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**Back to Basics: Private Equity and the Need for Rules and Values in Health Care**

**Mary Beckman and Jill R. Horwitz***

## I. Introduction

The American health care system has been troubled for decades. Compared to virtually every other high-income country, Americans have long paid higher costs, had worse outcomes on a host of important measures, and faced extreme barriers to access.[1] Things are likely to get much worse.

First, the U.S. population is aging at the fastest rate in more than a century.[2] At the same time as the baby boomers are retiring and living longer than previous generations and, therefore, needing more medical care, the health care workforce available to treat them is not keeping up.[3] Not only are medical workers aging out of the work force, recent anti-immigration policies, such as the Trump Administration's H-1B visa fee and travel ban policies, are further shrinking provider pools.[4] Second, enormous cuts to government spending on health insurance and health

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[1] With the exception of health care process measures, the U.S. has long performed extremely poorly in comparison to other high-income countries. *Compare*d to Australia, Canada, France, Germany, the Netherlands, New Zealand, Sweden, Switzerland, and the United Kingdom, United States has come out at or near the bottom in terms of access to care, process, administrative efficiency, equity, and health outcomes. David Blumenthal et al., *Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System: Comparing Performance in 10 Nations* (Commonwealth Fund Sept. 19, 2024), https://www.commonwealthfund.org/sites/default/files/2024-10/Blumenthal_mirror_mirror_2024_final_v4.pdf.

[2] Zoe Caplan, *U.S. Older Population Grew From 2010 to 2020 at Faster Rate Since 1880 to 1890*, U.S. Census Bureau (May 25, 2023), https://www.census.gov/library/stories/2023/05/2020-census-united-states-older-population-grew.html.

[3] *See generally* Charles H. Jones & Mikael Dolsten, *Healthcare on the Brink: Navigating the Challenges of an Aging Society in the United States*, 10 NPJ AGING 22 (2024); Imani Telesford et al., *What Are the Recent Trends in Health Sector Employment?*, Peterson-KFF Health System Tracker (Mar. 27, 2024), https://www.healthsystemtracker.org/chart-collection/what-are-the-recent-trends-health-sector-employment/#Cumulative%20%%20change%20in%20health%20sector%20employment%20by%20setting,%20February%202020%20-%20February%202024.

[4] Drishti Pillai & Samantha Artiga, *Potential Impacts of Trump Administration H-1B Visa Policies on the Health Care and Social Assistance Industries*, KFF, https://www.kff.org/immigrant-health/potential-impacts-of-trump-administration-h-1b-visa-policies-on-the-health-care-and-social-assistance-industries/; Miriam Jordan, *Trump's Immigration Policy Sidelines Foreign Doctors Amid Shortage*, THE NEW YORK TIMES (Apr. 4, 2026), https://www.nytimes.com/2026/04/04/us/trumps-immigration-policy-sidelines-foreign-doctors-amid-shortage.html. Limiting immigration and deporting health care workers not only limits the health care workforce but also undermines a path toward controlling costs through competition. *See* Jill R. Horwitz & Austin Nichols, *Fixing Prices*: *Immigration and Physician Competition*, PETRIE-FLOM CTR. BILL OF HEALTH (May 21, 2021), https://petrieflom.law.harvard.edu/2021/05/21/immigration-physician-competition/.



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care[5] are predicted to reverse improvements in insurance coverage, including access related to the Affordable Care Act and for low-income Americans[6] currently insured under Medicaid expansion policies.[7] There is evidence that these large reductions are happening.[8] Nonetheless, as harmful as these and related problems will be for Americans, they are likely the kinds of problems that can be addressed through good public policy.[9]

Amidst all these challenges, however, a new and potentially more damaging shift in the structure and ownership of health care resources threatens to degrade access to quality health care for many. A type of finance loosely known as "private equity" ("PE") that includes several investment and ownership structures has increasingly appeared in health care.[10] PE investments have been made in virtually every medical specialty, with particularly high penetration in relatively profitable areas such as emergency medicine, anesthesia, dentistry, dermatology, and

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[5] *See* One Big Beautiful Bill Act, Pub. L. No. 119-21, §§ 71101–71121, 139 Stat. 72 (2025) (restricting Medicaid eligibility, imposing community-engagement requirements, and limiting state-directed payments and provider taxes); *see also* KFF, *Health Provisions in the 2025 Federal Reconciliation Law* (Aug 22, 2025) https://www.kff.org/medicaid/health-provisions-in-the-2025-federal-budget-reconciliation-law/.

[6] Alice Burns et al., *How Will the 2025 Reconciliation Law Affect the Uninsured Rate in Each State?*, KFF (Aug. 20, 2025), https://www.kff.org/uninsured/how-will-the-2025-reconciliation-law-affect-the-uninsured-rate-in-each-state/ (estimating, based on CBO projections, that the law will increase the uninsured population by 10 million by 2034, with 7.5 million of that increase attributable to changes in Medicaid).

[7] Matthew Buettgens et al., *Projected Reductions in Medicaid Expansion Enrollment Under OBBBA's Work Requirements and Six-Month Redeterminations: National and State Estimates for 2028*, URBAN INST. (Mar. 25, 2026), https://www.urban.org/research/publication/projected-reductions-medicaid-expansion-enrollment-under-obbbas-work.

[8] For example, "[f]or the first time since 2019, the number of people without health coverage and the uninsured rate increased in 2024." Jennifer Tolbert et al., *Key Facts about the Uninsured Population,* KFF (June 16, 2026) https://www.kff.org/uninsured/key-facts-about-the-uninsured-population/?entry=executive-summary-introduction. Analysists expected to see this decrease since the passage of OBBBA and have been tracking it since then. Justin Lo et al., *ACA Marketplace Enrollment is Down in 2026—But All of the Data Isn't in Yet,* KFF (Feb. 5, 2026), https://www.kff.org/affordable-care-act/aca-marketplace-enrollment-is-down-in-2026-but-all-of-the-data-isnt-in-yet/; Reed Abelson & Margot Sanger-Katz , *Since Congress Let Obamacare Subsidies Expire, Millions Are Dropping Coverage*, N.Y. TIMES (May 7, 2026), https://www.nytimes.com/2026/05/01/business/obamacare-enrollment-decline.html.

[9] *See Health Workforce Projections*, Bureau of Health Workforce, Health Res. & Servs. Admin., https://bhw.hrsa.gov/data-research/projecting-health-workforce-supply-demand (projecting an overall shortage of 141,160 physicians by 2038); Tim Dall et al., *The Complexities of Physician Supply and Demand: Projections from 2021 to 2036*, ASS'N OF AM. MED. COLLS. (Mar. 2024), https://www.aamc.org/media/75236/download (projecting a shortage of 13,500 to 86,000 physicians by 2036, driven in part by 34.1% growth in the population aged 65 and older) at 1. The Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), expanded health-insurance coverage through Medicaid expansion, the individual mandate, and the establishment of state and federal exchanges. *See generally* Patient Protection and Affordable Care Act §§ 1311, 1401, 2001, 124 Stat. at 173, 213, 271.

[10] *See, e.g.,* Global Healthcare Private Equity Report 2026: Record Highs, Renewed Momentum, Ready for More, Bain & Co., https://www.bain.com/insights/topics/global-healthcare-private-equity-report/ (showing "a record high in global deal value in 2025"); Both the reach of private equity and associated problems extend beyond the United States. For example, Singh et al., identify global PE investments in health care totaling $446 billion between 2018 and 2022, and argue that PE firms target private companies to restructure, streamline, or expand operations, raising concerns that profit motives may outweigh long-term patient care. Yashaswini Singh et al., *The Rise of Private Equity in Health Care—Not a Uniquely American Phenomenon*, 392 NEW ENG. J. MED. 627, 627 (2025).



