments) to retain use of the property.<sup>143</sup>

Second, private equity tends to operate with a short-term perspective, generally between three to seven years, necessitating an exit strategy to realize significant returns.<sup>144</sup> In contrast, traditional companies focus on long-term viability without an immediate need for exit to achieve profitability.<sup>145</sup> This brief

136. Brian Ayash & Mahdi Rastad, *Leveraged Buyouts and Financial Distress*, FIN. RSCH. LETTERS, Jan. 2021, at 5.

137. See Cai & Song, *A Policy Framework*, *supra* note 41, at 1545 (explaining how private equity firms will accumulate debt when acquiring companies, then pursue strategies like raising prices, cutting labor costs, and shifting to higher-margin services to generate quick returns before exiting and leaving the debt with the acquired company).

138. See Fuse Brown & Hall, *Private Equity*, STAN L. REV., *supra* note 21, at 594.

139. See *id.* at 530–31 (describing private equity's unique risk of financialization or corporatization).

140. Cai & Song, *A Policy Framework*, *supra* note 41, at 1545.

141. *Id.*

142. See, e.g., Rosemary Batt, Eileen Appelbaum & Tamar Katz, *The Role of Public REITs in Financialization and Industry Restructuring* 22–40 (Inst. for New Econ. Thinking, Working Paper No. 189, 2022) (explaining the sale-leaseback arrangements between HCR ManorCare and REIT HCP and between Steward Healthcare and Medical Properties Trust, in which both health care entities sold properties to the REITs and then leased them back, paying rent at increasing rates each year).

143. Jarred Kessler, *Reverse Mortgage Vs. Residential Sale Leaseback: Which is Right For You?*, FORBES (Sep. 19, 2017), <https://www.forbes.com/sites/forbesrealestatecouncil/2017/09/19/reverse-mortgage-vs-residential-sale-leaseback-which-is-right-for-you/> [https://perma.cc/92ZZ-CMZS].

144. See Ikram, Aung & Song, *supra* note 100 (identifying the average exit time frame for different types of private equity firms).

145. MAZZUCATO, *supra* note 17, at 168.

investment horizon encourages practices such as financial engineering to boost revenues rather than pursuing strategies that create enduring value.<sup>146</sup> Financial engineering involves exploiting payment loopholes and identifying arbitrage opportunities (expanding the firm to enhance its valuation), among other strategies.<sup>147</sup> Generating a quick margin also requires cost-cutting, particularly labor.<sup>148</sup> Reductions in the caregiving workforce have been widely attributed to be the cause of the declining quality outcomes after private equity investments, such as increased mortality in nursing homes and higher incidence of hospital-acquired infections and readmissions in the hospital setting.<sup>149</sup>

The interplay of excessive leverage and short-term investment goals results in moral hazard.<sup>150</sup> Private equity investors' willingness to take excess risks reflects their impunity from reputational, legal, or competitive consequences—the third characteristic of financialization.<sup>151</sup> They enjoy the benefits of rapidly increasing profits without bearing the associated risks, as the debt is tied to the acquired company, and their potential losses are confined to their limited capital investment.<sup>152</sup> Furthermore, because they are not long-term participants in the industry and not locally accountable to a community, they suffer little reputational risk.<sup>153</sup> As a result, investors can benefit even if the health care entity struggles, files for bankruptcy, or discontinues essential but less profitable services or facilities.<sup>154</sup> Complex legal structures also obscure the controlling role played by the private equity fund managers, which allows the private equity

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146. See *id.* (“[W]hereas traditional institutional investors were often satisfied to ‘buy and hold’, and to await share price gains via profit being reinvested rather than paid out, PE seeks to buy and resell at a higher price within a few years.”).

147. Anaeze C. Offodile II et al., Private Equity Investments In Health Care: An Overview Of Hospital And Health System Leveraged Buyouts, 2003–17, 40 HEALTH AFFS. 719, 719–26 (2021).

148. Cai & Song, *A Policy Framework*, *supra* note 41, at 1545 (listing reduced labor costs as one technique private equity firms employ to generate rapid returns).

149. Atul Gupta et al., Owner Incentives and Performance in Healthcare: Private Equity Investment in Nursing Homes, 37 REV. FIN. STUD. 1029 (2024); Sneha Kannan, Joseph Dov Bruch & Zirui Song, *Changes in Hospital Adverse Events and Patient Outcomes Associated With Private Equity Acquisition*, 330 JAMA 2365, 2371–73 (2023).

150. Cai & Song, *A Policy Framework*, *supra* note 41, at 1545–46 (providing examples of how legislatures can regulate leveraged buyouts to limit moral hazard).

151. See Fuse Brown & Hall, *Private Equity*, STAN L. REV., *supra* note 21, at 534, 553 (explaining how underdeveloped legal tools, minimal penalties, and limited transparency and competition shield private equity firms from meaningful consequences).

152. Cai & Song, *A Policy Framework*, *supra* note 41, at 1545.

153. See Fuse Brown & Hall, *Private Equity*, STAN L. REV., *supra* note 23, at 534 (“PE’s short-term pursuit of revenue growth and use of debt financing means it may lack the reputational concerns and risk aversion of longer-term institutional players.”).

154. See McLean, *supra* note 45 (“Thanks to modern financial engineering tricks, investors can prosper even if the underlying business is failing.”); Ballou, *supra* note 53.



firm to escape legal liability for harms to patients or competition that flow from their actions.<sup>155</sup>

The opening story of Sungida Rashid's untimely and unnecessary death from poorly treated postpartum hemorrhage at a Steward hospital illustrates the human toll of financialization. The private equity firm Erus earned lucrative transaction fees from the sale-leasebacks of the Steward hospitals' real estate assets to the REIT Medical Properties Trust and used the sale proceeds to purchase more hospitals.<sup>156</sup> However, because the hospitals faced rising rent on buildings and land they once owned, they were forced to implement draconian cost-cutting measures—including cutting staff, supplies, and vendor payments—which contributed to Sungida Rashid's unnecessary postpartum death at a Steward Hospital.<sup>157</sup> The private equity firm, Cerberus, that initially bought Steward exited its investment with handsome profits years before the Steward Health System's collapse in 2024.<sup>158</sup> This is moral hazard at play: a heads-I-win-tails-you-lose situation in which the private equity firm takes outsized risks with other people's money and earns its profit even if the target company goes bankrupt.<sup>159</sup> Even while Steward Healthcare and its colorful CEO, Ralph de la Torre, have been publicly lashed by angry policymakers, the private equity firm Cerberus that orchestrated this calamity has escaped without consequence.<sup>160</sup> Beyond Steward, the private equity firm Leonard Green used the same real estate-stripping playbook to profit while sending the sixteen-hospital system

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155. See Memorandum Op. & Ord., *supra* note 53, at 1, 8–16 (dismissing private equity fund, Welsh Carson, as a defendant in the case by the FTC alleging the monopolization of anesthesiology markets in Texas); Ord. at 8–11, *Salley v. Heartland-Charleston of Hanahan, SC*, Civ. No. 2:10-cv-00791 (D.S.C. Dec. 10, 2010) (dismissing private equity fund Carlyle Group from lawsuit alleging negligence and wrongful death, among other claims, against bankrupted nursing home chain that it operated, HCR Manorcare).

156. Batt, Applebaum & Katz, *supra* note 142, at 39 (“Cerberus used the sale proceeds [of Steward’s real estate] to pay itself and its investors almost \$500 million in dividends, pay down debt, and launch a massive debt-driven acquisition—buying out 27 hospitals in 9 states in three years between 2016 and 2019.”).

157. Mark Arsenault, *They Died in Hallways. In Line. Alone. Their Deaths are the Human Cost of Steward’s Financial Neglect*, BOS. GLOBE (Sep. 6, 2024), <https://apps.bostonglobe.com/metro/investigations/spotlight/2024/09/steward-hospitals/steward-for-profit-hospitals-investigation/> [https://perma.cc/RKL4-M3ZS].

158. McLean, *supra* note 45.

159. See Ballou, *supra* note 53 (explaining how private equity firms benefit from “a legal double standard” as they exert control over the companies they buy and earn a generous profit when its risky use of the companies’ funds goes well, but face no legal consequences when it does not).

160. See Dan Diamond, *Senate Votes to Hold Steward Hospital CEO in Criminal Contempt*, WASH. POST (Sep. 26, 2024), <https://www.washingtonpost.com/health/2024/09/19/steward-hospital-ceo-senate-contempt-de-la-torre/> [https://perma.cc/P2WA-KLTK] (“In a July hearing, lawmakers contrasted de la Torre’s multimillion-dollar compensation and luxury purchases with his hospitals’ challenges to stay solvent.”); McLean, *supra* note 45.

Prospect Medical Holdings into bankruptcy.<sup>161</sup> By April 2025, Prospect closed two hospitals in Pennsylvania and shuttered nearly all the services at a hospital in Connecticut.<sup>162</sup>

Private equity's short-term stakes, heavy reliance on debt, and financial engineering tactics such as asset-stripping extract rather than create value.<sup>163</sup> As observed by economist Mariana Mazzucato, private equity is one of the most aggressive forms of financialization, or "MSV [maximizing shareholder value] turbocharged."<sup>164</sup> In short, private equity investment in health care is a paradigmatic case of financialization.

### *B. How Medicare Advantage Financializes Health Care*

The second example of health care financialization is Medicare Advantage, and particularly the rise of vertical consolidation within the program. Vertical consolidation, also known as vertical integration, refers to the combining of organizations operating at different levels of production or supply chain.<sup>165</sup> Today, the nation's largest Medicare Advantage insurers are restructuring as vertically integrated conglomerates, owning key aspects of the health care delivery and drug distribution systems.<sup>166</sup> Though these combinations, in theory, can deliver value for patients and taxpayers,<sup>167</sup> substantial evidence suggests that Medicare Advantage plans are pursuing vertical acquisitions to further numerous strategies of financialization.<sup>168</sup>

Medicare Advantage is the private insurance version of Medicare, which now covers more than half of all Medicare beneficiaries.<sup>169</sup> Through risk

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161. Caitlin Owens, *A Second Hospital Bankruptcy Draws More Private Equity Scrutiny*, AXIOS (Jan. 15, 2025), <https://www.axios.com/2025/01/15/prospect-bankruptcy-private-equity> [https://perma.cc/6U9W-C6WP].

162. Peter Hall, *Two Hospitals to Close After Pa. Officials Provided \$40 Million to Help Company Find a Buyer*, PA. CAP.-STAR (Apr. 21, 2025), <https://penncapital-star.com/uncategorized/two-hospitals-in-fifth-largest-county-set-to-close-after-pa-officials-provided-40-million-to-help-find-a-buyer/> [https://perma.cc/G7MM-EQST]; Katy Golvava, *CT Regulator Approves Major Reduction in Services at Prospect-Owned Hospital*, CT MIRROR (May 23, 2025), <https://ctmirror.org/2025/05/23/prospect-medical-holdings-rockville-hospital-cutbacks/> [https://perma.cc/YN7A-ZZ43].

163. See Fuse Brown & Hall, *Private Equity*, STAN L. REV., *supra* note 21, at 531.

164. MAZZUCATO, *supra* note 17, at 158.

165. Khullar, Casalino, & Bond, *supra* note 107, at 965.

166. Rooke-Ley, Shah & Fuse Brown, *Medicare Advantage*, *supra* note 27, at 97.

167. Laurence C. Baker, M. Kate Bundorf & Daniel P. Kessler, *Vertical Integration: Hospital Ownership of Physician Practices Is Associated with Higher Prices and Spending*, 33 HEALTH AFFAIRS 756, 756–57 (2014) (explaining that vertical integration can improve efficiency by reducing transaction costs); Lina M. Khan, *The Separation of Platforms and Commerce*, 119 COLUM. L. REV. 973, 1045 (2019) (noting that vertical integration can eliminate "double marginalization," or multiple profit markups, at each stage of production).

168. Rooke-Ley, Shah & Fuse Brown, *Medicare Advantage*, *supra* note 27, at 97.

169. See Meredith Freed et al., *Medicare Advantage in 2024: Enrollment Update and Key Trends*, KFF (Aug. 8, 2024), <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-enrollment->

adjustment, the government funds Medicare Advantage plans using a capitated rate (per member per month) that increases based on how sick a beneficiary appears through diagnosis codes.<sup>170</sup> Contrary to its intent, Medicare Advantage now costs the government substantially more than traditional Medicare.<sup>171</sup> Medicare pays Medicare Advantage plans in excess of \$450 billion annually to administer the program; an estimated \$83 billion of which are overpayments: payments beyond what these beneficiaries would cost if they were enrolled in Traditional Medicare.<sup>172</sup>

The largest driver of overpayments in the Medicare Advantage program is known as risk “upcoding,”<sup>173</sup> and it is estimated to cost taxpayers \$40 to \$50 billion annually.<sup>174</sup> Because payments to plans are “risk adjusted” based on the acuity of the members, Medicare Advantage plans that exaggerate or fabricate their members’ diagnoses can inflate these payments they receive from Medicare.<sup>175</sup> By vertically integrating with physicians and other providers, Medicare Advantage plans can control clinician behavior and ensure that they are engaging in maximal diagnostic coding.<sup>176</sup> Medicare Advantage insurers pursue vertical consolidation to acquire primary care practices, in-home care, and other outpatient provider groups to grow their roster of Medicare Advantage beneficiaries and their data and to capture more diagnosis codes to increase risk-adjusted Medicare Advantage payments from the government.<sup>177</sup> In particular, the insurer can control the health care providers with financial incentives, coding targets and defaults, and access to the patients’ electronic health records to engage in a significant degree of risk code inflation.<sup>178</sup> Recent reporting depicts

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update-and-key-trends/ [https://perma.cc/3XWD-Q5QE] (reporting that 54% of Medicare beneficiaries were enrolled in a Medicare Advantage plan in 2024).