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oncology.[11] A growing body of research on the outcomes associated with PE financing has begun to demonstrate that compared to other forms of financing and ownership—public, nonprofit, and more traditional forms of for-profit—entities financed by private equity perform worse on multiple measures.[12] Health care entities and specialties financed with PE have higher market concentration and prices as well as lower quality compared to others. As the recent bankruptcies of Steward Health Care, Prospect Medical Holdings, and others have shown, PE financed providers have failed spectacularly, harming the neediest patients.[13]

Numerous scholars and policy analysts have identified the growth and consequences of private equity in health care. They have highlighted failures of regulation to contain associated harms, and they have suggested increased enforcement of existing legislative and regulatory responses as well as proposing adoption of new rules.[14] We argue that although some proposals for heightened enforcement of existing laws and addition of more stringent ones may well do some good, they will likely fail to address the fundamental problem of PE in health care.

That fundamental problem with PE financing stems from the deep mismatch between the purpose of health care—serving the needs of individual patients, communities and the national population—and the purposes, incentives, and legal constraints associated with private equity, generally characterized by investor expectations of rapid realization of high returns and an exit from the investment within a few years. This mismatch renders conventional regulatory tools and the regulators who apply them poorly armed to protect the public good from investors facing overwhelming incentives to profit and little to gain from longer term commitment of resources.

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[11] Lynn Unruh & Thomas Rice, *Private Equity Expansion and Impacts in United States Healthcare*, 155 HEALTH POL'Y 105266, at 3 (2025).

[12] Erin Fuse Brown and Mark Hall usefully conclude that, "While it remains unclear whether private equity investment is fundamentally more threatening to health policy than other forms of acquisition and financial investment—whether by publicly traded companies, conglomerate health systems, or health insurers—private equity presents a heightened threat of commercialization. Even if private equity is not uniquely harmful, it is extremely adept at identifying and exploiting market failures and payment loopholes." Erin C. Fuse Brown & Mark A. Hall, *Private Equity and the Corporatization of Health Care*, 76 STAN. L. REV. 527, 527–28 (2024); *see also* Erin C. Fuse Brown et al., *Private Equity Investment as a Divining Rod for Market Failure: Policy Responses to Harmful Physician Practice Acquisitions*, BROOKINGS INST. (Oct. 5, 2021), https://www.brookings.edu/articles/private-equity-investment-as-a-divining-rod-for-market-failure-policy-responses-to-harmful-physician-practice-acquisitions/.

[13] In addition to Steward and Prospect, Hahnemann Hospital and Delaware County Memorial Hospital have represented high profile bankruptcies. Nori Gerardo Lietz & Zirui Song, *Does Private Equity Have Any Business Being in the Health Care Business?*, Harv. Bus. Sch. Fin. Working Paper No. 25-012, at 2 (Sept. 2024), https://www.hbs.edu/ris/Publication%20Files/25-012_6ca99cff-f3e0-482e-8d5e-d925c5981db7.pdf. For a thorough discussion of the Steward and Prospect failures *see, e.g.*, Dolan Bortner, *Private Inequity: Better Health Care Through Business Law* (May 14, 2025) (unpublished manuscript), https://ssrn.com/abstract=5254721.

[14] Erin C. Fuse Brown and Mark A. Hall lay out a detailed approach to applying current law as well as reforming it to "patch" existing problems. *See* Fuse Brown & Hall, *supra* note 12, at 553–88 (laying out existing legal tools and reform proposals as patches rather than systemic solutions).



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Our claim is simple: Health care providers and their controlling funding sources *both* must hold legally-enforceable duties to advance purposes appropriate to the assets they hold and the services they provide.

As discussed in detail below, we are cognizant of both the need for capital to fuel care provision[15] and the potential of profit-making incentives to inspire innovation in medical care inputs such as biotechnology and other products, management techniques, and delivery systems. The incentives to profit have always been an important feature of American health care, and we believe that, when applied appropriately, such incentives should and will continue to do good. In fact, it is not surprising that "[t]hough collectively fewer in number, investments in health care technology, pharmaceutical, and biotechnology firms are comparatively larger in dollar amount, driving the total value of those PE transactions significantly past those in health care service providers."[16] We remain far less sanguine about health-service related PE transactions. As many scholars have demonstrated, PE involvement in health services comes with heightened risks of price increases, quality declines, and the destruction of critical providers.[17] These risks are simply too great to accept.

Having regulated, worked in, and studied the U.S. health care system for decades, we understand that PE has often entered when there are no other potential private lenders or buyers, public resources, or the political will to offer an alternative to the kinds of investments that are inextricably linked to PE and its associated hyper-focus on huge, short-term returns. For these reasons, we consider the prospect of near-term bans on PE in health service provision unrealistic. Nonetheless, we have seen the transfer of wealth into private hands and out of the health care system, including from nonprofits that are required to advance the public interest. Such transfers need to be addressed.

As PE funded health care providers fail, the burdens will disproportionately fall on low-income people and others who are under- or uninsured. But it is a mistake to think that even affluent Americans will escape extreme harm if this pattern continues. As PE financing and the structures it tends to impose leave health care organizations financially vulnerable or insolvent, even wealthy and well-insured Americans will have difficulty accessing care. Institutions need to

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[15] Regan Parker, Misguided Attacks on Private Healthcare Investment Risk Hurting Patients, REALCLEARHEALTH (Apr. 6, 2026), https://www.realclearhealth.com/articles/2026/04/06/misguided_attacks_on_private_healthcare_investment_risk_hurting_patients_1174958.html.

[16] Christopher Cai & Zirui Song, *Private Equity in Health Care*: *Prevalence, Impact, and Policy Options for California and the U.S.*, CAL. HEALTH CARE FOUND. (May 2024), https://www.ch*cf*.org/wp-content/uploads/2024/05/PrivateEquityPrevalenceImpactPolicy.pdf. at 7.

[17] "It has been reported that PE firms were involved in 17 and Venture Capital accounted for an additional 12 or 36% of the 80 total health care bankruptcies in 2023 and more are anticipated in 2024." Lietz & Song, *supra* note 13, at 2 & ex. 1.



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exist to provide treatment, and no amount of concierge medicine can take the place of a nearby emergency room.

What can be done? We propose reforms to align duties and incentives for all individuals and entities that own or control health care providers and assets used in providing care—physician groups, hospitals, and others. All providers need to have purposes that further the fundamental goals of providing high quality health care and that support the stability of organizations to provide it, even while allowing for a reasonable return for investors (a duty in for-profit structures) or a reasonable margin to reinvest in support of charitable purposes (the appropriate use of profits by nonprofits), and legally enforceable duties to advance those purposes.

The remainder of this extended essay is organized as follows. In section II, we provide a brief review of terrain well covered by others, including a description of private equity and associated practices, their prevalence in health care, and the existing research regarding their effects. Section III, drawing on the history of Steward Health Care, considers how the current state has come about. In section IV, we outline both recent governmental efforts to address the failures associated with PE as well as the various suggestions offered by other scholars and the strengths and weaknesses of those approaches. Having identified what is missing from the mix, we offer our own suggestions in section V. Section VI concludes.

## II. PE and Health Care: A Brief Overview of Existing Research

### A. What is private equity?

There is no precise definition of the term "private equity." It has been used liberally to represent a wide range of investment activity.[18] We use the term to mean a type of investment in which a firm assembles capital from institutions such as pension funds and endowments or wealthy individuals and uses that capital to either acquire private, for-profit companies or convert nonprofit companies or publicly-held for-profit companies into private, for-profit companies. These funds are managed by general partners from the firm that owns the funds.