170. See Celli Horstman & Corinne Lewis, *The Basics of Risk Adjustment*, COMMONWEALTH FUND (Apr. 11, 2024), <https://www.commonwealthfund.org/publications/explainer/2024/apr/basics-risk-adjustment> [https://perma.cc/YC7W-S8VY] (explaining risk adjustment methodology); Fuse Brown et al., *Legislative and Regulatory Options for Improving Medicare Advantage*, *supra* note 27, at 925–26 (describing how Medicare Advantage plans can inflate beneficiaries’ diagnosis codes to increase risk-adjusted payments).

171. Freed et al., *supra* note 169.

172. Medicare Payment Advisory Comm’n, March 2024 Report to the Congress: Medicare Payment Policy, at 357–58 (2024).

173. Michael Geruso & Timothy Layton, Upcoding: Evidence from Medicare on Squishy Risk Adjustment, 128 J. POL. ECON. 984, 985 (2020) (defining upcoding as medical diagnostic coding that increases risk scores that are reported to regulators).

174. *Id.* at 361, 376 (estimating that in 2024, Medicare spent \$50 billion on overpayments due to risk coding, contributing to the \$83 billion in annual excess spending on MA relative to traditional Medicare).

175. Fuse Brown et al., *Legislative and Regulatory Options for Improving Medicare Advantage*, *supra* note 27, at 925–26.

176. ROOKE-LEY, *supra* note 21, at 24–26.

177. *Corporate Investors in Primary Care*, *supra* note 106, at 99–100.

178. Tara Bannow et al., *Inside UnitedHealth’s Strategy to Pressure Physicians: \$10,000 Bonuses and a Doctor Leaderboard*, STAT (Oct. 16, 2024), <https://www.statnews.com/2024/10/16/united-health-optum-care-medicare-advantage-strategy-dashboard-emails-documents/> [https://perma.cc/36ZN-A5QL].

how Medicare Advantage plans acquire medical practices and reconfigure them to generate risk coding, producing tens of billions in revenue.<sup>179</sup>

As the HHS Office of Inspector General has reported, Medicare Advantage plans also use strategies like in-home health risk assessments and chart reviews, where insurers send nurses to visit patients or administratively review their records to identify additional diagnoses.<sup>180</sup> These practices allow insurers to generate diagnosis codes independent of their beneficiaries' primary care providers and increase risk-adjusted Medicare Advantage payments by billions of dollars, even when the plans provide no follow-up care or treatment for these questionable diagnoses.<sup>181</sup> The use of health risk assessments and chart reviews to inflate risk-adjusted Medicare Advantage payments is facilitated by plans' vertical acquisitions of home care providers and data analytics companies.<sup>182</sup>

Meanwhile, these same insurers are encouraging shorter patient visits, higher volumes, substitution of physicians with advanced practice providers, and AI-driven prior authorization to deny services on a massive scale to these same beneficiaries to simultaneously cut costs and increase revenues.<sup>183</sup> Acquired physicians often find themselves demoralized by the feeling of being a cog in a revenue-generating wheel at odds with providing the type and quality of patient care they are ethically obligated to provide.<sup>184</sup> This transformation of medical practices and their clinicians into risk-coding machines—a product of vertical consolidation by Medicare Advantage plans—is quintessential financialization. These insurance conglomerates maximize profits via non-clinical financial engineering and labor suppression, despite clear harms to patient welfare and the health care providers who serve them.<sup>185</sup>

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179. HYACINTH EMPINADO, *How Insurers Use Doctors to Profit Off Medical Codes* (STAT, Jul. 25, 2024), <https://www.statnews.com/2024/07/25/video-explainer-insurance-companies-doctors-medical-codes/> [https://perma.cc/H27C-JHSV].

180. Off. of Inspector Gen., U.S. Dep't of Health & Human Servs., Report no. OEI-03-23-00380, *Medicare Advantage: Questionable Use of Health risk Assessments Continues to Drive Up Payments to Plans by Billions* (2024).

181. *Id.*

182. See Rooke-Ley, *supra* note 21, at 26 (noting in-home health assessments and risk coding as factors that have given vertically integrated MA companies more direct control over those in their system).

183. See Maj. Staff of U.S. Senate Permanent Subcomm. Investigations, 118th Cong., *Refusal of Recovery: How Medicare Advantage Insurers Have Denied Patients Access to Post-Acute Care* 12–13 (Oct. 17, 2024) (prepared by Sen. Richard Blumenthal) (finding an increasing use of AI by MA companies in the process of determining coverage); Casey Ross & Bob Herman, *Denied by AI: How Medicare Advantage Plans Use Algorithms to Cut Off Care for Seniors in Need*, STAT (Mar. 13, 2023).

184. Lizzy Lawrence et al., *UnitedHealth Pledged a Hands-Off Approach After Buying a Connecticut Medical Group. Then it Upended how Doctors Practice*, STAT (Aug. 28, 2024), <https://www.statnews.com/2024/08/28/unitedhealth-optum-prohealth-physicians-care-squeezed-for-profit-doctors-say/> [https://perma.cc/EB8F-VN7X].

185. See *supra* note 96 and accompanying text; Adam Gaffney, Stephanie Woolhandler & David U. Himmelstein, *Less Care at Higher Cost—The Medicare Advantage Paradox*, 184 JAMA Intern. Med. 865, 865 (2024) (noting several strategies, prominent among insurance conglomerates, which aim to increase profitability without making changes to, or even at the expense of, patient welfare).

Vertical consolidation by Medicare Advantage plans also enables another form of financial engineering: gaming of the medical loss ratio (“MLR”) requirements. MLR requirements operate as a form of a profit cap, mandating that insurance companies spend a minimum percentage of premium revenue on medical care, rather than on profits and administrative expenses.<sup>186</sup> However, if insurance companies also own providers, the joint entity can effectively evade MLR requirements by moving revenue from the insurance side to the provider side of the ledger.<sup>187</sup> For example, if a Medicare Advantage plan pays above-market prices to its own providers or pharmacy benefit manager (PBM), it can book profits on the provider side that otherwise would have been spent on medical care to an unaffiliated provider entity.<sup>188</sup> UnitedHealth Group, which is vertically integrated, spends over a quarter of its premium revenue on “intercompany transfers,” or related party payments from its insurance company to its sister companies on the provider side.<sup>189</sup> Other major Medicare Advantage plans are now mimicking this strategy.<sup>190</sup>

Beyond upcoding and MLR gaming, vertical consolidation by Medicare Advantage plans can result in anticompetitive abuses. As we explain above, a core characteristic of financialization is the avoidance of accountability.<sup>191</sup> Consolidation enables financialized entities to dodge accountability by allowing them to extract rents without the threat of market discipline.<sup>192</sup> Horizontal hospital consolidation and private-equity rollups provide straightforward examples: due to size, these entities can increase commercial prices without

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186. *Medical Loss Ratio*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Sep. 10, 2024), <https://www.cms.gov/marketplace/private-health-insurance/medical-loss-ratio> [https://perma.cc/KW96-K4ZX].

187. See Richard G. Frank & Conrad Milhaupt, *Medicare Advantage Spending, Medical Loss Ratios, and Related Businesses: An Initial Investigation*, BROOKINGS (Mar. 24, 2023), <https://www.brookings.edu/articles/medicare-advantage-spending-medical-loss-ratios-and-related-businesses-an-initial-investigation/> [https://perma.cc/4XK9-JESV] (recognizing that while certain expenditures from the parent company are used in the MLR calculation as costs to the insurance firm, that money ultimately represents profits to the parent company if they own both sides of the transaction, potentially allowing for gaming of MLR requirements).

188. *Id.*

189. Bob Herman, *The Health Insurer Will See You Now: How UnitedHealth is Keeping More Profits, as Your Doctor*, STAT (Dec. 5, 2022), <https://www.statnews.com/2022/12/05/unitedhealth-keeping-profits-as-your-doctor-insurer/> [https://perma.cc/EP8A-XCUT].

190. See Seth Glickman, *Gaming the System: Medical Loss Ratios and How Insurers Manipulate Them Health Care Uncovered*, HEALTH CARE UNCOVERED (Feb. 26, 2025), <https://healthcareuncovered.substack.com/p/gaming-the-system-medical-loss-ratios> [https://perma.cc/5A82-XEZE] (detailing the steps by which other companies could follow UnitedHealth’s strategies).

191. STARR, *supra* note 16, at 429; See *supra* notes 18, 153 and accompanying text.

192. See MAZZUCATO, *supra* note 17, at 4–5 (describing rent-seeking and rent-extraction as the generation of income not through productive labor, but through monopolization, creating barriers to competition and deregulation).

improving quality and without competitive threats.<sup>193</sup> But the combination of horizontal power in the insurance market and vertical consolidation also creates threats of anticompetitive abuse. As multiple lawsuits have alleged, vertically integrated Medicare Advantage plans can leverage their market power as insurance companies to squeeze unaffiliated providers and favor their own subsidiaries.<sup>194</sup> This can occur in the form of contract terminations,<sup>195</sup> low reimbursement rates,<sup>196</sup> steering,<sup>197</sup> and other tactics.<sup>198</sup> Once plans have been integrated into downstream markets, there is a risk that they can also foreclose competition in the insurance market by preferencing their own insurance companies in contracting.<sup>199</sup> As the examples of risk-coding and MLR gaming demonstrate, this vertical integration can be lucrative even if it does not reduce costs through improved delivery of care.<sup>200</sup> However, the nature of these markets—multi-layered and heavily regulated—makes it unlikely that competitors will enter or cure this conduct.<sup>201</sup>

Together, vertical consolidation by Medicare Advantage plans can manifest as financialization because the Medicare Advantage company's goals are not to provide better, higher quality, or higher value care to Medicare. As described

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193. Bhagwan Satiani et al., Systematic Review of Integration Strategies Across the US Healthcare System: Assessment of Price, Cost, and Quality of Care, 240 J. AM. COLL. SURG. 758, 761, 768 (2025).

194. See, e.g., Ord. Re: Motion to Compel Arbitration at \*1, *Emanate Health v. Optum Health et al.*, No. 2:23-cv-09872, 2024 WL 5413649, ECF no. 30 (C.D. Cal. July 23, 2024) (noting that plaintiffs in the action accused Optum Health of anticompetitive behavior); Phil Galewitz, *An Insurance Titan is Dropping Hundreds of N.J. Physicians to Enrich Itself, Doctors and Patients Charge*, NJ.COM (Feb. 23, 2020), <https://www.nj.com/healthfit/2020/02/an-insurance-titan-is-dropping-hundreds-of-nj-physicians-to-enrich-itself-doctors-and-patients-charge.html> [<https://perma.cc/Y22Q-MH6P>] (reporting on allegations that United Health Group attempted to move patients from their existing providers to those employed by United's subsidiaries).

195. See Galewitz, *supra* note 194.

196. See, e.g., *W. Penn Allegheny Health Sys., Inc. v. UPMC*, 627 F.3d 85, 103–05 (3d Cir. 2010) (finding sufficient evidence of anticompetitive practices by UPMC and their insurance partner, including the paying of artificially lowered reimbursement rates, to reverse a grant of UPMC's motion to dismiss).

197. See, e.g., *Northbay Healthcare Grp. v. Kaiser Found. Health Plan*, 838 F. App'x. 231, 233–34 (9th Cir. 2020) (finding sufficient grounds had been stated by Appellants to reverse the District Court's dismissal of their antitrust claim, including allegations that Appellees engaged in "steering" patients, who were likely to be less profitable, away from their own facilities and towards those of Appellants).

198. See, e.g., Ord. Re: Motion to Compel Arbitration, *supra* note 178, at \*1 (noting additional allegations by Emanate Health that Optum engaged in non-solicitation agreements that caused Emanate further injury).

199. Kevin Hahn & Brian J. Miller, A Framework for Evaluating Vertical Integration Among Payers and Providers, 39 ANTITRUST 45, 48 (2024).

200. See Gaffney, *supra* note 185 (noting that evidence of risk-coding behaviors continues among large MA plans); Frank & Milhaupt, *supra* note 180 (discussing transfer pricing as a possible mechanism to evade MLR requirements).

201. Bob Herman et al., *UnitedHealth Pays its Own Physician Groups Considerably More than Others, Driving Up Consumer Costs and its Profits*, STAT (Nov. 25, 2024), <https://www.statnews.com/2024/11/25/unitedhealth-higher-payments-optum-providers-converts-expenses-to-profits/> [<https://perma.cc/G46K-8EEV>].

above, vertical insurer-driven consolidation is heavily influenced by opportunities for financial engineering tactics, such as risk code inflation and MLR gaming, to convert public taxpayer-funded Medicare dollars into profit margins for the shareholders and investors of insurance companies.<sup>202</sup> The combination of vertical and horizontal power—and the anticompetitive abuses this encourages—embodies an avoidance of market accountability that is characteristic of health care financialization.

### III. THE RISK-REWARD TRADEOFFS OF FINANCIALIZATION

#### *A. Risks of Financialization in Health Care*

Proponents of unfettered private-sector capital investment claim, for example, that private-equity and insurance-company investment in medical practices supplies health care providers with managerial expertise and needed capital to improve the value and quality of health care.<sup>203</sup> However, the risks of a financialized health system are significant and may outweigh the benefits.<sup>204</sup> On net, financialized health care institutions may be extracting more than they are contributing to the health care system and the patients and communities they serve.<sup>205</sup>

There are three main risks that policymakers have raised concerns about related to financialization in health care: (1) Cost increases from market consolidation and financial engineering tactics that do not add value or improve care;<sup>206</sup> (2) Harms to patient care from cost-cutting, staffing reductions, closure of less profitable services and facilities, and denials of care through aggressive utilization management and prior authorization;<sup>207</sup> and (3) moral injury, burnout, and exit of the clinical workforce. The experience of financialization demoralizes

202. Rooke-Ley, *supra* note 21, at 17–18, 24–25; APPELBAUM, BATT & CURCHIN, PROFITING AT THE EXPENSE OF SENIORS, *supra* note 20, at 8.

203. Borsa et al., *supra* note 117, at 13.

204. See Bruch, Roy & Grogan, *supra* note 16, at 180 (describing a risk that health care financialization is taking value away from households who pay considerable health care costs and channeling this value to the owners of capital, and question “Is the country getting a good deal?”).