Aside from this basic definition, there are many characteristics associated with private equity investments, although observers tend to emphasize the following. First, PE generally accepts risk and relies on debt financing to produce high returns. For example, in their exhaustive book on private equity, Eileen Appelbaum and Rosemary Batt argue that PE tends to "undertake risky investments that promise to deliver higher-than average returns," using high

[18] For example, some firms that have made private equity investments in the health care industry have broader ranging activities. Cerberus, which at one time owned Steward Health Care, identifies itself as an "alternative investment advisor" and is not only a private equity investor but also provides other types of investments and loans. Cerberus Cap. Mgmt., https://www.cerberus.com/.



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levels of debt and active management of the target companies.[19] The significance of high levels of debt is central to PE; "PE funds often finance approximately 60%–80% of their acquisitions through borrowed money (i.e., debt), with the remaining 20%–40% through existing capital—the large majority of which (often over 90%) comes from institutional investors, and the small remainder from the equity of the parent PE firm. Of note, the acquired entity assumes the debt from an acquisition, with its assets typically used as collateral."[20] The risk of failure is externalized to the debt-holder.

Second, this form of debt financing demonstrates a particular focus on short term returns. As a consequence of the need to achieve high returns over the short term, PE investors tend to embrace a great deal of risk. In fact, they have extremely high rates of bankruptcy compared to other companies.[21] Moreover, short term focus not only means riskier investments, but also other actions that may benefit the bottom line in the short term while externalizing harms onto patients and communities, such as staff layoffs, replacement of highly skilled providers with cheaper less-skilled staff, exiting service lines, focus on profitable yet overprovided services, and more.

Third, PE investors are subject to the relatively light regulation by the federal government. They also tend to be treated as investors rather than as managers of the organizations they control,[22] while at the same time they experience freedom from the kinds of oversight and control that comes from shareholder powers over CEOs of public corporations.

Finally, at least in the health services context, management services agreements are integral to PE investments. This means that because the investors tend to be finance specialists, they "lack professional and institutional obligations to promote the higher ethical goals of medical care."[23]

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[19] EILEEN APPELBAUM & ROSEMARY BATT, PRIVATE EQUITY AT WORK: WHEN WALL STREET MANAGES MAIN STREET 2 (Russell Sage Found. 2014).

[20] Cai & Song, *supra* note 16, at 4.

[21] LAURA KATZ OLSON, ETHICALLY CHALLENGED: PRIVATE EQUITY STORMS US HEALTH CARE 3–4 (2022).

[22] Olson explains that "[s]ince the enactment of the Dodd-Frank Act in 2010s, GPs must register their shops with the SEC and report certain limited information about their funds, mostly related to debt. But unlike public companies, the SEC allows that material to remain confidential. And they do not have to disclose any data pertaining to the income of their senior leaders, which companies they hold in their portfolios, or financial details about them. Worse still, PE managers do not have to notify the employee, vendors or others affected parties that a private equity firm has taken over." Olson, *supra* note 21, at 9 (citing Appelbaum & Batt). The underlying registration regime is established by Title IV of the Dodd-Frank Wall Street Reform and Consumer Protection Act, Pub. L. No. 111-203, §§ 401–419, 124 Stat. 1376, 1570–80 (2010) (codified as amended in scattered sections of 15 U.S.C., principally amending the Investment Advisers Act of 1940, 15 U.S.C. §§ 80b-1 to 80b-21). For the implementing rules, *see Rules Implementing Amendments to the Investment Advisers Act of 1940*, 76 Fed. Reg. 42,950 (July 19, 2011) (codified at 17 C.F.R. pts. 275, 279); *Exemptions for Advisers to Venture Capital Funds, Private Fund Advisers With Less Than $150 Million in Assets Under Management, and Foreign Private Advisers*, 76 Fed. Reg. 39,646 (July 6, 2011); *see also* APPELBAUM & BATT, *supra* note 19, at 53–57.

[23] Fuse Brown & Hall, *supra* note 12, at 530.



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B. Prevalence and Operations in Health Care[24]

Because of a few spectacular bankruptcies of PE-owned hospital systems, much of the public attention to private equity in health has focused on hospitals. But private equity has found its way into every facet of the health care industry where money can be made.[25] In one of the earliest and most thorough assessments of private equity in health care, Professor Laura Katz Olson documents private equity's expanding role across physician practices—including highly profitable specialties such as dermatology, ophthalmology, orthopedics, gastroenterology, urology, dialysis, fertility services, urgent care, and medical staffing—as well as dental service organizations, home health care, hospice, substance abuse and rehabilitation centers, autism treatment centers, and ambulance companies.[26]

Overall, the numbers are astounding. In 2024, 6.5% of physicians characterized their practice as PE-owned, an increase from 4.5% in 2020 and 2022.[27] As of April 2025, 8.5% of all private hospitals were owned by PE firms; 22.6% of all proprietary for-profit hospitals are owned by PE firms.[28] As of 2022, between 25 and 40% of emergency departments were owned by PE.[29]

Recent estimates for PE ownership of nursing homes range from 5 to 13%.[30] The US Government Accountability Office estimated in 2022 that 5% of about 14,700 nursing homes enrolled in Medicare had private equity owners.[31] Using a proprietary database "that enabled them to better capture ownership information," Health Affairs published a study in 2024 showing

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[24] For a useful overview of private equity and health care, *see* Lietz & Song, *supra* note 13.

[25] *See* Cai & Song, *supra* note 16; AM. ANTITRUST INST., *SOARING PRIVATE EQUITY INVESTMENT IN THE HEALTHCARE SECTOR: CONSOLIDATION ACCELERATED, COMPETITION UNDERMINED, AND PATIENTS AT RISK* (May 2021), https://www.antitrustinstitute.org/wp-content/uploads/2021/05/Private-Equity-I-Healthcare-Report-FINAL-1.pdf; Priv. Equity Stakeholder Project, *Private Equity Hospital Tracker*, https://pestakeholder.org/private-equity-hospital-tracker/; S. Budget Comm., *Profits Over Patients: The Harmful Effects of Private Equity on the U.S. Health Care System* (2025), https://www.budget.senate.gov/imo/media/doc/profits_over_patients_the_harmful_effects_of_private_equity_on_the_ushealthcaresystem1.pdf.

[26] Olson, *supra* note 21, at 15.

[27] Carol K. Kane, *Physician Practice Characteristics in 2024: Private Practices Account for Less Than Half of Physicians in Most Specialties* 7, AMA ( 2025), https://www.ama-assn.org/system/files/2024-prp-pp-characteristics.pdf.

[28] *PESP Private Equity Hospital Tracker*, PRIVATE EQUITY STAKEHOLDER PROJECT (Apr. 2025)., https://pestakeholder.org/private-equity-hospital-tracker/.

[29] *The Influence of Private Equity in Health Care*, HEALTH AFFAIRS INSIDER REPORT (Oct. 22, 2025), https://www.healthaffairs.org/do/10.1377/hpb20251007.715449/.

[30] According to the Private Equity Stakeholder Project, "[t]he higher estimate is more likely given the continued issues around nursing home ownership transparency." MICHAEL FENNE ET AL., PRIVATE EQUITY IS CONTINUING TO ACQUIRE – AND BANKRUPT – NURSING HOMES 3 (2025).

[31] U.S. GOV'T ACCOUNTABILITY OFF., GAO-23-106163, *NURSING HOMES: LIMITATIONS OF USING CMS DATA TO IDENTIFY PRIVATE EQUITY AND OTHER OWNERSHIP* 9 (2023). HOWEVER, the GAO cautioned that the Medicare data was imperfect because "many nursing homes did not have all of their owners listed, including those that had private equity ownership," either because a part-owner owned less than 5% of the nursing home and reporting was not required, or because the nursing home did not report the owner even though it was required. Additionally, the data did not identify which of the owners are PE firms. *Id.* at 10–11.