205. *Id.*

206. See, e.g., Fuse Brown et al., *The Rise of Health Care Consolidation*, *supra* note 27 (finding evidence that consolidation has led to increased prices and spending without measurable improvements in health care quality or access).

207. See, e.g., Yasmin Rafiei, *When Private Equity Takes Over a Nursing Home*, NEW YORKER (Aug. 25, 2022), <https://www.newyorker.com/news/dispatch/when-private-equity-takes-over-a-nursing-home> [<https://perma.cc/W47H-QZJE>] (reporting on the deterioration in care provided by nursing homes acquired by private equity); Suhas Gondi, Kushal T. Kadakia & Thomas C. Tsai, *Coverage Denials in Medicare Advantage—Balancing Access and Efficiency*, JAMA HEALTH F., Mar. 1, 2024, at 1 (noting that around 5.6 million claims submitted to MA plans in 2021 were denied, and approximately 15% of those denials were attributable to MA plans holding more restrictive coverage policies than allowed under official Medicare programs).

the clinical workforce,<sup>208</sup> leads to increased turnover, staffing shortages, and loss of physician autonomy and clinical oversight.<sup>209</sup>

The emerging evidence from private equity investment and insurer-driven Medicare Advantage consolidation confirms these concerns.<sup>210</sup> Private equity acquisitions of medical practices have been shown to increase prices and spending, affect the workforce compositions of acquired practices, and, in some cases, decrease safety and service quality.<sup>211</sup> Acquisitions of practices by insurers lead to higher payments to affiliated physicians and higher risk-coded payments to Medicare Advantage plans.<sup>212</sup>

### *1. Financialization's Impact on Spending*

Substantial evidence suggests private equity acquisition increases prices and spending for health care entities.<sup>213</sup> Private equity-driven consolidation allows hospitals to leverage their enhanced bargaining power with insurers to increase prices, leading to an eleven-percent increase in negotiated prices between private equity-owned hospitals and insurers as well as higher prices in

208. See, e.g., ERIN C. FUSE BROWN, YASHASWINI SINGH & CHRISTOPHER WHALEY, CTR. FOR ADVANCING HEALTH POL'Y THROUGH RES., POLICY OPTIONS TO ADDRESS THE GROWTH OF PRIVATE EQUITY AMONG U.S. PHYSICIAN PRACTICES 4 (Mar. 2024) [hereinafter CTR. FOR ADVANCING HEALTH POL'Y THROUGH RES.] (noting research that physician turnover increases when practices are acquired by private equity firms suggests discontent among practitioners facing new pressures and a lack of professional autonomy); Eyal Press, *The Moral Crisis of America's Doctors*, N.Y. TIMES MAG. (July 14, 2023), <https://www.nytimes.com/2023/06/15/magazine/doctors-moral-crises.html> [https://perma.cc/7AAR-85TH] (describing the professional demoralization experienced by particular clinicians as a result of financialization).

209. See Yashaswini Singh et al., *Physician Turnover Increased in Private Equity-Acquired Physician Practices*, 44 HEALTH AFFS. 280, 285 (2025) (finding that PE acquisition increased physician turnover rates by 13 percentage points or 265% relative to baseline); Joseph Dov Bruch et al., *Workforce Composition in Private-Acquired Versus Non-Private Equity-Acquired Physician Practices*, 42 HEALTH AFFS. 121, 126 (2023) (finding that private equity acquisitions of gastroenterology, dermatology, and ophthalmology practices were associated with higher rates of physician turnover and increased hiring of lower-cost "advanced practice providers" such as nurse practitioners and physicians assistants).

210. CTR. FOR ADVANCING HEALTH POL'Y THROUGH RES., *supra* note 208 at 4.

211. Brian Keyser, Alexandra Thornton, Claire Koyle, *5 Consequences of Private Equity's Expansion in Health Care Services*, CTR. FOR AM. PROGRESS (Oct. 30, 2025), <https://www.americanprogress.org/article/5-consequences-of-private-equitys-expansion-in-health-care-services/> [https://perma.cc/6LMQ-V4F5] (finding that private equity ownership decreases competition, increases costs for patients and payers, can compromise patient care, and can harm health care workers).

212. See *infra* 220–221 and accompanying text.

213. See Borsa et al., *supra* note 117, at 13 (finding from a systematic review that "the most unequivocal evidence points to PE ownership being associated with an increase in health care costs to patients or payers, primarily by increased charges and negotiated higher rates with payers."); see also Tong Liu, *Bargaining with Private Equity: Implications for Hospital Prices and Patient Welfare* 1, 8–11 (Nov. 2022) (unpublished manuscript), [https://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=3896410](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3896410) [https://perma.cc/79H6-XVMX] (finding data showing that following private equity acquisitions, observed hospitals saw negotiated prices increase by around 32%, with approximately 4% of this increase falling on patients and the remainder on the insurers).



local hospital markets.<sup>214</sup> In the physician practice context, research indicates that physician practices acquired by private equity also result in increased spending, driven by increases in the volume of patient encounters and the cost of services.<sup>215</sup> For instance, private equity firms have raised prices by about eleven-percent in specialties such as dermatology, gastroenterology, and ophthalmology, while neonatology saw an astonishing increase of seventy-percent.<sup>216</sup> Further, this price hike is accompanied by alterations in prescribing habits, as practices linked to private equity tend to prescribe more expensive medications (exploiting Medicare Part B payment loopholes for physician administered drugs), contributing to higher Medicare expenditures.<sup>217</sup>

Higher costs follow from vertical insurer consolidation, as well.<sup>218</sup> While research on the impacts of insurer-provider consolidation on commercial prices is still emerging, such vertical consolidation is contributing to billions in Medicare Advantage overpayments through risk code inflation and evasion of the medical loss ratio rules.<sup>219</sup> One study found that after primary care physicians became employed by a practice operated by a Medicare Advantage insurer, their risk scores increased by 25 to 35 percent with no evidence of additional care provided, resulting in approximately \$1.8 billion in additional taxpayer-funded spending to Medicare Advantage insurers annually.<sup>220</sup> Another study found that large, vertically consolidated insurer UnitedHealth Group paid its affiliated Optum physicians between 17 to 61 percent more than unaffiliated physicians, suggesting regulatory gaming of the MLR rules through intercompany transfers, anticompetitive foreclosure of rivals, or both.<sup>221</sup>

214. Liu, *supra* note 213, at 42 (finding that “PE buyouts lead to an 11% increase in bargained prices between PE-owned hospitals and insurers.”).

215. Yashaswini Singh et al., *Association of Private Equity Acquisition of Physician Practices with Changes in Health Care Spending and Utilization*, JAMA HEALTH F., Sep. 2, 2022, at 1, 5–8 [hereinafter Singh et al., *Private Equity Acquisition of Physicians*].

216. *Id.* at 6, Jiani Yu et al., *Physician Management Companies and Neonatology Prices, Utilization, and Clinical Outcomes*, PEDIATRICS, Apr. 2023, at 7.

217. See Yashaswini Singh et al., *Increases in Medicare Spending and Use After Private Equity Acquisition of Retina Practices*, 131 AM. ACAD. OPHTHALMOLOGY 150, XX (2024) [hereinafter Singh et al., *Increases in Medicare Spending*] (finding retina practices acquired by PE firms increased the use of higher cost drugs by 22%, driving a 21% increase in Medicare expenditures on those drugs).

218. See MEDICARE PAYMENT ADVISORY COMM’N, *supra* note 172, at 333–34 (noting concerns over the possibility of anticompetitive behavior and increasing prices among vertically integrated insurers).

219. *Id.* at 396–97.

220. See David Meyers, Jay Schroff, Yashaswini Singh, & Christopher Whaley, *Corporate Practice of Medicine: Vertical Alignment and Medicare Advantage Risk Coding* 27 (Brown University Sch. Pub. Health, Ctr. For Advancing Health Pol’y through Res. Working Paper 202502, Oct. 2025), [https://drive.google.com/file/d/1PeA-TqXpZ\\_F95SuJXrYAE8MJAYJckmOP/view?usp=sharing](https://drive.google.com/file/d/1PeA-TqXpZ_F95SuJXrYAE8MJAYJckmOP/view?usp=sharing) [<https://perma.cc/B2E4-EJFL>] (finding “when providers switch their affiliation to CPCPs, corporate primary care practices with strong vertical ties with Medicare Advantage plans, that there is a 25 to 35 percent increase in risk scores, contributing to \$1.6 billion in additional Medicare spending.”).

221. See Daniel Arnold & Brent Fulton, *UnitedHealthcare Pays Optum Providers More Than Non-Optum Providers*, 44 HEALTH AFFS. 1395, 1401–02 (2025).

## 2. *Financialization's Impact on Quality*

Regarding quality and patient care, the evidence is more mixed. Private equity firms' desire for quick returns leads to cost-cutting measures, such as staffing reductions, that can negatively affect patient care, particularly in institutional settings.<sup>222</sup> Research indicates a twenty-five percent increase in hospital-acquired adverse events following private equity acquisitions, with central-line bloodstream infections rising by thirty-eight percent, despite fewer central lines being used.<sup>223</sup> Additionally, hospitals acquired by private equity reduced staffing and salaries and experienced 13.4 percent more deaths in emergency departments relative to non-acquired hospitals.<sup>224</sup> Private equity-acquired nursing homes experienced an eleven percent increase in mortality, along with declines in patient well-being, such as reduced mobility and increased pressure ulcers and pain.<sup>225</sup> Hospices owned by private-equity funds or publicly traded companies perform worse than hospices operated by nonprofit or other for-profit companies on caregiver-reported measures of quality.<sup>226</sup>

However, not all studies show negative outcomes. For instance, one study found that private equity-acquired acute care hospitals had improved in-hospital and thirty-day mortality rates for acute myocardial infarction patients compared to non-private equity hospitals.<sup>227</sup> Nevertheless, there were no significant improvements in other care dimensions, such as readmissions or mortality rates for common conditions like stroke and pneumonia.<sup>228</sup> Another analysis of private equity acquisitions of fertility clinics showed improvements in the success rates of in-vitro fertilization post-acquisition.<sup>229</sup> These varied findings of private equity's impact across health care sectors suggest that, for all the spending increases, there are few gains and, in some instances, reductions in quality.

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222. See Kannan, Bruch & Song, *supra* note 149, at 2371–73 (finding a 38% increase in central-line infections in private equity hospitals and suggesting decreased staffing as one of the causal factors).

223. *Id.* at 2371.

224. Sneha Kannan et al., *Hospital Staffing and Patient Outcomes After Private Equity Acquisition*, 178 ANN. INTERNAL MED. 1529 (2025).

225. Gupta et al., *supra* note 149, at 1032.

226. Alexander E. Soltoff et al., *Caregiver-Reported Quality in Hospices Owned by Private Equity Firms and Publicly Traded Companies*, 332 JAMA 2029, 2030 (2024).

227. Marcelo Cerullo et al., *Association Between Hospital Private Equity Acquisition and Outcomes of Acute Medical Conditions Among Medicare Beneficiaries*, JAMA NETW. OPEN, Apr. 29, 2022, at 8.

228. *Id.* at 6, 10.

229. See Ambar La Forgia & Julia Bodner, *Getting Down to Business: Chain Ownership and Fertility Clinic Performance*, 71 MGMT. SCI. 5022, 5023 (2025) (finding higher in-vitro fertilization success rates at fertility clinics which were acquired by private equity).

### 3. *Financialization's Impact on the Workforce*

Research on the health care workforce effects of private equity investment is just emerging.<sup>230</sup> Once a practice is acquired, the composition of its workforce changes.<sup>231</sup> Private equity acquisitions of physician practices increased physician turnover and replacement of clinicians with advanced practice providers, such as nurse practitioners or physician assistants, who provide lower-cost alternatives to physicians.<sup>232</sup> In theory, private equity acquisitions can relieve physicians of administrative duties and allow them to focus on care delivery. However, in practice, acquisitions can reduce physician autonomy and contribute to burnout.<sup>233</sup>

Private equity firms may strategically focus on reducing operational costs by relying more on advanced practice providers post-acquisition, with potential consequences for health care delivery and practice management. A survey of internal medicine physicians found that more than sixty percent viewed private equity ownership unfavorably, negatively affecting perceptions of physician well-being, professional satisfaction, and autonomy.<sup>234</sup> Physicians acquired by insurance giant UnitedHealth and other corporations similarly report burnout, exit, and moral injury from the increasing focus on profit maximization at the expense of patient care, in conflict with their professional ethical obligations to their patients.<sup>235</sup>

Research on the impacts of Medicare Advantage and insurer-driven forms of financialization is even more nascent and difficult to study than that of private equity. However, the societal anger and despair over the financialization of our

230. See Joseph Dov Bruch et al., *Workforce Composition in Private Equity–Acquired Versus Non–Private Equity–Acquired Physician Practices*, 42 HEALTH AFFS. 121, 121 (2023) (showcasing that research on the effects of private equity investment on the health care workforce is emerging, “but that little is known about its effects on physician practices—and specifically on workforce composition overtime.”).

231. CTR. FOR ADVANCING HEALTH POL’Y THROUGH RES., *supra* note 208, at 4.

232. See Bruch et al., *supra* note 230, at 122, 127 (finding the “probability of a physician both entering and exiting a practice was higher at PE-acquired practices than at non-PE-acquired practices, suggesting a degree of workforce turnover.”).

233. See Zhu, Rooke-Ley & Fuse Brown, *supra* note 40, at 966.

234. See Jane M. Zhu, Andrew Zeveney, Susan Read, & Ryan Crowley, *Physician Perspectives on Private Equity Investment in Health Care*, JAMA Internal Med. At E1-E2, published online Mar. 11, 2024, doi:10.1001/jamainternmed.2024.0062.

235. See Lizzy Lawrence et al., *UnitedHealth Pledged a Hands-Off Approach After Buying a Connecticut Medical Group. Then it Upended How Doctors Practice*, STAT (Aug. 28, 2024), <https://www.statnews.com/2024/08/28/unitedhealth-optum-prohealth-physicians-care-squeezed-for-profit-doctors-say/> [<https://perma.cc/YW2D-WKMQ>] (reporting the experiences of several doctors who originally welcomed acquisitions by UnitedHealth now regret their decisions due to deteriorating patient relationships); see Eyal Press, *The Moral Crisis of America's Doctors*, N.Y. TIMES MAG. (July 14, 2023), <https://www.nytimes.com/2023/06/15/magazine/doctors-moral-crises.html> [<https://perma.cc/7AAR-85TH>] (discussing how doctors are becoming increasingly unhappy with the medical profession because the system makes it difficult to prioritize patient care).

health care system by giant insurance conglomerates were laid bare by the public reaction to the murder of UnitedHealthcare CEO, Brian Thompson.<sup>236</sup> The anger was not simply over AI-driven prior authorization denials, corporate consolidation, ransomware attacks, or increasing out-of-pocket costs. Rather, the spasm of fury decried the dehumanizing cruelty of a health care system that puts profits over patients—in essence, financialization.<sup>237</sup> United and Steward are merely examples of the larger forces of financialization in the U.S. health care system. Although he doesn't use the term "financialization," *New Yorker* author, physician, and researcher Dhruv Khullar aptly sums up the phenomenon, noting "Increasingly, health insurers, private hospitals, and even nonprofits are behaving as though they aim first to extract revenue, and only second to care for people."<sup>238</sup>

Taken together, a larger threat emerges from this picture of financialization. Private equity and insurance conglomerates are contributing to a growing trend of financialization within the health care sector, wherein investors seek to extract wealth from health care service organizations. This shift towards financialized health care prioritizes profit generation and relegates the quality and accessibility of patient care to a secondary status. Efforts to control health care costs are fundamentally at odds with the profit motives of these investors, highlighting a significant conflict of interest inherent in a financialized health care system.

As the health care landscape increasingly incorporates profit-driven intermediaries—including firms such as Cerberus or UnitedHealthcare, and various real estate investment trusts—these entities are capturing a larger share of healthcare expenditures.<sup>239</sup> These public health care dollars are funneled to investors via dividends, stock buybacks, fees, sale-leasebacks, and carried interest payments, and not reinvested in care.<sup>240</sup> Thus, financialization is fundamentally extractive rather than productive, and as described by Mariana Mazzucato, "[t]he result is a transformation of public goods into private

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236. See Zeynep Tufekci, *The Rage and Glee that Followed a C.E.O.'s Killing Should Ring All Alarms*, N.Y. TIMES (Dec. 6, 2024), <https://www.nytimes.com/2024/12/06/opinion/united-health-care-ceo-shooting.html> [<https://perma.cc/98C8-J2UA>] (discussing the public response to the killing of UnitedHealthcare's chief executive Brian Thompson).

237. Wendell Potter, *I Was a Health Insurance Executive. What I Saw Made Me Quit.*, N.Y. TIMES (Dec. 18, 2024), <https://www.nytimes.com/2024/12/18/opinion/health-insurance-united-ceo-shooting.html> [<https://perma.cc/RT2P-SVDY>].

238. Khullar, *supra* note 28.

239. See Borsa et al., *supra* note 117, at 1, 13–14 (finding private equity firms and real estate investment trusts have "increasingly invested in, acquired, and consolidated healthcare facilities with global healthcare buyouts exceeding \$200bn . . . since 2021 alone.").

240. Victor Roy, et al., *Shareholder Payouts Among Large Publicly Traded Health Care Companies*, 185 JAMA INTERN. MED. 466, 466 (Apr. 202) (finding that large publicly traded health care companies allocated 95% of the net income to shareholder payouts in the form of dividends and stock buybacks); MEDPAC JUNE 2021 REPORT TO CONGRESS, *supra* note 131, at 79–80 (describing how private equity firms use real estate sales and charge portfolio companies substantial management or consulting fees to generate profits before the carried interest profits are realized when portfolio company is sold).

goods.”<sup>241</sup> Consequently, as they become intertwined in the health care system, financial firms also gain substantial political and economic influence, which can impede efforts toward meaningful reforms that may jeopardize their revenue streams.<sup>242</sup> This dynamic raises critical concerns regarding the sustainability and equity of health care delivery in a system where financial interests dominate decision-making processes.

### *B. Considering the Role of Private-Sector Investment*

The emergence of financialization raises foundational questions about private-sector investment (and, by extension, ownership) in U.S. health care. The positive case for promoting flows of private-sector investment into the health care sector, including investment from financial firms, is the same one that undergirds capitalism writ large: in a competitive market, the flow of private-sector capital and the opportunity for personal profit generates valuable investment to produce more innovation, efficiency, and quality.<sup>243</sup> Proponents of these investments caution against reform that could chill overall private-sector investment.<sup>244</sup> Detractors, however, stress the capacity for unfettered private-sector investment, particularly from financial firms, to produce extraction rather than value-creation—the sort we depict above with examples from private equity and vertical integration in Medicare Advantage.<sup>245</sup> And evidence from other countries calls into question the theoretical position that health care provided by

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241. MAZZUCATO, *supra* note 17, at 182–83.

242. See Richard M. Scheffler & David Blumenthal, *Private Equity Impacts on Health Care: Federal and State Legislative and Regulatory Actions, Will It Matter?*, MILBANK Q. OP. (Apr. 29, 2024), <https://www.milbank.org/quarterly/opinions/private-equity-impacts-on-health-care-federal-and-state-legislative-and-regulatory-actions-will-it-matter/> [https://perma.cc/3VGL-4HUC] (noting that the political and economic influence of private equity firms make federal and state reforms unlikely).

243. See Viral V. Acharya et al., *Corporate Governance and Value Creation: Evidence from Private Equity*, 26 REV. FIN. STUD. 368, 398 (2013) (analyzing large private equity deals in Western Europe and finding that abnormal returns—beyond leverage and market factors—are linked to improvements in operating performance, such as EBITDA margins and valuation multiples, with part of this success explained by the skill and background of deal partners); Fauna Atta Frimpong, Ellis Kofi Akwaa-Sekyi & Ramon Saladríguez, *Venture Capital Healthcare Investments and Health Care Sector Growth: A Panel Data Analysis of Europe*, 22 BORSA ISTANBUL REV. 388, 398 (2022) (examining the effects of venture capital in health care in 23 European countries and proposing that venture capital investments significantly increase growth and innovation within the health care sector); Adaeze Enekwechi, *Private Capital Is a Key Component to Improving Health Equity*, HEALTH AFFS. FOREFRONT (Jun. 29, 2023), (arguing private equity in health care will allow for advancements that are not obtainable in public or nonprofit systems).

244. See generally Letter from Rebekah Goshorn Jurata, Gen. Couns., Am. Inv. Council, to Grace Lee, Competition Pol’y and Advoc. Section, U.S. Dep’t Just., Antitrust Div. (June 5, 2024) (on file with author) (responding to the Request for Information on Consolidation in Health Care Markets, Dkt. No. ATR 102 (RFI), that was issued by the Antitrust Division of the U.S. Department of Justice, the Department of Health and Human Services, and the Federal Trade Commission).

245. See, e.g., Jose R. Guardado & Carol K. Kane, Am. Med. Ass’n, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets 3* (2024) (arguing private equity in health care will more likely lead to financialization rather than value-creation).

the private sector outperforms public sector provision in terms of efficiency, quality, outcomes, or other metrics.<sup>246</sup>

In confronting these core questions of health care political economy, we resist rigid dichotomies—of private-sector versus public-sector investment, for-profit versus nonprofit ownership, regulation versus deregulation. Our account of financialization, we hope, aids in confronting the more textured questions necessary to confront the risks of extraction and an ethos that places profits above patient welfare. Where do we, and where don't we, want private-sector investment, and what guardrails should structure that investment? What forms of private-sector investment are optimal, and in what instances should government control investment and production? How do factors like ownership type, geographic distribution, size and consolidation of markets, and business model shape the risk-reward curve?

Answering these questions begins by observing that private-sector investment in health care derives its profit largely from publicly financed sources.<sup>247</sup> Indeed, when one includes tax-subsidies for private insurance, taxpayers finance nearly seventy-percent of the U.S. health care system.<sup>248</sup> Federal, state, and local governments pay for nearly half of health spending,<sup>249</sup> and Medicare payments for inpatient and outpatient hospital services include direct reimbursement for certain capital expenditures.<sup>250</sup> In the case of Medicare Advantage, as described above, the government directly outsources nearly half a trillion dollars annually to private insurance companies.<sup>251</sup> Accordingly, the laws that structure the publicly financed health care system are deeply intertwined with and a key source of returns for investors in health care.<sup>252</sup> For policymakers, then, the task is to be intentional about where in health care to encourage private-

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246. See Sanjay Basu et al., *Comparative Performance of Private and Public Healthcare Systems in Low- and Middle-Income Countries: A Systematic Review*, PLOS MED., June 19, 2012, at 10–11 (finding studies do not support “claims that the private sector is usually more efficient, accountable, or medically effective than the public sector.”).

247. Gaffney, Woolhandler & Himmelstein, *supra* note 23, at 326.

248. *Id.*

249. See *NHE Fact Sheet*, CTRS. FOR MEDICARE & MEDICAID SERVS. (June 24, 2025), <https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet> [<https://perma.cc/4B9F-CNDT>] (reporting that in 2023, federal government spent 32% and state and local governments spent 16% of the total health spending, or 48% combined).

250. See 42 C.F.R. pt. 413 subpt. G (2025) (providing rules for Medicare reimbursement of hospitals' capital costs).

251. See *National Health Expenditures 2022 Highlights*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Dec. 13, 2023), <https://www.cms.gov/newsroom/fact-sheets/national-health-expenditures-2022-highlights> [<https://perma.cc/5YSR-FBFD>] (reporting that, in 2022, total Medicare expenditures were \$944.3 billion and Medicare Advantage plans accounted for about 50% of total Medicare spending equaling \$472.15 billion); MEDICARE PAYMENT ADVISORY COMM'N, *supra* note 172, at 319 (reporting that in 2024, Medicare Advantage program paid plans \$494 billion).

252. See e.g., 42 C.F.R. pt. 413 subpt. G (2025), *supra* note 250; see also Appelbaum & Batt, *infra* note 254.

sector investment, and how to create guardrails that will promote valuable, not extractive, investment.

Engaging with health care financialization reveals another key point: market logic and profit maximization map uncomfortably onto the provision of medical services. Proponents of unfettered private-sector investment argue that the flow of capital and the possibility of private gains inject value into the health care system by providing a source of capital to fuel health care innovation and improved efficiency.<sup>253</sup> Yet medical care as a commodity is highly susceptible to financialization.<sup>254</sup> At the point of care delivery, consumers have asymmetric information and inelastic demand, and they face highly concentrated, non-competitive markets.<sup>255</sup> Even with these deficiencies rectified, relying on markets to allocate medical care is likely to offend basic notions of distributive justice. Consumers' differential willingness to pay for services is essential to producing the fruits of a market structure—namely, allocative efficiency and price discipline.<sup>256</sup> But because one's willingness to pay is a product of one's ability to pay<sup>257</sup>—and because health care is widely recognized as a good to which everyone deserves access—market logic is inherently constrained at the point of care delivery. Moreover, the production of health care services, as discussed above, is intrinsically labor-intensive, making care delivery resistant to productivity gains. Thus, private-sector investment in care delivery that is aimed primarily toward profit maximization can lead to value extraction rather than value creation.<sup>258</sup>

Yet these realities do not necessarily point to a blanket ban on private-sector investment in health care. After all, forms of private-sector investment and ownership do not always result in financialization. For example, a small physician practice, financed by a bank and owned and operated by its physician-partners, is a private for-profit enterprise, reliant on investment from a financial

253. See generally AM. INV. COUNCIL, A PARTNER TO HEALTH CARE: HOW PRIVATE EQUITY COMPLEMENTS AND STRENGTHENS THE HEALTH CARE INDUSTRY (Feb. 2024) (arguing in support of private capital investments in health care by private equity trade association).

254. See Appelbaum & Batt, Financialization in Health Care, *supra* note 18, at 10 (discussing the financialization of hospitals by PE); APPELBAUM, BATT & CURCHIN, PROFITING AT THE EXPENSE OF SENIORS, *supra* note 20, at 51–53 (discussing financialization of hospice and home health companies).

255. See Erin C. Fuse Brown, *Resurrecting Health Care Rate Regulation*, 67, U.C. L.J. 85, 92–103 (2015) [hereinafter *Resurrecting Health Care Rate Regulation*] (describing health care market imperfections).

256. Luke Herrine, *What Do You Mean by Efficiency? An Opinionated Guide*, LPE PROJECT (Oct. 11, 2023), <https://lpeproject.org/blog/who-cares-about-efficiency/> [https://perma.cc/82E7-EQXY] (explaining that, for neoclassical economists, allocative efficiency is achieved through perfectly competitive markets in which price reflects marginal cost).

257. *Id.*

258. See Andersen, *supra* note 22 (questioning the effectiveness of private capital as a solution to health inequities in the U.S. and proposing stronger public oversight of private capital investments in health care to ensure access to affordable, high-quality care); MAZZUCATO, *supra* note 17, at 182 (“the financialization of the productive sector extracts value—objectively, rent.”).

firm (the bank). But its success, even in financial terms, hinges on maintaining its reputation in the community and its professional fiduciary obligations to its patients. This model diverges considerably from a large medical chain platform run by a Medicare Advantage insurer or a private equity company, for whom financial success derives from short-term financial engineering, labor cuts, and market dominance.<sup>259</sup> On the flip side, the ethos of financialization has now permeated many health care institutions that are not supposed to generate private profits at all.<sup>260</sup> Indeed as we explain above, even consolidated health systems made up of nonprofit hospitals have come to exhibit the characteristics of financialization.<sup>261</sup>

Although we emphasize the labor intensity of care delivery, the health care system encompasses non-clinical elements that might benefit from private sector innovation, such as health care data and analytics, technology to assist practice workflows, pharmaceuticals production and distribution, organizational and operational competence. The challenge is to determine how law and policy can structure a health care economy that produces the right amount, the right types, and the right aims of private-sector capital investment to augment public financing.