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that as of 2021, 13% of nursing homes were owned by PE.[32] One study found that as of 2019, 7.28% of hospices were owned by private equity, representing an increase from 3.35% in 2011.[33] And, as of 2024, 6.2% of mental health facilities are owned by PE.[34] As of 2024, 7.1% of substance abuse disorder facilities are owned by PE.[35] As of 2022, 17% of urgent care centers were owned by PE.[36] As of 2021, less than 20% of dental practices are affiliated with dental service organizations (DSOs). Though not all DSOs are PE-owned, 27 of the 30 DSOs with the largest number of affiliated locations are owned by PE.[37]

Health care providers sell their operations to private equity for a host of reasons. For example, individual practitioners looking to cash out the value of their practices into retirement are attracted to large payouts and a smooth path towards retirement.[38] In other cases, both large and small providers have found themselves in dire need of capital, and private equity has represented the only way to access it. On the large end of the provider spectrum, for example, before deciding to sell its assets to Steward Health Care, an affiliate of the private equity firm Cerberus Capital Management, the struggling Caritas Christi health care system in Massachusetts spent several years pursuing all other viable financing and affiliation opportunities, to no avail.[39] On the small end of the provider spectrum, small groups have found that their lack of access to capital has prevented them from competing in modern markets. For example, "the majority of gastroenterology (GI) groups are still fewer than 10 physicians," whereas "[t]rue scale in GI, including a management team and mature infrastructure, typically is experienced as groups get closer to 75 to 100 physicians. In general, the larger groups are able to spread the fixed costs of the organization across more providers, thereby allowing the group to have more capital to invest in people, processes, and systems toward delivering a higher level of care, with a reduced administrative burden."[40]

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[32] FENNE ET AL., *supra* note 30, at 7 (citing Dunc Williams, Jr. et al., *Nursing Home Finances Associated with Real Estate Investment Trust and Private Equity Investments*, 2 HEALTH AFFS. 1 (2024)).

[33] In 2019, 409 out of 5,615 hospices were owned by PE; in 2011, 106 out of 3,162 hospices were owned by PE. Robert Tyler Braun et al., *Acquisitions of Hospice Agencies by Private Equity Firms and Publicly Traded Corporations*, 181 JAMA INTERNAL MED. 1113, 1113 (2021).

[34] Jane M. Zhu et al., *Geographic Penetration of Private Equity Ownership in Outpatient and Residential Behavioral Health*, 81 JAMA PSYCHIATRY 732, 733 (2024).

[35] *Id.*

[36] *Influence of Private Equity in Health Care, supra* note 29.

[37] EILEEN O'GRADY, DECEPTIVE MARKETING, MEDICAID FRAUD, AND UNNECESSARY ROOT CANALS ON BABIES 2 (PRIV. EQUITY STAKEHOLDER PROJECT 2021).

[38] *See* Soleil Shah, Hayden Rooke-Ley & Erin C. Fuse Brown, *Corporate Investors in Primary Care — Profits, Progress, and Pitfalls*, 388 N. Engl. J. Med. 99 (2023); *see also* Fuse Brown & Hall, *supra* note 12, at 540–42.

[39] "The decision of the Board [of Caritas Christi] to sell to a private equity firm affiliate is, in essence, the end-result of an ongoing process begun in 2006, during which all other options available to Caritas were appropriately vetted and explored." OFFICE OF THE MASS. ATT'Y GEN., *STATEMENT OF THE ATTORNEY GENERAL AS TO THE CARITAS CHRISTI TRANSACTION* 15 (Oct. 6, 2010).

[40] Mark Gilreath, Steven Morris & Joel V. Brill, *Physician Practice Management and Private Equity: Market Forces Drive Change*, 17 CLINICAL GASTROENTEROLOGY AND HEPATOLOGY 1924, 1926 (2019).



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In addition, the days of billing by paper and pencil are long over and with PE providing management services, physicians can outsource "the day-to-day nonclinical decisions related to practice management, including: compliance, accounting, revenue cycle management, information technology, business analytics, human resources, payer negotiations, marketing, procurement, acquisitions, and related business decisions."[41]

C. The Effects of PE in Health Care

The private practice of medicine for profit has existed as long as doctors have existed.[42] Physicians historically practiced independently, essentially running a business. Increasingly, physicians have shifted their practice into large, profit-making groups, some affiliated with charitable hospitals and others with large, profit-making hospital chains. These companies, including nonprofit and government health care organizations as well as for-profit companies, need to make money to operate, including to advance their charitable and public purposes. In fact, for many decades both for-profit and nonprofit providers have used some of the techniques associated with private equity to access capital.[43]

But PE is different, and its effects on health care are beginning to be well documented. A growing body of scholarship has largely identified negative effects associated with PE acquisitions. For example, overall, Erin Fuse Brown & Mark Hall characterize them as the most lethal form of an ongoing trend towards the "corporatization" of health care.[44] On the other hand,

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[41] *Id.* at 1927. For a discussion of the benefits of investor management of dermatology practices, *see generally* Barry Leshin, *Private Equity: The Good*, 41 DERMATOLOGIC CLINICS 589 (2023).

[42] *See generally* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 198–232 (1982) (tracing the early-twentieth-century professionalization of medicine and the corresponding restraint on corporate ownership of practice).

[43] For example, during the 1990s, to monetize their most valuable asset, land, struggling hospitals sold their real estate assets to Real Estate Investment Trusts (REITs). James C. Robinson, *Financial Capital and Intellectual Capital in Physician Practice Management*, 17 HEALTH AFF. 53 (1998), https://www.healthaffairs.org/doi/10.1377/hlthaff.17.4.53; James C. Robinson, *Capital Finance and Ownership Conversions in Health Care*, 19 HEALTH AFF. 56 (2000), https://www.healthaffairs.org/doi/10.1377/hlthaff.19.1.56. These companies then lease the land back to the hospital. Sandy Lutz, *Turning Mortar into Money: REIT Is First to Help Not-for-Profit Systems Capitalize on Their Real Estate Holdings*, MODERN HEALTHCARE (June 8, 1998), https://www.modernhealthcare.com/article/19980608/NEWS/806080325/turning-mortar-into-money-reit-is-first-to-help-not-for-profit-systems-capitalize-on-their-real-estate-holdings/; Sui-Lee Wee, *Health REITs Provide Bright Spot*, WALL ST. J. (June 18, 2008), https://www.wsj.com/articles/SB121373019061081799. The terms of the purchase and lease, undertaken to advance the interest of investors and not the health care entities, often left providers struggling.

[44] Fuse Brown & Hall, *supra* note 12.



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other scholarship finds mixed and, by some measures, some positive results[45] such as findings that private equity can improve health care[46] and increase access to certain services.

First, PE serves as a significant source of capital and management services. In a system in which funding for capital investments largely comes from the private sector and cannot be found elsewhere,[47] the need for capital is great and private equity is an obvious current source.[48] In addition to acknowledging its role in providing capital, scholars mention the ability of private equity management to offer expertise and care coordination.[49]

More capital can translate into improved access to care. For example, an early study of service adoption by PE-acquired hospitals from 2006-2015, showed that they were more likely to provide more of some services than non-PE hospitals, including both relatively profitable services and some relatively unprofitable services such as emergency mental health services, although the authors could not show that these relatively unprofitable services could be made newly-profitable.[50]

Nonetheless, PE-provided access to capital, on the one hand, can come with increased access to care and PE management expertise, but on the other, can also come with practice patterns that undermine health care and health organizations. Even compared to the previous generations of for-profits, which typically sought to earn profits through efficient production of health care and health care related management expertise applied over the long term, private equity has a focus on the short term. PE makes its money by promising quick returns, leading to repeated dealmaking and ownership changes that can destabilize organizations and undermine

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[45] Medicare Payment Advisory Comm'n, *Chapter 3: Congressional Request: Private Equity and Medicare*, in Report to the Congress: Medicare and the Health Care Delivery System 75 (June 2021), https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/default-document-library/jun21_ch3_medpac_report_to_congress_sec.pdf.