#### IV. A RESEARCH AND POLICY AGENDA IN RESPONSE TO FINANCIALIZATION

The rise of financialization presents a policy challenge: How can our health care institutions operate in the interest of patients, clinicians, and their communities? How can health care providers access needed capital, including private or even financial capital, without becoming financialized and subject to extraction?

Having a specific definition of health care financialization begins to provide policy direction: it pinpoints the primary ends of financialized health care institutions—the priority of extractive profit for financial investors and corporate executives over patients and other stakeholders and illuminates the day-to-day consequences one would expect to see, including the transfer of power from community stakeholders and care providers to financial investors and corporate executives; the use of financial engineering and the exploitation of labor; and accountability avoidance through de-localization, consolidation, and obscure corporate arrangements.<sup>262</sup>

We have written elsewhere about various responses to the concerns of private equity involvement and Medicare Advantage’s vertical consolidation of

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259. See *The Advantages of Physician-Owned Medical Care*, COAL FOR PATIENT-CENTERED CARE (Jan. 23, 2024), <https://patientcenteredcare.com/hello-world/> [<https://perma.cc/AVC2-2TYD>] (discussing the benefits of physician-owned medical care and how it contrasts with private equity-owned models).

260. Appelbaum & Batt, *Financialization in Health Care*, *supra* note 18, at 11–12.

261. *Id.* at 1, 4.

262. See *supra* Section I.A.



the health care system—a series of legal and policy guardrails protecting against some of the risks of financialization.<sup>263</sup> For instance, antitrust law and policy should be further sharpened to address the serial and vertical forms of consolidation engendered by private equity and vertically integrated insurance conglomerates.<sup>264</sup> Fraud and abuse laws can be used to enforce the patient self-referrals, upcoding and inappropriate billing practices pursued by private equity-backed physician practices and Medicare Advantage plans.<sup>265</sup> Policymakers should close Medicare payment loopholes, such as Part B payments for physician-administered drugs, Medicare Advantage risk-code inflation, and transfer pricing to game medical-loss ratio requirements, that are being exploited for profit with no discernible value.<sup>266</sup> States should strengthen protections for clinician professional autonomy from corporate control through strengthened corporate practice of medicine laws and bans on restrictive covenants such as

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263. See, e.g., Fuse Brown & Hall, *Private Equity*, STAN. L. REV., *supra* note 21, at 579–593 (2024) (discussing different legal interventions available to address concerns of private equity’s involvement in health care); Fuse Brown et al., *Legislative and Regulatory Options for Improving Medicare Advantage*, *supra* note 27, at 928–39 (2023) (evaluating different policy options aimed at improving Medicare Advantage); Rooke-Ley, *supra* note 27, at 33–40 (highlighting a wide range of policies aimed at addressing vertical consolidation); Fuse Brown et al., *The Rise of Health Care Consolidation*, *supra* note 27 (same).

264. See Premerger Notification; Reporting and Waiting Period Requirements, 89 Fed. Reg. 89216, 89234–36 (Nov. 12, 2024) (to be codified at 16 C.F.R. pts. 801, 803 (demonstrating how antitrust law should be sharpened to address consolidation in health care)); ERIN C. FUSE BROWN & KATHERINE L. GUDIKSEN, THE MILLBANK MEM’L FUND, MODELS FOR ENHANCED HEALTH CARE MARKET OVERSIGHT — STATE ATTORNEYS GENERAL, HEALTH DEPARTMENTS, AND INDEPENDENT OVERSIGHT ENTITIES 12–18 (2024) (stating numerous recommendations for how states can improve market oversight authority by learning from other states who already have enhanced health care market oversight authority).

265. See Fuse Brown & Hall, *Private Equity*, STAN. L. REV., *supra* note 21, at 558–61; Robert I. Field et al., *Private Equity in Health Care: Barbarians at the Gate?*, 15 DREXEL L. REV. 821, 866, 877–79 (2023).

266. FUSE BROWN, ET AL, PRIVATE EQUITY INVESTMENT, *supra* note 112, at 17–18; Paul B. Ginsburg & Steven M. Lieberman, *Medicare Payment for Physician-Administered (Part B) Drugs: The Interim Final Rule and a Better Way Forward*, BROOKINGS (Feb. 10, 2021), <https://www.brookings.edu/articles/medicare-payment-for-physician-administered-part-b-drugs/> [https://perma.cc/WP3J-Q9UA]; Richard G. Frank & Conrad Milhaupt, *Medicare Advantage Spending, Medical Loss Ratios, and Related Businesses: An Initial Investigation*, BROOKINGS (Mar. 24, 2023), <https://www.brookings.edu/articles/medicare-advantage-spending-medical-loss-ratios-and-related-businesses-an-initial-investigation/> [https://perma.cc/66Z8-M85C].

noncompetes and gag clauses.<sup>267</sup> All of these financial control relationships need to be more transparent to policymakers, regulators, researchers, and the public.<sup>268</sup>

Yet, if financialization reflects a marked development in the industrial organization and orientation of health care institutions, an adequate response demands more than one-off policies. It requires an updated approach for governing and organizing U.S. health care. Our goal here is not to provide a fully developed agenda but instead to outline a framework for further research and policy development, organized in three categories: reforming payment policy, shaping markets, and building and allocating supply.

### *A. Reforming Payment Policy*

Health care price regulation and administration have been deprioritized in payment policy but can be a powerful tool to address financialization. Today, variable and unregulated prices, particularly in the commercial insurance market, systematically promote consolidation and rent-seeking.<sup>269</sup> With market power, large consolidated firms can charge supracompetitive prices, which drives health spending and growing unaffordability of health care.<sup>270</sup> In addition to pushing up costs, small medical practices become untenable, as insurers, providers, and suppliers consolidate to achieve negotiating leverage with one another.<sup>271</sup> As a result, a small independent medical practice or community hospital today will receive rates that are a fraction of their counterparts in a large hospital system—not because that entity delivers poorer quality care (often quite the opposite), but because a small independent entity does not have the negotiating leverage with payers.<sup>272</sup>

For private equity investors, these independent practices look like “market fragmentation,” ripe for their classic financial engineering playbook: roll-up,

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267. See Zhu, Rooke-Ley & Fuse Brown, *supra* note 40, at 967 (arguing that states, to decrease corporate investors control, could bar contracts from having restrictive covenants such as noncompete clauses and gag clauses); see also Erin C. Fuse Brown, Megha Reddy & Christopher M. Whaley, *The FTC’s Noncompete Rule: Legal Challenges and Potential Solutions for Physician Markets*, HEALTH AFFS. FOREFRONT (Aug. 30, 2024), <https://www.healthaffairs.org/content/forefront/ftc-s-noncompete-rule-legal-challenges-and-potential-solutions-physician-markets> [<https://perma.cc/9LDK-684L>] (discussing the Federal Trade Commission’s issuance of a final rule to ban noncompete clauses and the benefits for banning noncompete clauses in health care).

268. See Yashaswini Singh & Erin C. Fuse Brown, *The Missing Piece in Health Care Transparency: Ownership Transparency*, HEALTH AFFS. FOREFRONT (Sep. 22, 2023), <https://www.healthaffairs.org/content/forefront/missing-piece-health-care-transparency-ownership-transparency> [<https://perma.cc/5ADE-G5EE>] (discussing the importance of ownership transparency in health care and why it is necessary to address health care consolidation).

269. Whaley et al., *Understanding Health Care Price Variation: Evidence from Transparency-in-Coverage Data*, HEALTH AFF. SCH., Jan. 21, 2025, at 1.

270. Fuse Brown, *Resurrecting Health Care Rate Regulation*, *supra* note 255, at 94–97 (2015).

271. Rooke-Ley, Song & Zhu, *supra* note 105, at 871–72.

272. *Id.*

raise prices, and engage in multiple arbitrage.<sup>273</sup> For vertically integrated insurance conglomerates, opaque and variable prices enable self-preferencing and regulatory gaming.<sup>274</sup> As antitrust enforcement has been unable to prevent extant monopolies from exerting their market power, price regulation is an alternative policy approach capable of constraining dominant market actors' pricing power.<sup>275</sup>

Price-based policies in private insurance could range from price growth caps, standardizing prices across purchasers and providers in a region (bans on price discrimination), or setting rates administratively.<sup>276</sup> Such concepts are not new: states experimented with regulation of private hospital rates in the commercial market during the health planning era, prior to the health care industry's turn to managed care in the 1980s.<sup>277</sup> And quite notably, states are once again moving in this direction. Some are pursuing price caps for certain segments of the market,<sup>278</sup> while others have proposed broad commercial price caps to constrain health care price growth through forms of rate regulation.<sup>279</sup> In the 2025 legislative session, Indiana and Vermont passed sweeping price control laws, capping hospital prices across all private payers.<sup>280</sup> Vermont also capped prices for physician-administered drugs, marking a further expansion of price regulation outside of facility fees and into physician payments.<sup>281</sup>

273. See Casalino et al., *supra* note 44, at 114 (describing the arbitrage opportunity in physician practice rollups from the increased valuation and acquisition/sales price increasing with the size of the practice, without making any changes to the care delivery, quality, volume, or efficiency).

274. See *supra* Section II.B (discussing Medicare Advantage and vertical integration).

275. See Thomas L. Greaney, *Regulators as Market-Makers: Accountable Care Organizations and Competition Policy*, 46 ARIZ. STATE L.J. 1, 27, 36 (2014) ("A common misapprehension among legislators and policymakers is that antitrust law provides a reliable counterforce to monopoly. With respect to extant monopolies, legally acquired, the opposite is true: antitrust law tolerates the exercise of market power (which includes charging higher prices, reducing output, and lowering quality) and generally intervenes only where monopolists wrongfully exercise that power to exclude or harm rivals.").

276. See SARAH L. BARBER, LUCA LORENZONI & PAUL ONG, WORLD HEALTH ORG., PRICE SETTING AND PRICE REGULATION IN HEALTH CARE 31, 75 (2019) (discussing different price-based policies and the impacts of price setting on health care).

277. John E. McDonough, *Tracking The Demise of State Hospital Rate Setting*, 16 HEALTH AFFS 142, 142–43 (1997).

278. See Roslyn C. Murray et al., *Hospital Facility Prices Declined As A Result of Oregon's Hospital Payment Cap*, 43 HEALTH AFFS. 424, 424 (2024) (stating that Oregon has taken steps to address high prices through legislation); Aaron Baum et al., *Health Care Spending Slowed After Rhode Island Applied Affordability Standards To Commercial Insurers*, 38 HEALTH AFFS. 237, 237 (2019) (discussing Rhode Island's implementation of price-based affordability standards).

279. See MICHAEL E. CHERNEW, LEEMORE S. DAFNY & MAXIMILIAN J. PANY, HAMILTON PROJECT, A PROPOSAL TO CAP PROVIDER PRICES AND PRICE GROWTH IN THE COMMERCIAL HEALTH-CARE MARKET 10 (2020) (proposing hospital price caps to address price growth in health care).

280. Cf. H.B. 1004, 124th Gen. Assemb., 1st Reg. Sess. (Ind. 2025) (capping hospital prices at Indiana's five major nonprofit health systems at the statewide average price); 2025 Vt. Acts & Resolves No. 55 (establishing a reference-based pricing model for Vermont's hospitals, which limits hospital prices to a multiple of Medicare rates for the same).

281. *Id.*

In public programs such as Medicare and Medicaid, administrative price regulation has long been a cornerstone.<sup>282</sup> However, payment policy in the last few decades has deprioritized pricing policy and has instead replaced it with forms of managed care through Medicare Advantage and value-based care models.<sup>283</sup> The aim of these payment policies, as we have written elsewhere, has been to empower private-sector “risk bearing entities” to manage health care utilization and ultimately reduce spending.<sup>284</sup> Instead of direct regulation through price administration, these policies effectively outsource the cost-containment function to the private sector.<sup>285</sup>

This risk-shifting policy of value-based payment is not only failing to achieve its primary goal of cost containment, it is fueling financialization.<sup>286</sup> The proliferation of Medicare Advantage in recent years, and its substantial over-subsidization, provides the capital directly to insurance conglomerates to acquire medical providers.<sup>287</sup> As described above, ownership and control of these physicians allows them to reproduce overpayments through financial engineering like upcoding.<sup>288</sup> Moreover, the shift in payment policy toward value-based payment imposes substantial burdens on independent practices, creating a buyer’s market for corporate investors.<sup>289</sup> Moving away from managed care models would remove incentives and money flows that are encouraging financialization.

A renewed focus on pricing policy would facilitate more effective cost containment and also allow policymakers to fix core pricing distortions that fuel financialization, such as site-differential payments and under-investment in primary care.<sup>290</sup> Additionally, the pharmaceutical drug supply chain is an area receiving greater attention for price regulation and standardization—particularly

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282. See Alex Cottrill, Juliette Cubanski & Tricia Neuman, *What to Know About How Medicare Pays Physicians*, KFF (Mar. 24, 2025), <https://www.kff.org/medicare/what-to-know-about-how-medicare-pays-physicians/> [<https://perma.cc/Q7KQ-QJHC>] (discussing the results of price regulation in Medicare payments for physician services); *Financial Management*, MEDICAID.GOV, <https://www.medicaid.gov/medicaid/financial-management> [<https://perma.cc/LE8T-SJUW>] (last visited Nov. 5, 2025) (stating that Medicaid providers must set their rates in accordance with federal rules).

283. See Hayden Rooke-Ley & Andrew M. Ryan, *A New Medical Agenda — Moving Beyond Value-Based Payment and the Managed Care Paradigm*, 333 JAMA 1203, 1203 (2025) (detailing the shift in recent decades towards managed care through Medicare Advantage and value-based payments).

284. *Id.*

285. *Id.* at 1204.

286. *Id.* at 1203.

287. See Rooke-Ley, Shah & Fuse Brown, *Medicare Advantage*, *supra* note 27, at 98 (stating that government payments from the Medicare Advantage program have allowed insurance companies to acquire physician practices and care companies).

288. *Id.*

289. See Rooke-Ley, Song & Zhu, *supra* note 105, at 871 (detailing the negative impact value-based payments have on independent practices).

290. Rooke-Ley & Ryan, *supra* note 283, at 1204.

how pharmacy benefit managers (PBMs) pay independent pharmacies—and may be a fruitful avenue for further investigation.<sup>291</sup>

In sum, a renewed focus on pricing regulation and administration in health care payment policy can be a powerful tool that limits rent-seeking by dominant health care entities and dampens underlying drivers of financialization. By limiting the advantages of sheer size, price regulation could serve as a mechanism to preserve power locally in health care by preserving the viability of smaller, independent entities with less market power.

### *B. Shaping Markets*

A related set of policy tools concerns the legal rules that govern markets. Such questions of market design are unavoidable in any domain,<sup>292</sup> but they require particular attention in sectors like health care, where traditional laissez-faire market ordering is highly vulnerable to the extractive risks of financialization. Policymakers must actively structure rules of commerce to ensure that health care entities are operating and producing outcomes in the public's interest.

#### *1. Structural Separation and Antitrust*

Structural separations can be a forceful measure to address regulatory arbitrage, anticompetitive conduct, and other financialized strategies and modes of corporate governance. Structural separation refers to breaking up consolidated entities, particularly along distinct lines of commerce that would otherwise bargain or compete.<sup>293</sup> In the case of vertical consolidation of Medicare Advantage insurance companies, structural separation would prevent the insurer from buying medical practices or pharmacy benefit managers from owning pharmacies—thus obviating the fundamental conflict of interest that arises when the company functions both as the buyer and seller of goods and services.<sup>294</sup> Structural separation would make Medicare Advantage less financialized by making it harder for insurance companies to engage in financial engineering through risk code inflation—a practice that generates insurer profits at the

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291. See *FTC Issues PBM Report Signaling Consolidation Is Impacting Pharmaceutical Prices*, MCCARTER & ENGLISH, LLP (Jan. 22, 2025), <https://www.mccarter.com/insights/ftc-issues-pbm-report-signaling-consolidation-is-impacting-pharmaceutical-prices/> [https://perma.cc/KQF6-6HWM] (stating that widespread markups of generic drugs are occurring).

292. KARL POLANYI, *THE GREAT TRANSFORMATION: THE POLITICAL AND ECONOMIC ORIGINS OF OUR TIME* 1, 50 (3d. ed. 2001).

293. *New Bipartisan Bill Will Break Structural Conflicts of Interest in Healthcare to Lower Drug Costs and Protect Patients*, AM. ECON. LIBERTIES PROJECT (Dec. 11, 2024), <https://www.economicliberties.us/press-release/new-bipartisan-bill-will-break-structural-conflicts-of-interest-in-healthcare-to-lower-drug-costs-and-protect-patients> [https://perma.cc/2LRN-4F8R].

294. *Id.*

expense of taxpayers, demoralizes the clinical workforce, and provides no value to patients.<sup>295</sup>

In addition, structural separation is key to enforcing, and potentially expanding, medical loss ratio (MLR) requirements.<sup>296</sup> Currently, an integrated company with both an insurer and delivery arm can avoid these requirements by shifting profits to its delivery arm through above-market transfer prices.<sup>297</sup> A bar against health insurers owning health care providers would prevent that.

Structural separation would also improve the ability of policies such as minimum clinical staffing requirements to combat labor cuts used by financialized health care institutions to reduce staffing costs and boost revenues.<sup>298</sup> In the nursing home context, federal and state policies have sought to impose minimum staffing ratios to prevent associated patient harms, but these rules have been legally invalidated or underenforced.<sup>299</sup> Some states are experimenting with provider-facing minimum spending requirements for nursing homes, requiring that facilities spend a minimum percentage of revenue on patient care instead of on profits or related-party transfers.<sup>300</sup> What would this form of regulation look like for other providers, such as hospitals, and how would it intersect with rate regulation? Structural separation, minimum staffing, and clinical spending requirements could protect against practices like “tunneling,” in which nursing homes justify demands for Medicaid rate increases by moving profits to related parties to appear less profitable.<sup>301</sup>

295. Christopher Weaver, Anna Wilde Mathew & Tom McGinty, *UnitedHealth's Army of Doctors Helped it Collect Billions More From Medicare*, WALL ST. J. (Dec. 29, 2024), <https://www.wsj.com/health/healthcare/unitedhealth-medicare-payments-doctors-c2a343db> [https://perma.cc/3YFM-P2CQ].

296. See *supra* notes 186–202 and accompanying text.

297. Richard G. Frank & Conrad Milhaupt, *supra* note 289.

298. Charlene Harrington & Toby S. Edelman, *Private Equity and Nursing Home Care: What Policies Can Be Adopted to Address the Growing Problems?*, 33 PUB. POL'Y & AGING REP. 44, 44–45 (2023).

299. See Brendan Pierson, *Judge Blocks Biden Rule Requiring More Staff at Nursing Homes*, REUTERS (Apr. 9, 2025), <https://www.reuters.com/legal/government/judge-blocks-biden-rule-requiring-more-staff-nursing-homes-2025-04-08/> [https://perma.cc/S64R-KLY7] (discussing an executive push toward minimum staffing ratios in nursing homes that was struck down by a Texas federal court); Jordan Rau, *States Set Minimum Staffing Levels for Nursing Homes. Residents Suffer When Rules Are Ignored or Waived.*, KFF HEALTH NEWS (Jul. 12, 2024), <https://kffhealthnews.org/news/article/nursing-home-minimum-staffing-state-laws-enforcement-residents-suffer> [https://perma.cc/33QV-54G6] (explaining that despite state minimum staffing requirements, nursing homes frequently fall below required levels due to lack of enforcement).

300. See NAT'L CONSUMER VOICE FOR QUALITY LONG-TERM CARE, WHERE DO THE BILLIONS OF DOLLARS GO? A LOOK AT NURSING HOME RELATED PARTY TRANSACTIONS 13 (2023).

301. Ashvin Gandhi & Andrew Olenski, *Tunneling and Hidden Profits in Health Care* 25–26 (Nat'l Bureau of Econ. Rsch., Working Paper No. 32258, rev. Sep. 2024), <https://www.nber.org/papers/w32258> [https://perma.cc/3DUT-DHZ2] (finding that nursing homes “tunnel” or hide their profits and assets off the facility's books by making inflated payments to commonly-owned related parties for their goods and services).

Further, structural separation of payers and providers could protect against anticompetitive risks of self-preferencing and patient steering. Currently, antitrust authorities must police anticompetitive conduct case-by-case, made more difficult by the inability of enforcers to sanction “collusion” within the same firm.<sup>302</sup> Instead, structural separation establishes bright-line rules against cross-market co-ownership that raises anticompetitive risks.<sup>303</sup> Such rules, which could be pursued through legislation or forceful antitrust remedies, would mitigate the ability of vertically integrated insurers to exploit conflicts of interest, to self-preference their own provider subsidiaries, and to leverage their market power as an insurer to gain an unfair advantage or erect barriers to entry in a related market.<sup>304</sup>

Here, too, there is growing policy interest. In 2024, a bipartisan bill was introduced in the U.S. Senate that would structurally separate pharmacy benefit managers (PBMs) from pharmacies and the Arkansas legislature passed a similar law—the first-of-its-kind—in 2025.<sup>305</sup> PBMs, which intermediate between insurers and pharmacies, have vertically integrated into both adjacent markets, drawing increasing scrutiny.<sup>306</sup> Future legislation may seek structural separation of a broader scope of payers and providers.<sup>307</sup> These efforts reflect a growing scrutiny of vertical integration in health care.

Yet structural separation reflects a fundamental break with the accepted wisdom of current health policymaking that has permitted—and often promoted—vertical integration.<sup>308</sup> To reconcile this tension, the phenomenon of financialization and its risks must be confronted.

## 2. Universal Access and Nondiscrimination

Access and nondiscrimination requirements for health care institutions are another lever for policymakers. These related concepts are not novel to health care. For example, the Emergency Medical Treatment and Active Labor Act (EMTALA) requires emergency rooms to treat patients who present with an

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302. Murat C. Mungan & John M. Yun, *A Reputational View of Antitrust’s Consumer Welfare Standard*, 61 HOUS. L. REV. 569, 569 (2024).

303. See Lina M. Khan, *The Separation of Platforms and Commerce*, 119 COLUM. L. REV. 973, 973, 1063 (2019) (discussing that the bright line rules that separation creates enhance administrability).

304. See Jonathan Kanter, *Assistant Attorney General Jonathan Kanter Delivers Remarks on the Platformization of Health Care*, U.S. DEPT. JUST. (Nov. 12, 2024), <https://www.justice.gov/archives/opa/speech/assistant-attorney-general-jonathan-kanter-delivers-remarks-platformization-health-care> [https://perma.cc/45PZ-XQGY] (urging consideration of antitrust remedies to address market-power concerns of vertically integrated insurers).

305. See S. 5503, 118th Cong. § 2(a) (2024) (making it unlawful for insurance entities or PBMs to own pharmacies). See generally ARK. CODE ANN. § 17-92-416 (2025) (prohibiting PBMs from obtaining specific pharmacy permits).

306. Rooke-Ley, Shah & Brown, *Medicare Advantage*, *supra* note 27, at 97.

307. *Id.* at 98–99.

308. Rooke-Ley & Ryan, *supra* note 283, at 1204.

emergency condition, no matter their health insurance status.<sup>309</sup> A broader application of this concept could address issues of disinvestment and de-localization, in which a financialized institution closes a hospital or service line that may be vital to a community but is simply not lucrative for the broader organization.<sup>310</sup> The widespread closure of labor and delivery units illustrate this point today.<sup>311</sup> By placing stronger minimum requirements to offer particular services in certain locations, policymakers could head off these closures.

Relatedly, policymakers could limit network and price discrimination by payers—a concept that becomes more viable alongside more price regulation.<sup>312</sup> This conception of nondiscrimination—tailored to address financialization arising from vertically integrated health conglomerates—would prohibit discrimination not just of consumers but also against smaller providers, pharmacies, and the like. Such “any willing provider” laws were in fact common in the 1980s and 1990s in medical services, but they have since retreated.<sup>313</sup> The Medicare Part D program currently includes an “any willing pharmacy” provision to mitigate steering and self-preferencing.<sup>314</sup> Any willing provider laws have been criticized as limiting the ability of insurers to reduce prices via selective or narrow network agreements, thus potentially raising costs.<sup>315</sup> However, these concerns may be alleviated if these tools are one part of a larger system of price regulation that does not rely on private insurers to negotiate and establish prices.

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309. Of note, EMTALA does not prohibit the emergency department from charging different amounts to patients based on source of coverage, including charging self-pay patients full charges. Erin C. Fuse Brown, *Irrational Hospital Pricing*, 14 HOUS. J. HEALTH L. & POL’Y 11, 46 (2014); See 42 U.S.C. § 1395dd (2024) (mandating emergency care regardless of payor status but not mandating billing rates, thereby leaving charges up to hospital discretion).

310. ERIN C. FUSE BROWN, ALL. FOR FAIR HEALTH PRICING, HEALTH CARE CONSOLIDATION: BACKGROUND, CONSEQUENCES, AND POLICY LEVERS 19–20 (2023).

311. Stefanie Fischer, Heather Royer & Corey White, *Health Care Centralization: The Health Impacts of Obstetric Unit Closures in the United States*, 16 AM. ECON. J. APPL. ECON. 113, 113–14 (2024).

312. See MORGAN RICKS ET. AL, NETWORKS, PLATFORMS, AND UTILITIES: LAW AND POLICY 26 (2022) (discussing “Equal Access Rules” and “Universal Service Requirements,” which describe regulatory methods to limit non-discriminatory service).

313. See STARR, *supra* note 16, at 453–58 (discussing the growth and retreat of managed care and regulatory efforts that limited provider networks).

314. Letter from Amy K. Larrick, Acting Director, Medicare Drug Benefit & C&D Group, to All Medicare Part D Plan Sponsors (Aug. 13, 2015) (on file with Dep’t Health & Hum. Servs., Ctrs for Medicare & Medicaid Servs.) (providing guidance on Medicare Part D’s “any willing pharmacy” requirements).

315. See, e.g., PAUL GINSBERG, AM.’S HEALTH INS. PLANS, HOW ANY WILLING PROVIDER MAKES HEALTH CARE MORE EXPENSIVE 2 (2014) (describing how any willing provider laws can lead to higher health care costs).



### 3. *Ownership and Governance Rules*

A final set of market shaping policies would center—or arguably re-center—questions of *ownership structure* and *governance* of health care delivery, returning us to first principles: which individuals, corporations, or public entities should own health care institutions?

Like price regulation, U.S. health policy has a rich tradition of regulating ownership and governance structure, though it has receded in the era of financialization.<sup>316</sup> For instance, state bans on the corporate practice of medicine (“CPOM”) are fundamentally a form of ownership regulation.<sup>317</sup> These laws require that for-profit medical practices are owned by licensed clinicians delivering the care, but they are rife with loopholes and only weakly enforced.<sup>318</sup> A modernized version would address pervasive contractual workarounds, prohibiting investor-backed management companies, such as private equity or insurance companies, from being *de facto* owners of medical practices.<sup>319</sup> Channeling the cooperative tradition, a revitalized CPOM ban might allow all health professionals—and other workers, as well as patients—to be collective owners of private medical practices.

Outside of medical practices, should private equity be allowed to own hospitals, or should this form of capital investment be channeled toward other aspects of health care? What about publicly traded for-profit hospital chains? The 2019 acquisition of North Carolina’s Mission Hospital System by HCA Healthcare—a publicly traded, for-profit hospital chain—serves as a cautionary tale.<sup>320</sup> After acquisition, Mission saw increased profits but decreased clinical staffing, greater turnover, and lower quality.<sup>321</sup> Should certain services that serve vulnerable populations and are largely publicly financed, like home health, hospice, and skilled nursing facilities,<sup>322</sup> be organized as nonprofits, as was

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316. Bruch, Roy & Grogan, *supra* note 16, at 178–79.

317. See Zhu, Rooke-Ley & Fuse Brown, *supra* note 40, at 965; Rooke-Ley et al., *supra* note 40, at 2.

318. See AM. MED. ASS’N, ISSUE BRIEF: CORPORATE PRACTICE OF MEDICINE 1 (2019) (explaining that, while most states prohibit the corporate practice of medicine, many have exceptions which allow for certain health care entities to employ physicians).