[46] For example, some studies show possible quality improvements in selected process measures or lower inpatient mortality for specific conditions. For one overview, *see* ARK. CTR. FOR HEALTH IMPROVEMENT, *Private Equity in Health Care* (Oct. 2, 2025), https://achi.net/publications/private-equity-in-health-care/.

[47] *See* Press Release, Detroit Medical Center, *Vanguard, DMC Announce Letter of Intent* (Mar. 19, 2010), https://www.truscottrossman.com/2010/03/vanguard-dmc-announce-letter-of-intent-dmc-to-join-vanguard-health-system/ (quoting DMC Board Chair Steve D'Arcy that "For years DMC has had significantly less cash-on-hand than any of our competitors" and that the Vanguard transaction was "the solution to allow us to continue our mission to provide quality care for all"); Noah Ovshinsky, *Non-Profit Detroit Medical Center Selling Out to For-Profit Vanguard*, NPR (May 20, 2010) (reporting that "officials say the health system's payer mix makes raising money on Wall Street all but impossible"), https://pnhp.org/news/non-profit-detroit-medical-center-selling-out-to-for-profit-vanguard/. The Michigan Attorney General reviewed and approved the transaction subject to conditions. *See* Mich. Att'y Gen., *Sale of DMC Hospitals to Vanguard Health Systems*, https://www.michigan.gov/consumerprotection/charities/charitable-asset-sales/hospital-sales/detroit-medical-center/sale-of-dmc-hospitals-to-vanguard-health-systems.

[48] Robert I. Field, *Can Current Legal Tools Respond Adequately to Risks of Private Equity Investment in Health Care?*, 27 AMA J. ETHICS 333 (2025).

[49] *See, e.g.*, Christopher Cai & Zirui Song, *Protecting Patients and Society in an Era of Private Equity Provider Ownership: Challenges and Opportunities for Policy*, 43 HEALTH AFFS. 666 (2024).

[50] Marcelo Cerullo et al., *Private Equity Acquisition and Responsiveness to Service-Line Profitability at Short-Term Acute Care Hospitals*, 40 HEALTH AFFS. 1697 (2021).



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the long-term missions of health care organizations, corporate stability, and even patient safety. The emphasis on extraction of value and repeated sales leaves PE-acquired organizations worse off; the financial performance of hospitals after the sale of PE-owned hospitals to either another PE firm or a non-PE for-profit owner declines significantly.[51] In addition, PE tends to engage in deep staff cuts and sell-offs of infrastructure, and lack of ongoing investment undermines the stability of needed providers. Physician turnover has been shown to increase after a PE acquisition.[52]

Second, studies of the relationship between PE and quality of care show some positive results but largely give cause for concern. For example, studies demonstrate reductions in many measures such as patient experiences[53] as well as quality-reducing staffing cuts in hospitals,[54] nursing homes,[55] and other long-term care facilities,[56] which house and treat particularly vulnerable residents. For example, in one study of over 1 million emergency department visits and 121,000 ICU hospitalizations, Kannan et al. showed large reductions in salary expenditures, staffing cuts, and a 13.4% increase in ED mortality (7 additional deaths per 10,000 visits), but no significant changes in ICU mortality.[57] In addition to traditional types of poor quality, Park

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[51] Hospitals sold to a second PE owner experienced an 8.4 percentage point decline in operating margins relative to hospitals sold to non-PE for-profit owners, suggesting that repeated PE ownership may further weaken a hospital's financial health. Sneha Kannan & Zirui Song, *Financial Health After Private Equity Hospitals Are Sold*, JAMA HEALTH F., Aug. 2025.

[52] *See, e.g.,* Victoria Berquist, Lev Klarnet, & Leemore Dafny, *Sale of Private Equity-Owned Physician Practices and Physician Turnover*, JAMA HEALTH F., Feb. 2025 (showing physicians at PE-exiting practices were 16.5 percentage points more likely to work at a different practice two years after the sale compared to controls, indicating increased turnover); Yashaswini Singh et al*., Physician Turnover Increased in Private Equity-Acquired Physician Practices,* 44 HEALTH AFF. 280 (2025) (showing that among 200 ophthalmology practices studied, accounting for 1,980 physicians, between 2015 and 2021, practices acquired by PE firms saw a 46.8% increase in total physicians, driven by growth in both ophthalmologists and optometrists. However, they also experienced a significant rise in physician turnover, with the annual share of physicians leaving increasing by 13 percentage points (265%) relative to non-acquired practices).

[53] Anjali Bhatla et al., *Changes in Patient Care Experience After Private Equity Acquisition of U.S. Hospitals*, 333 JAMA 490 (2025) (showing that PE acquisition of U.S. hospitals is associated with reductions in patient evaluation of overall hospital ratings and willingness to recommend the hospital, with differences increasing over time and largest three years after acquisition).

[54] *See Cai & Song, supra* note 49.

[55] In a system review of the relationship between PE ownership and nursing home quality and financial performance, Orewa et al. synthesize evidence from twelve empirical studies published between 2000 and 2024 and show that PE ownership is consistently correlated with worse or unchanged nursing home quality outcomes; they also show higher operating margins, higher Medicare charges, and greater use of cost-cutting strategies, including lower staffing expenditures and reduced investment in facility resources. Gregory N. Orewa et al., *The Effects of Private Equity Ownership in U.S. Nursing Homes Quality and Financial Performance: A Systematic Review*, HEALTH POL'Y, Nov. 2025.

[56] *See, e.g.,* Robert I. Field et al., *Private Equity in Health Care: Barbarians at the Gate?*, 15 DREXEL L. REV. 821 (2023); Alesha Ignatius Brereton, *Toward a Preliminary Theory of Organizational Incentives: Addressing Incentive Misalignment in Private Equity-Owned Long-Term Care Facilities*, 47 AM. J.L. & MED. 455 (2021).

[57] Sneha Kannan et al., *Hospital Staffing and Patient Outcomes After Private Equity Acquisition*, 178 ANNALS OF INTERNAL MED. 1529 (2025).



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identifies the heightened risks to patient privacy given the deployment of AI within PE-acquired health care entities.[58]

Yet, one study showed greater improvements in process quality measures among PE-acquired hospitals and PE-controlled hospitals, potentially reflecting better care; however, the improved measures were concentrated among hospitals that had previously been owned by one large for-profit chain that largely operated in the south,[59] and may well have had particularly low levels of quality before the acquisition and, thus, introduction of managerial systems that might lower quality in a well-functioning system can improve quality.

Third, PE has also been shown to be associated with increased consolidation, including horizontal consolidation through acquisitions of previously competing organizations as well as vertical acquisitions of multiple companies in a complex supply chain. For example, after a PE acquisition, a hospital's net income and charge-cost ratio for various services were more likely to increase than measures for comparable hospitals over the same time period.[60] Arnold et al. document increased colonoscopy prices and spending in a comparison of PE-acquired gastroenterology practices with independent practices.[61] Moreover, Field documents the reliance of long-term care residents as essential, captive customers of products and services sold by companies owned by the same PE investors.[62]

To be sure, health care consolidation is occurring across the sector, not only among PE-financed entities.[63] And consolidation can be good for care since large systems can bring the benefits of operational efficiencies related to management skills and the ability to move services during times of need. Consider, for example, that large hospital systems were able to concentrate patients with Covid at sites where the best equipment and personnel to treat them could be assembled, leaving other sites of care for patients with other needs. More recently, for example,

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[58] Eunice Park, *Private Equity and A.I. in Healthcare: A Perilous Pairing for Patient Privacy*, 53 HOFSTRA L. REV. 349 (2025).