319. See Hayden Rooke-Ley & Erin C. Fuse Brown, *Lessons from Oregon’s Attempt to Strengthen the “Corporate Practice Of Medicine” Ban*, HEALTH AFFS. FOREFRONT (May 2, 2024), <https://www.healthaffairs.org/content/forefront/lessons-oregon-s-attempt-strengthen-corporate-practice-medicine-ban> [<https://perma.cc/H9TW-7N8N>] (describing a bill that requires medical practices to maintain “de facto control” of their businesses).

320. See generally Mark A. Hall, *Lessons Learned from HCA’s Purchase of Mission Hospital in Asheville, North Carolina*, WAKE FOREST UNIV., January 2025, <https://ssrn.com/abstract=5125905> [<https://perma.cc/X5Q4-GSZ6>] (discussing the negative effects of for-profit ownership and hospital consolidation on health care access and treatment in the context of the 2019 North Carolina Mission Hospital acquisition).

321. *Id.* at 7–9.

322. MEDICARE PAYMENT ADVISORY COMM’N, *supra* note 172, at 325, 329.

initially required in Medicare?<sup>323</sup> Even if health facilities are allowed to be for-profit, should these publicly financed assets be protected from sale-leasebacks and other intercompany transfers that extract assets for profit?<sup>324</sup>

Direct public provisioning of medical services and production of pharmaceuticals also merit consideration. Public ownership of health care institutions, as is pervasive in peer nations, used to be commonplace in U.S. health care, and still exists in many vital if hidden ways today.<sup>325</sup> Policymakers should view public provisioning as a viable ownership form through which to channel public investment, because it is free from incentives to de-locate and extract—that is, to financialize.

The questions of ownership are intertwined with questions of *governance*.<sup>326</sup> What purposes do the governing bodies of health care entities serve and to whom are their fiduciary duties owed?<sup>327</sup> How can the organizational purposes and duties be refocused on communities and health and away from shareholder primacy? Though it may have lost its way in recent decades, the nonprofit corporate form and its accompanying tax exemptions may be a good place to start. The nonprofit corporation is organized for charitable purposes,<sup>328</sup> and at least on paper, must be operated for the benefit of the community with a governing board drawn from the community as a condition of receiving federal tax exemption.<sup>329</sup> But like the corporate practice of medicine doctrine, lax enforcement and loosening standards have made the modern nonprofit health care enterprise indistinguishable from its for-profit counterpart.<sup>330</sup> Some states have begun to increase scrutiny of nonprofit hospitals

323. Joan K. Davitt & Sunha Choi, *Tracing the History of Medicare Home Health: The Impact of Policy on Benefit Use*, 35 J. SOCIO. & SOC. WELFARE 247, 250 (2008).

324. See, e.g., Nathan Hostert et al., *How Massachusetts's New Health Care Reform Takes Aim at Private Equity*, HEALTH AFFS. FOREFRONT (May 6, 2025), <http://www.healthaffairs.org/doi/10.1377/forefront.20250505.300895/full/> [<https://perma.cc/DT47-5HUT>] (describing Massachusetts' 2025 legislation that increases oversight of health care entities, requiring them to inform the state when they enter into sale-leaseback agreements with real estate investment trusts).

325. See Hayden Rooke-Ley, Dana Brown & Colleen Grogan, *Reviving Public Provisioning in US Health Care*, HEALTH AFFS. SCH., Mar. 17, 2025, at 1 (advocating for a revival of public ownership of health care institutions).

326. See generally Isaac D. Buck, *Patients as Stakeholders*, 67 WM. & MARY L. REV. (forthcoming 2026) (exploring how hospital ownership influences governance structures and the role of patients in decision-making).

327. *Id.* (manuscript at 21, 50–51) (exploring the fiduciary duties of health care governance entities and advocating for increased accountability to patients as stakeholders).

328. Restatement of the Law: Charitable Nonprofit Org. § 1.01 (A.L.I. 2021).

329. Rev. Rul. 69-545, 1969-2 C.B. 117; Brietta R. Clark et al., HEALTH LAW: CASES, MATERIALS, AND PROBLEMS 789 (9th ed. 2022).

330. See COMM. FOR RESP. FED. BUDGET, THE FEDERAL TAX BENEFITS FOR NONPROFIT HOSPITALS 1 (2024) (explaining that lack of enforcement has enabled nonprofit hospitals to maintain nonprofit status despite their failure to meet the “community health standards”).

and questioning whether they have elevated private profit over their charitable purposes to their communities.<sup>331</sup>

To counter financialization's prioritization of profit over patients, policymakers and enforcers could impose stricter governance requirements on nonprofit organizations, hold officers and directors more accountable for fulfilling their fiduciary duties of loyalty and care to the entity's charitable mission, and strengthen the community benefit standard for nonprofit tax-exempt hospitals. Moreover, as a condition of receiving local property tax exemptions, a nonprofit charitable organization should be governed by and accountable to the local community, not by corporate parents many states away and populated not by financiers but by those who represent the community—patients, local leaders, clinicians, and workers.<sup>332</sup>

The corollary to ownership and governance is liability. It may be impractical or undesirable to ban private-sector capital from health care altogether, but the limitations of liability inherent in the corporate form could be revisited for health care entities, corporate parents, and their investors. To reduce the moral hazard and risky management tactics of financialization, we may want to attach liability to control entities, governing boards, and investors that assume operational control—for example, holding private equity investors liable if a patient dies due to staffing cuts that their managers implemented.<sup>333</sup> We should explore legal mechanisms to force private equity firms, like Cerberus, to disgorge their profits unjustly enriched by their extraction from the health care system.<sup>334</sup>

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331. See, e.g., *Pottstown Sch. Dist. v. Montgomery Cnty. Bd. of Assessment Appeals*, 289 A.3d 1142 (Pa. Cmmw. Ct. 2023); see also Ashad Hajela, *A Pa. Hospital's Revoked Property Tax Exemption Is a 'Warning Shot' to Other Nonprofits, Expert Says*, WHYY (Mar. 13, 2023), <https://whyy.org/articles/pa-hospitals-revoked-property-tax-exemption/> [https://perma.cc/UQJ3-EUZ4]; *AHS Hosp. Corp. v. Town of Morristown*, 28 N.J. Tax 456 (2015). Stricter state requirements for nonprofit tax exemption is not necessarily a recent phenomenon; see e.g., *Utah County v. Intermountain Healthcare Inc.* 709 P.2d 265 (Utah 1985); *Provena Covenant Med. Ctr. v. Dep't of Rev.* 925 N.E.2d 1131 (Ill. 2010).

332. See Suhas Gondi, Sanjay Kishore & J. Michael McWilliams, *Professional Backgrounds of Board Members at Top-Ranked U.S. Hospitals*, 38 J. GEN. INTERN. MED. 2428, 2428 (2023) (studying the composition of hospital boards of the 20 top-rated hospitals in the US news & World Report in 2022 and finding that the most common professional background was finance, which greatly outnumbered members with health care backgrounds).

333. See Field et al., *supra* note 265, at 880–81 (describing a breach of fiduciary duty theory of liability against PE-owned nursing homes); Isaac D. Buck, *Patients vs. Profits*, 97 TEMPLE L. REV. 321, 322 (2025) (describing the applicability and difficulty of finding private equity investors liable under the False Claims Act).

334. See *Senators Warren, Markey Introduce the Corporate Crimes Against Health Care Act of 2024*, ELIZABETH WARREN (June 11, 2024), <https://www.warren.senate.gov/newsroom/press-releases/senators-warren-markey-introduce-the-corporate-crimes-against-health-care-act-of-2024> [https://perma.cc/9BWB-PPE5] (detailing Warren's support for holding corporate executives liable for taking advantage of health care organizations to the detriment of patients); see also *Corporate Crimes Against Health Care Act*, S. 4503, 118th Cong. (2024) (proposing criminal and civil penalties for corporate actors whose financial misconduct in health care companies ends in harm to patients, and permitting recovery of compensation linked to such misconduct).

Other policies could curb private equity investors' riskiest financial tactics, including limiting dividend recapitalizations, capping the extent of debt, lengthening holding periods, or requiring deposit of a community bond to draw upon in the event of financial distress.<sup>335</sup> Lawmakers and enforcers could create pathways to pierce the corporate veil designed to obscure, obfuscate, and evade liability and keep investors' skin in the game.<sup>336</sup>

### *C. Building and Allocating Supply*

A final category of reforms would focus on how resources in the health care system—especially public resources—are used to build and allocate health care supply. Indeed, a health care sector that is seventy-percent taxpayer-financed demands a more coordinated approach to capital and labor allocation.<sup>337</sup>

The most common objection to attempts to rein in private equity and corporate consolidation of health care providers is reflected by this statement by physician David Eagle: “I don’t see how in a consolidated healthcare landscape anyone can work without a source of capital.”<sup>338</sup> As noted above, many independent community health facilities and physician practices need capital to purchase electronic health records, assume population risk, enter into value-based contracts, and track the quality and other metrics required to get paid.<sup>339</sup> Similar financial pressures face post-acute providers, skilled nursing facilities, behavioral health, hospices, and independent pharmacies—all targets of financialization.<sup>340</sup> Rural and underserved areas struggle to maintain access to

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335. See Stop Wall Street Looting Act, H.R. 9985, 118th Cong. (2024) (proposing limitations on private equity practices such as dividend recapitalizations, capping leverage ratios, extending minimum holding periods, and requiring a community fund to mitigate harm from financial distress).

336. BRENDAN BALLOU, PLUNDER: PRIVATE EQUITY’S PLAN TO PILLAGE AMERICA 221, 229, 238, 245 (2023) (suggesting pathways to pierce the corporate veil that insulates private actors); Stop Wall Street Looting Act §101.

337. See Gaffney, Woolhandler & Himmelstein *supra* note 23, at 341 (finding that the percentage taxpayers contribute to this market grew from 9% in 1923 to 69% in 2020).

338. Chris Cumming, *Doctors Organize to Push Back Against Private-Equity Takeovers*, WALL ST. J. (Sep. 22, 2024), <https://www.wsj.com/articles/doctors-organize-to-push-back-against-private-equity-takeovers-16aa2c94> [<https://perma.cc/4Q48-N9DT>] (quoting David Eagle, Oncologist and Executive Vice President of American Independent Medical Practice Association, a group that supports private equity investment in physician practices).

339. See Kristine Namhee Kwon et al., *Community Health Centers Grew Through 2023, But Serious Hazards Are on the Horizon*, GEIGER GIBSON PROGRAM IN CMTY. HEALTH (Sep. 17, 2024), <https://geigergibson.publichealth.gwu.edu/72-community-health-centers-grew-through-2023-serious-hazards-are-horizon> [<https://perma.cc/6C26-MGAX>] (finding that health centers rely on grants to fund services that insurance does not cover).

340. See *generally* Atul Gupta et al., Owner Incentives and Performance in Healthcare: Private Equity Investment in Nursing Homes, 37 REV. FIN. STU. 1029 (2024) (showing nursing homes as investment targets); Jane M. Zhu et al., Geographic Penetration of Private Equity Ownership in Outpatient and Residential Behavioral Health, 81 JAMA PSYCHIATRY 733 (2024) (showing PE penetration altering behavioral health market); Markian Hawryluk, Hospices Have Become Big Businesses for Private Equity Firms, Raising Concerns About End-of-Life Care, KFF HEALTH NEWS (July 29, 2022),

basic health care services where demand for primary, reproductive, and behavioral health care far outstrips supply or the funds to pay for it.<sup>341</sup> In this environment, many health care providers and practices believe their only option is to sell to private equity, UnitedHealth's Optum, or a large health system to survive.<sup>342</sup>

What alternative sources of capital could be plumbed and expanded, whether in the form of traditional bank loans, municipal or tax-exempt bonds, and public grants and investments? Why does obtaining financing necessarily require health care professionals to cede managerial control to financiers?

Our current health care system is largely publicly financed, and private investors have figured out how to mine the health care system for profit in the form of taxpayer-funded Medicare and Medicaid reimbursement.<sup>343</sup> Yet with the growth of Medicare and Medicaid managed care models, public investment has been channeled through increasingly convoluted reimbursement formulas that are both game-able for corporate investors and administratively unsustainable for small, independent providers.<sup>344</sup> What might it look like to simplify public health care financing and redirect some funds from reimbursement to capital financing targeting underserved and unmet needs? Currently, a patchwork of programs may offer lessons for greater policy direction, including grant funding via Section 330 of the Public Health Service Act for community health centers and low-interest loans and grants for rural providers through the Department of Agriculture.<sup>345</sup> Smaller providers today can also access federally guaranteed

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<https://kffhealthnews.org/news/article/hospices-private-equity-firms-end-of-life-care/> [<https://perma.cc/PBC5-WNJQ>] (seeing significant shift in hospice care due to private equity owners); Maira Imtiaz & Annie Sabater, Private Equity Investment Plunges in Troubled Drug Retail Sector, S&P GLOB. MKT. INTEL. (Nov. 14, 2023), <https://www.spglobal.com/marketintelligence/en/news-insights/latest-news-headlines/private-equity-investment-plunges-in-troubled-drug-retail-sector-78269071> [<https://perma.cc/TL4X-QFPC>] (describing trends of PE investments in retail pharmacy).

341. See *Why Health Care Is Harder to Access in Rural America*, U.S. GOV'T ACCOUNTABILITY OFF. (May 16, 2023), <https://www.gao.gov/blog/why-health-care-harder-access-rural-america> [<https://perma.cc/M8WB-E8ZC>] (expressing challenges rural residents face concerning health risks and lack of health care facilities).

342. See Khullar, Casalino & Bond, *supra* note 107 (describing the dynamics leading to vertical hospital-physician consolidation); Rooke-Ley, Shah, & Fuse Brown, *Medicare Advantage*, *supra* note 27 (describing the rise of vertical physician acquisition by Medicare Advantage insurers); Rooke-Ley, Song, & Zhu, *supra* note 105 (describing how value-based payment models push independent physicians to sell to corporate owners such as private equity or health insurance companies).