[59] Joseph D. Bruch, Suhas Gondi & Zirui Song, *Changes in Hospital Income, Use, and Quality Associated with Private Equity Acquisition*, 180 JAMA INTERNAL MED. 1428 (2020).

[60] Bruch, Gondi & Song, *supra* note 59.

[61] Daniel R. Arnold, et al. *Private Equity Acquisition of Gastroenterology Practices and Colonoscopy Price and Quality*, JAMA HEALTH F., June 2025 (finding that, in a study of more than 1.1 million patients undergoing 1.3 million colonoscopies between 2015 and 2021, private equity acquisition was associated with a 4.5% increase in colonoscopy prices relative to independent practices, rising to 6.7% in high-market-share private equity practices, and a 16% increase in spending per physician, while colonoscopy volume and the number of unique patients per physician also increased, although no statistically significant differences were found across multiple quality measures).

[62] Field et al., *supra* note 56.

[63] For example, Singh et al. document the growth of hospital affiliations of primary care physicians in the United States: relative to independent PCPs, both hospital-affiliated and PE-affiliated physicians negotiated significantly higher prices for the same evaluation and management office visits—about 10.7 % higher for hospital-affiliated and 7.8 % higher for PE-affiliated PCPs—suggesting that both consolidation by hospitals and PE firms correlate with higher commercial prices in primary care. Yashaswini Singh et al., *Growth of Private Equity and Hospital Consolidation in Primary Care and Price Implications*, JAMA HEALTH F., Jan. 2025.



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fertility clinics that are acquired by a chain (i.e., a multi-unit firm), have been shown to have higher quality in terms of IVF success overall and a reduction in higher-risk multiple births than other fertility clinics; PE funding eases financial constraints of these clinics, allowing higher volume at the clinics although the improved quality was not related to PE funding.[64].

Operations that focus on return to shareholders or investors rather than reinvesting in operations can be efficient at making money, yet ineffective and inefficient at achieving social goals or otherwise costly.[65] During the 1990s, for example, hospitals that converted from nonprofit to for-profit form were able to cut costs and increase profits at the hospital level, but they did so by changing their service lines and finding ways to increase government reimbursements thus increasing social costs.[66]

Fourth, PE acquisitions have repeatedly been shown to be associated with price increases,[67] possibly because of the consolidation discussed above. Borsa et al. produced a meta-analysis of twelve studies, which identified increased costs to patients or payers in nine studies, and no difference in three studies. No study found decreased costs to patients or payers. The authors identified numerous explanations for increased costs: the studies found increased charges, increased charge-to-cost ratios, and increased negotiated prices between hospitals and insurers. However, another possible explanation for increased costs is a shift to procedures that are reimbursed at higher rates.[68]

Price increases are not necessarily unwarranted if they raise prices that were too low to produce care of sufficient quantity or quality to meet patient needs. In one study finding that

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[64] Ambar La Forgia & Julia Bodner, *Getting Down to Business: Chain Ownership and Fertility Clinic Performance*, 71 MGMT. SCI. 5022 (2025). La Forgia and Bodner cite several finance-literature studies on PE's impact on volume. *See* Quentin Boucly, David Sraer & David Thesmar, *Growth LBOs*, 102 J. FIN. ECON. 432 (2011); Shai Bernstein & Albert Sheen, *The Operational Consequences of Private Equity Buyouts: Evidence from the Restaurant Industry*, 29 REV. FIN. STUD. 2387 (2016); Cesare Fracassi, Alessandro Previtero & Albert Sheen, *Barbarians at the Store? Private Equity, Products, and Consumers*, 77 J. FIN. 1439 (2022).

[65] Chris Cumming, *Antitrust Authorities Take Aim at Private-Equity Healthcare Deals*, WALL ST. J. (June 14, 2022), https://www.wsj.com/articles/antitrust-authorities-take-aim-at-private-equity-healthcare-deals-11655243804; Andrew Forman, Deputy Assistant Att'y Gen., U.S. Dep't of Justice, *Keynote at the ABA's Antitrust in Healthcare Conference: The Importance of Vigorous Antitrust Enforcement in Health Care* (June 3, 2022), https://www.justice.gov/opa/speech/deputy-assistant-attorney-general-andrew-forman-delivers-keynote-abas-antitrust.

[66] *See, e.g.,* David M. Cutler & Jill R. Horwitz, *Converting Hospitals from Not-for-Profit to For-Profit Status: Why and What Effects*, in THE CHANGING HOSPITAL INDUSTRY: COMPARING NOT-FOR-PROFIT AND FOR-PROFIT INSTITUTIONS 45 (David M. Cutler ed., 2000) (discussing the purchase of two large, nonprofit hospitals by a for-profit chain).

[67] Arnold et al., *supra* note 61 (showing that in a study of data from 2015 to 2021 covering over 1.1 million patients undergoing 1.3 million colonoscopies, colonoscopy prices at PE-acquired practices increased by 4.5% relative to independent practices, rising to 6.7% in high market share PE practices, while spending per physician increased by 16%; Colonoscopy volume and the number of unique patients per physician also increased, though these trends were already present before acquisition and no statistically significant differences were found across multiple quality measures).

[68] Alexander Borsa et al., *Evaluating Trends in Private Equity Ownership and Impacts on Health Outcomes, Costs, and Quality: Systematic Review*, 382 BMJ e075244 (2023).



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prices paid to anesthesia practitioners have been shown to increase after hospital outpatient departments and ambulatory surgery centers contract with physician management companies, which are often backed by private equity, the authors argue that the welfare effects of increased prices are uncertain because it is unclear whether the prices are too high or the practitioners were previously underpaid.[69]

Finally, as discussed below in some detail, PE is associated with the "financialization" of health organization assets. Although not limited to PE, increases in the purchase of health entities by financial actors, as opposed to nonprofit, government, or for-profit health care companies that specialize in long-term health care operations have led to an increase in selling off the most valuable assets of these entities, such as the real estate properties owned by facilities, leaving the entities with a great deal of debt and, sometimes, lease and management contracts that they cannot afford.[70] One study showed that some ill-effects of REIT-held investments in the nursing home context, the replacement of skilled nursing staff with less expensive and lower-skilled staff, was concentrated among smaller-sized deals.[71]

## III. What has led to PE investment in health care and related harms?

Using the hospital sector as an example, with a particular focus on Steward Health Care, we identify the factors that have led to the growth of PE, and how some of the associated harms came to pass. Then we turn to gaps and problems with existing hospital oversight mechanisms that have failed to prevent harm to patients, disproportionately but not only those in lower socio-economic status groups, and communities arising from or associated with PE management practices. We explore why the underlying conditions leading to PE ownership and subsequent patient and community harm are both more prevalent in and likely to affect lower income and rural communities, exposing equity issues that PE ownership has exacerbated.

### A. The Example of Steward Health Care

Steward Health Care was created in 2010 when Cerberus Capital Management acquired the Caritas Christi Health Care System.[72] Although it was not the first PE-network, it became the

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[69] Ambar La Forgia et al., *Association of Physician Management Companies and Private Equity Investment with Commercial Health Care Prices Paid to Anesthesia Practitioners*, 182 JAMA INTERNAL MED. 396 (2022).

[70] Tarun Ramesh et al., *Hospitals as Tenants: The Rise of Real Estate Investment Trusts in Health-Care Delivery*, 407 LANCET 657 (2025).

[71] Robert Tyler Braun et al., *The Role of Real Estate Investment Trusts in Staffing US Nursing Homes*, 42 HEALTH AFFS. 207 (2023); for an industry-side defense of REITs as passive investors in the Steward Health Care case, *see* David W. Johnson, *REITs Revisited: Rebutting Misleading and Inaccurate Policy Analysis*, 4SIGHT HEALTH (Sept. 29, 2022), https://www.4sighthealth.com/hospital-reits-revisited-rebutting-misleading-and-inaccurate-policy-analysis/.

[72] Applebaum & Batt, *supra* note 19, at 59-60 (discussing the 2010 Cerberus–Caritas transaction among others as an example of the entry of private equity into nonprofit hospital ownership).



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largest privately owned for-profit hospital network in the country,[73] and the conditions leading to its creation and demise are informative.[74]

Before Steward purchased them, many of the Caritas hospitals were in poor physical and financial condition. Some of them served a predominantly low-income population and were disproportionately reimbursed by government payers.[75] With a relatively small percentage of commercial payer revenue and limited market power to negotiate higher rates from commercial payers, Caritas had few options for generating capital through margin or accessing the debt necessary to invest in plant and operations. Seeking solutions to financial problems, Caritas had engaged outside experts to examine its books, operations, and opportunities for several years prior to the proposed Steward transaction, and those experts uniformly[76] advised that it should seek affiliation with a system with more resources. Several attempts to affiliate with Catholic and other nonprofit systems failed, and Caritas' financial condition continued to deteriorate. Thus, with dire need for access to capital and no other avenues to obtain it, Caritas turned to private equity.

The broad outlines of Caritas' story are not unique. Providers that serve rural and lower-income communities often rely on government payers, largely Medicare and Medicaid, more than those serving higher-income communities where higher-paying commercial insurance is more common. Even with government programs designed to benefit those hospitals beyond direct payment for services—including the "340B program" that requires significant discounts on certain pharmaceuticals, the "disproportionate share" program that requires states to subsidize treating a high percentage of uninsured and Medicaid-insured patients, and other subsidy programs—payers relying on such "high public payer" providers often have trouble accessing sufficient capital to maintain the facilities, systems, technology, and workforce investments necessary for them to remain vibrant. Federal and state payment policies that directly or indirectly rely on private insurance payments to cross-subsidize hospital operating costs leave

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[73] Mary Beckman & Jill Horwitz, *The Steward Debacle: Legal And Ethical Risks Of The New Breed Of Health Care For-Profits*, HEALTH AFFAIRS FOREFRONT (Sept. 5, 2025), https://www.healthaffairs.org/content/forefront/steward-debacle-legal-and-ethical-risks-new-breed-health-care-profits.

[74] *See generally,* MASS. ATT'Y GEN., Statement as to the Caritas Christi Transaction, 2010 *supra* note 39.

[75] *Reports on Steward Health Care System Pursuant to 2010 and 2011 Assessment & Monitoring Agreement*, OFF. OF THE ATT'Y GEN. OF MASS. 21–22, Tbl. 7 at app. 42–44 (Dec. 30, 2015), https://www.mass.gov/doc/reports-on-steward-health-care-system-pursuant-to-2010-and-2011-assessment-monitoring/download (showing Caritas/Steward hospitals had higher government payer mix and lower commercial payer mix than regional peers); *Interim Reports on Steward Health Care System Pursuant to 2010 and 2011 Assessment & Monitoring Agreement*, OFF. OF THE ATT'Y GEN. OF MASS. 17–19, 32 & Tbls. 3, 12 (Jan. 30, 2013), https://www.mass.gov/doc/interim-reports-on-steward-health-care-system-pursuant-to-2010-and-2011-assessment-monitoring/download (finding Caritas's FY10 financial performance "weak compared to other hospitals in Massachusetts, including hospitals serving disproportionate percentages of low-income and Medicare patients"). *See also* Div. of Health Care Fin. & Pol'y, *Hospital Inpatient and Emergency Department Utilization Trends Fiscal Years 2004–2008*, at 22 (2010), https://archives.lib.state.ma.us/entities/archivalmaterial/cc3bb754-1b95-47b0-b72f-e1dc6132733e.

[76] MASS. ATT'Y GEN., *supra* note 39, at 15.



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high public payer hospitals starving for capital and contribute to circumstances that can drive them to seek PE investment.

Perhaps counter-intuitively, the fact that state and local governments are highly averse to the failure of hospitals they rely on to provide care to the population for which (and to which) they are responsible can make high public payer hospitals attractive acquisition targets. As Appelbaum and Batt have documented, the public responsibility to the people who rely on these hospitals allows PE hospital owners to take risks they otherwise might not, such as loading the hospitals with unsupportable debt on the expectation that government will continue to support the hospitals rather than allow them to close.[77] Steward's 2020 demand that Pennsylvania bail out Easton Hospital, made while Cerberus was still completing its exit from Steward, is a notable example.[78]

We turn now to the harmful consequences of Steward's operation and management of the former Caritas hospitals, and the failure of existing regulatory oversight to prevent them. Our primary focus is on the consequences that have been central to public discussion: the sale/leaseback of real estate and hospital facilities, and the management of service and supply contracts and accounts payable in a manner that failed to account for its impact on patient care.

In the case of Steward and Prospect Medical Holdings, a key method to raise additional funds was the sale of the hospital facilities and real estate to Medical Properties Trust, a publicly traded Real Estate Investment Trust, along with execution of long-term leases. These transactions are blamed as saddling the hospitals with debt they could not afford. Although there has been no suggestion that the transactions were illegal at the time,[79] the terms of the property purchases and

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[77] *See* Rosemary Batt, Eileen Appelbaum & Tamar Katz, *The Role of Public REITs in Financialization and Industry Restructuring* 38–42, 47–48 (INST. FOR NEW ECON. THINKING, Working Paper No. 189, July 9, 2022), https://www.ineteconomics.org/uploads/papers/WP_189-Batt-Appelbaum-Public-REITS-2.pdf (documenting Cerberus's debt-loading and sale-leaseback strategies at Steward in partnership with Medical Properties Trust, and the 2020 Easton Hospital bailout demand); Rosemary Batt & Eileen Appelbaum, *Hospital Bailouts Begin—for Those Owned by Private Equity Firms*, AM. PROSPECT (Apr. 2, 2020), https://prospect.org/economy/hospital-bailouts-begin-for-those-owned-by-private-equity-firms/ (detailing how PE-owned hospitals demanded government bailouts after PE firms loaded them with debt).

[78] Eileen Appelbaum & Rosemary Batt, *Private Equity Buyouts in Healthcare: Who Wins, Who Loses?*, INET Working Paper No. 118 (Mar. 15, 2020), https://ssrn.com/abstract=3593887 (describing the PE-in-healthcare model as "a classic case of moral hazard" producing "excessive risk-taking by the PE firm, using other people's money — often to the detriment of the portfolio company"). On the Easton episode, see Eileen Appelbaum & Rosemary Batt, *Hospital Bailouts Begin — for Those Owned by Private Equity Firms*, AM. PROSPECT (Apr. 2, *2020);* PRIVATE EQUITY STAKEHOLDER PROJECT, THE PILLAGING OF STEWARD HEALTH CARE (2024).

[79] As noted below, states have enacted new laws and regulations aimed at prohibiting this type of transaction or requiring notice and review by state authorities. See infra Part II.B (discussing state oversight regimes). For example, Massachusetts legislation signed in early 2025 prohibits the sale-leaseback of a main hospital facility and requires notice to the Health Policy Commission of certain other significant transactions involving a change in control or "significant" control of the hospital or system. Other states have enacted comparable restrictions on hospital sale-leaseback transactions. *See* 2024 Mass. Acts ch. 343, https://malegislature.gov/Laws/SessionLaws/Acts/2024/Chapter343.