343. See *supra* section II.B.

344. *Id.*

345. See SARAH ROSENBAUM ET AL., KFF, COMMUNITY HEALTH CENTER FINANCING: THE ROLE OF MEDICAID AND SECTION 330 GRANT FUNDING EXPLAINED (2019) (explaining that health centers are reliant on Medicaid and Section 330 grants); *Federally Qualified Health Centers and the Health Care Program*, RURAL HEALTH INFO. HUB (Aug. 11, 2025), <https://www.ruralhealthinfo.org/topics/federally-qualified-health-centers> [<https://perma.cc/E7WH-YTPY>] (describing the role of FQHCs in rural areas); *340B Drug Pricing Program*, HEALTH RES. & SERVS (Aug. 31, 2025) (describing the program that allows qualifying provider entities to purchase pharmaceuticals at a discounted price); U.S. DEP'T AGRIC,

loans through the Small Business Administration for capital investments.<sup>346</sup> Policymakers could expand upon or model larger public financing of health care infrastructure on these programs.

The labor side of the equation requires attention as well. Current government policy plays a central role in structuring the production and allocation of clinicians. Medicare directly funds medical residency slots and caps how many it will fund.<sup>347</sup> Moreover, Medicare payment policy is the biggest driver of relative reimbursement among medical specialties, and reimbursement differences in turn dictate the residency decisions of graduates.<sup>348</sup> In many other ways, such as loan repayment, the government is structuring the health care labor, particularly physicians.<sup>349</sup> Yet these policies are not delivering the desirable distribution of clinicians—by specialty or geography.<sup>350</sup> Scarcity and under-resourcing in areas like primary care can exacerbate conditions of financialization.<sup>351</sup> Policymakers should be thinking about payment policy, residency funding, and loan repayment with an eye toward labor supply and financialization.<sup>352</sup> Other, more innovative policies could create incentives for medical schools to admit and train enough future physicians in specialties to meet societal needs or open immigration channels for high-need clinicians.

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COMMUNITY FACILITIES DIRECT LOAN PROGRAM GUIDANCE BOOK FOR APPLICANTS 3 (detailing a loan program that provides affordable funding to rural areas).

346. 7(a) *Loan Program*, U.S. SMALL BUS. ADMIN. (May 30, 2025), <https://www.sba.gov/funding-programs/loans/7a-loans> [<https://perma.cc/BHK9-M78J>].

347. U.S. Gov't Accountability Off., GAO-21-391, *Physician Work Force: Caps on Medicare-Funded Graduate Medical Education at Teaching Hospitals 2* (2021).

348. See Kent J. Moore et al., *What Every Physician Should Know About the RUC*, 15 FAM. PRACT. MGMT. 36, 38 (2008) (stating that RUC collects data on practicing physicians views of working in the service as approach to determine values of physician services); see also Mark H. Ebell & Julie P. Phillips, *The Association Between Physician Salary and Competitiveness of that Specialty in the Match: Money Still Matters*, FAM. PRACT., May 12, 2025, at 3 (finding that the Resource Based Relative Value Scale, which is central to reimbursement determinations, influences medical students' specialty preferences).

349. See generally, e.g., *Loan Repayment Programs for Health Careers*, HEALTH RES. & SERVS. ADMIN. (Aug. 2025), <https://bhw.hrsa.gov/funding/apply-loan-repayment> [<https://perma.cc/K4DM-T9RD>] (listing various loan repayment programs).

350. Stephanie Khoury, Jonathan M. Leganza, & Alex Masucci, *Public Policy Can Encourage Physicians to Practice in Underserved Areas*, VOX EU (Sep. 1, 2025), <https://cepr.org/voxeu/columns/public-policy-can-encourage-physicians-practice-underserved-areas> [<https://perma.cc/CHS3-X9S5>] (explaining that several communities suffer from limited access to health care and limited physician services).

351. Chris Cumming, *Doctors Organize to Push Back Against Private-Equity Takeovers*, WALL ST. J. (Sep. 22, 2024), <https://www.wsj.com/articles/doctors-organize-to-push-back-against-private-equity-takeovers-16aa2c94> [<https://perma.cc/4Q48-N9DT>] (quoting David Eagle, Oncologist and Executive Vice President of American Independent Medical Practice Association, a group that supports private equity investment in physician practices).

352. See STEPHEN M. PETTERSON ET AL., ROBERT GRAHAM CTR., *UNEQUAL DISTRIBUTION OF THE U.S. PRIMARY CARE WORKFORCE 1* (2013) (emphasizing the need for policies to focus on increasing the overall number of practicing physicians in areas that need it most).

In addition to building supply, policymakers can deploy and streamline entry and exit restrictions to ensure efficient allocation of capacity. State-based “certificate of need” (“CON”) laws are a longstanding example of entry restrictions that require health care entities to obtain state approval (a CON) to open or acquire a health care facility or make significant capital investments.<sup>353</sup> In response to rising health care costs in the 1970s, CON laws sought to address “Roemer’s law”: that a bed built is a bed filled.<sup>354</sup> The purpose of CON is to constrain costs by constraining supply.<sup>355</sup> With mixed evidence of cost-containment, CON laws have come under intense criticism that they create barriers to entry and restrict competition.<sup>356</sup> A further critique is that CON laws have been co-opted by incumbents, who have used litigation or political power to block potential competitors from entry, investment, or expansion as a way to entrench their monopoly power.<sup>357</sup> While we share concerns about potential abuses of CON laws by incumbents, discarding the authority altogether may be ill-advised because it would eliminate an avenue of oversight and a lever against health care consolidation.<sup>358</sup> How can CON-type laws be democratically responsive, rather than captured? What processes or mechanisms need to be in place? What is the correct locus of governance for these laws—local, state, or even federal?

One solution may be to move towards a different but related kind of entry restriction: material transaction review laws.<sup>359</sup> These laws, which are increasingly being adopted at the state level, combine aspects of antitrust, CON,

353. National Conference of State Legislatures, *Certificate of Need Laws*, NAT’L CONF. STATE LEGISLATURES (Apr. 29, 2025), <https://www.ncsl.org/health/certificate-of-need-state-laws> [https://perma.cc/3WY9-DBHZ].

354. See Matthew D. Mitchell, *Certificate of Need Laws in Health Care: Past, Present, and Future*, 61 INQUIRY 1, 2 (2024) (explaining that lawmakers wanted CON laws to cause hospitals to acquire fewer beds, admit fewer patients, and thus, spend less money).

355. *Id.*

356. See Barak D. Richman & Steven L. Schwarcz, *Macromedial Regulation*, 82 OHIO STATE L.J. 727, 776 (2021) (describing CON laws as causing monopolies and restricting health care delivery); Sean Healey, *Con Laws and the Capture of Care*, THE FLAW (March 24, 2024), <https://theflaw.org/articles/con-laws-and-the-capture-of-care/> [https://perma.cc/9DA4-N2JB] (stating that patients in CON states face higher health care costs and possess access to fewer services).

357. See Healey, *supra* note 356.

358. Johanna Butler, Adney Rakotoniaina & Vicki Veltri, *Weighing Policy Trade-Offs: Building State Capacity to Address Health Care Consolidation*, NAT’L ACAD. FOR STATE HEALTH POL’Y (Jul. 24, 2023), <https://nashp.org/weighing-policy-trade-offs-building-state-capacity-to-address-health-care-consolidation/> [https://perma.cc/PH7J-88NC] (suggesting updates to CON laws rather than eliminating them altogether).

359. See Alexandra D. Montague, Katherine L. Gudiksen, & Jaime S. King, Milbank Mem’l Fund, *State Action to Oversee Consolidation of Health Care Providers* 10 (2021), <https://www.milbank.org/publications/state-action-to-oversee-consolidation-of-health-care-providers/> [https://perma.cc/N6M9-EBTN] (describing one of the goals of material transaction review laws is to prevent anticompetitive business ventures).

and existing requirements for pre-approval of nonprofit hospital transactions.<sup>360</sup> In Oregon, for example, nearly all health care transactions (e.g., mergers, acquisitions, changes of control) are required to receive approval under the state's broad "public interest" standard, which considers impacts of a transaction not just on competition, but also on cost, access, quality, and equity.<sup>361</sup> Unlike CON laws, material transaction oversight does not aim to prevent market entry by new would-be competitors, but rather seeks to prevent market consolidation.<sup>362</sup> In addition to restrictions on consolidation, these laws can be used as exit restrictions.<sup>363</sup> For example, another way to address service-line closures—in addition to or instead of minimum access requirements described above—is through material transaction review laws.<sup>364</sup>

Taken together, these categories of policy reform are meant to help frame a research and policy agenda to combat financialization. As noted, many of these policies are gaining a foothold at the state level.<sup>365</sup> This may suggest the emergence of an alternative governing approach to health care, headlined by an emphasis on pricing policy, structural separations, ownership and governance requirements, and entry and exit restrictions. These reforms contrast sharply with the prevailing approach since the turn to managed care in the 1980s that has deprioritized pricing policy, promoted vertical integration, and entrusted markets to self-correct and efficiently allocate health care resources.<sup>366</sup>

Observers may also note that our categories for reform bear a resemblance to the tradition of "regulated industries" or "public utilities."<sup>367</sup> Popularized in

360. See generally Erin Fuse Brown & Katherine Gudiksen, Milbank Mem'l Fund, Models for Enhanced Health Care Market Oversight—State Attorneys General, Health Departments, and Independent Oversight Entities (2024) (indicating that states have expanded oversight of health care transactions by requiring notice and, in some case, approval, of proposed transactions).

361. OR. HEALTH AUTH. 'S HEALTH CARE MKT. OVERSIGHT PROGRAM, HEALTH CARE MARKET OVERSIGHT ANALYTIC FRAMEWORK 4 (2025).

362. See *Comprehensive Consolidation Model Addressing Transaction Oversight, Corporate Practice of Medicine and Transparency*, NAT'L ACAD. FOR STATE HEALTH POL'Y (July 7, 2024), <https://nashp.org/a-model-act-for-state-oversight-of-proposed-health-care-mergers/> [<https://perma.cc/T8TZ-9GDA>] [hereinafter *Comprehensive Consolidation*] (describing a comprehensive model to address health care consolidation and issues of corporate and private equity involvement in health care markets).

363. See Hostert et al., *supra* note 324 (describing Massachusetts' 2025 legislation that would require state notification and oversight of anticipated service line or facility closures via the state's "determination of need" authority, its CON office).

364. See *Comprehensive Consolidation*, *supra* note 362 (specifying that facility and service line closures are among the types of transactions states should review as they address issues of private equity in the health care industry).

365. See *supra* Part IV (discussing responses to financialization, including from the state level).

366. See Rooke-Ley & Ryan, *supra* note 283, at 1203 (describing that health policy has retreated from pricing regulation in favor of vertically integrated managed care organizations).

367. See WILLIAM J. NOVAK, THE PUBLIC UTILITY IDEA AND THE ORIGINS OF MODERN BUSINESS REGULATION, IN THE TURN TO REGULATION 141 (2017) (situating the rise of public-utility regulation within broader shifts from laissez-faire markets to modern administrative governance).



response to a Gilded Age economy that exhibited many of the same features of financialization now manifesting in health care, Progressive-Era reformers developed a range of legal and policy tools that rejected the prevailing laissez-faire approach to markets.<sup>368</sup> Reformers targeted railroads, telecommunications, banks, and other essential industries with new rules of commerce, such as price regulation, nondiscrimination rules, access requirements, structural separations, public and cooperative ownership of production, and rules of market entry and exit.<sup>369</sup> Fundamentally, public utility governance was about exercising democratic or “social control” over businesses that “affected the public interest,” especially where classical liberal market competition produced profiteering, exploitation, and domination, rather than value-creation.<sup>370</sup>

A version of this regulatory tradition may be a promising framework for combating financialization and orienting our system around clinicians, patients, and their local communities. And here we are not the first to note the connection between public utility and health care.<sup>371</sup> While we have outlined broad categories consistent with a public utility approach, we leave for another day the full development of this framework, which requires deeper theoretical work and a fully fleshed-out policy agenda.

## V. CONCLUSION

Is health care just another saleable commodity or does it have special status as a social good that is necessary for fundamental human participation in society? If the latter, then we ought to be concerned about financialization. This is because financialized health systems operate for the profit of private financial firms outside the health system and extract assets and health care resources away from the patients and providers of health care within the system. By specifying the phenomenon of financialization, we can study its effects, target policies to

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368. See NAOMI R. LAMOREAUX & WILLIAM J. NOVAK, CORPORATIONS AND AMERICAN DEMOCRACY 139, 161–62 (2017) (explaining that, following the Gilded Age, states increased regulations and oversight in various industries).

369. MORGAN RICKS ET AL., *supra* note 312, at 24–31

370. See K. Sabeel Rahman, *Challenging the New Curse of Bigness*, AM. PROSPECT (Nov. 29, 2016), <https://prospect.org/economy/challenging-new-curse-bigness/> [https://perma.cc/3CY8-9WFE] (explaining that there was support for public utility regulation in industries “where the vulnerability of citizens, businesses, and communities to exploitation by the private provider was most threatening and troubling”); Nicholas Bagley, *Medicine as a Public Calling*, 114 MICH L. REV. 58, 77 (2015) (“An extraordinary range of market features—the costs of shopping around, bargaining inequalities, informational disadvantage, rampant fraud, collusive pricing, emergency conditions, and more—could all frustrate competition and . . . warrant state intervention.”).

371. See generally Bagley, *supra* note 370, at 77 (noting that the public utility governing tradition has plausible application to the health care sector); Josh Macey & Genevieve Lakier, *What Are Networks, Platforms, and Utilities and What Should We Do with Them?* YALE J. REGUL.: NOTICE & COMMENT (Jan. 24, 2023), <https://www.yalejreg.com/nc/symposium-networks-platforms-utilities-07/> [https://perma.cc/6FZD-CJUQ] (suggesting that health care would fit the definition of NPU law).

constrain its most harmful effects, and lay out a research and policy agenda to reorient the industrial organization of the health care system to promote the welfare of actual living people and their communities rather than profits for corporate persons and investors.