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leases, including high property valuations and lease payments, are blamed as a central reason for the systems' ultimate financial failure.[80]

Investigations into patient harm at Steward have revealed that Steward's failure to pay vendors, including suppliers of clinical equipment, led to at least some of those patient harms. Most notable is the case of a new mother who died shortly after giving birth at a Steward hospital because a routine supply needed to stop internal bleeding had been repossessed by a vendor for nonpayment.[81] Some reports indicate that Steward finance personnel strategized about how to minimize payments to vendors for years, sometimes deferring payment until the vendor threatened or pursued legal action.[82] One analysis of lawsuits brought against Steward for nonpayment showed that this practice extended to staffing agencies as well as medical equipment and supplies over a number of years.[83]

Understaffing is also blamed for many of the patient care harms identified in the Boston Globe's investigatory series.[84] Without examining the particular circumstances of each case identified in Boston Globe series, it seems clear that clinical staff at Steward hospitals experienced extremely stressful conditions, including inadequate staffing, that contributed to adverse patient experiences and outcomes.

B. Was there a failure in regulation?

Some observers assert that existing regulatory regimes failed to capture information that would have highlighted the scope of problems at Steward earlier.[85] For example, mechanisms for overseeing hospital quality of care--state health department inspections, mandated incident reports, and plans of correction, and similar standards maintained by state licensing agencies, The Joint Commission and other certifying bodies that generally track adverse events, deficiencies and corrections at the facility level, or sometimes at the state level—were in place.

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[80] Erin C. Fuse Brown & Hayden Rooke-Ley, *Health Care Financialization*, 29 J. HEALTH CARE L. & POL'Y 1 (2026) (arguing notice and disclosure are insufficient without approval or denial authority, and describing Oregon's "public interest" standard for health care transactions).

[81] *See* Jessica Bartlett, *Steward's Medical Devices Were Repossessed. Weeks Later, a New Mother Died*, *Boston Globe* (Jan. 25, 2024), https://www.bostonglobe.com/2024/01/25/business/steward-health-care-mother-death/ (reporting the death of Sungida Rashid following the repossession of medical devices from a Steward hospital amid the system's financial collapse).

[82] Susanna Vogel, *Steward's Legal Battles Offer Insight into a Pattern of Mismanagement, Healthcare Dive* (March 20, 2024), https://www.healthcaredive.com/news/steward-health-care-mismanagement-lawsuits/710102/ .

[83] Amy Goldstein and Vani Agarwal, *Lessons from the Collapse of Steward Health Care,* BROOKINGS (Oct. 2, 2025), https://www.brookings.edu/articles/lessons-from-the-collapse-of-steward-health-care/.

[84] Elizabeth Koh et al., *Read the Stories of Patients Who Died After Seeking Care at Steward Hospitals,* BOSTON GLOBE (Sept. 6, 2024), https://apps.bostonglobe.com/metro/investigations/spotlight/2024/09/steward-hospitals/patients/.

[85] Amy Goldstein & Vani Agarwal place at least part of the blame on regulators for the collapse of Steward Health Care. "[A]cross the country, oversight of hospitals by states and the federal government is inadequate—at times weakly enforced, at times absent." Goldstein & Agarwal, *supra* note 83. For a contrasting view emphasizing the difficulties regulators face, *see* Bortner, *supra* note 13.



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However, systems for tracking problems with clinical quality across an entire system and reporting those to all states affected are lacking.[86]

Better oversight of clinical problems across all operations is needed, and to be effective, it should be combined with a change in authority and means to intervene. State officials have responsibility and authority over the facilities located in their state. System-level problems, including patterns that might emerge from reporting on system-wide regulatory violations or clinical care adverse events, are not the responsibility of any particular state. This gap is significant, particularly in light of Steward's emphasis on system-wide management. Some may point to CMS (and national accrediting organizations like The Joint Commission, on which CMS relies) as a national source of authority, but neither CMS nor the federal government more generally has the responsibility or the authority to oversee national operations of a health care system. CMS dictates conditions of participation in federal health care programs. States oversee clinical care provided to patients in their state. A different level of coordination among states is needed to address this gap.

Stronger and clearer financial reporting requirements also could have been useful in the Steward situation. Financial conditions that lead to practices such as deferring accounts payable should be visible in financial reporting required by many states, including Massachusetts. But Steward failed to file complete required financial reports for nearly a decade while it litigated the state's authority to require them, arguing that CHIA lacked statutory authority to demand confidential system-level financial information from a privately held, multi-state for-profit hospital system.[87] As litigation proceeded slowly, state regulators did not have access to information that the state Attorney General had seen and identified as problematic in 2015.[88]

Even if the state had seen Steward's system-level financial information for those years, there is a question what the state would have done about the financial weakness it could have revealed. For example, state officials could have asked Steward to report about the underlying reasons for apparent financial weaknesses and asked for remediation plans. Whether Steward

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[86] Goldstein & Agarwal, *supra* note 83.

[87] *See* Complaint, *Steward Health Care Sys., LLC v. Ctr. for Health Info. & Analysis*, No. 1784CV03481 (Mass. Super. Ct., Suffolk Cnty. filed Oct. 27, 2017) (arguing CHIA lacked statutory authority to demand system-level consolidated financial statements from a privately held, multi-state for-profit hospital system); Informational Brief of the Commonwealth of Massachusetts at 11–12, *In re Steward Health Care Sys., LLC*, No. 24-90213 (CML) (Bankr. S.D. Tex. May 7, 2024) (recounting Steward's refusal to comply with M.G.L. c. 12C reporting requirements since 2014 and noting ongoing appeal of Superior Court order compelling disclosure).

[88] *See* MASS. ATT'Y GEN., 2015 Monitoring Report, *supra* note 75, citing the 2015 monitoring report. As noted, the Attorney General's access to system-wide information was based on a contract tied to the original Caritas Christi purchase – a contract that expired in 2015. For reporting on the litigation, *see* Priyanka Dayal McCluskey, *Steward Health Care Sues State Over Financial Data*, BOSTON GLOBE (Oct. 31, 2017), https://www.bostonglobe.com/business/2017/10/31/steward-health-care-sues-state-over-financial-data/QWoXVntO8mrAuYqXROoioN/story.html.



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officials would have complied or would have provided truthful information is a different set of questions.

Other sources of information about a health system's operations, such as a review of lawsuits filed against it, could reveal problems not evident from information filed with state or federal agencies. This information could have illuminated some of what was happening at Steward, as the authors of a Brookings case study observe.[89] While reviewing dockets to ascertain patterns in allegations against health care providers could yield useful information about otherwise undisclosed problems, we hope it would be useful only in outlier cases. Perhaps use of automated data aggregation tools could aid regulators in identifying systems meriting closer examination.

But being sued is not a regulatory violation, and identifying problems in administration of an organization does not give regulators or prosecutors the authority to intervene. What is needed is a more general authority to investigate administrative practices and to intervene if they are harming the public or misusing health care assets.

Still, in general, states have neither the authority nor the expertise to intervene in hospital financial and operational management issues, let alone to take over a hospital. Consider Steward's alleged under-staffing practices. Massachusetts did not intervene in those staffing practices. In fact, with the exception of ICU staffing and overtime, Massachusetts does not regulate specific hospital staffing decisions. Instead, hospitals are required to develop staffing plans sufficient to meet the clinical needs of patients, taking into account staff capabilities.[90] Debates about the benefits and drawbacks of mandated staffing levels are longstanding and there are good arguments on both sides. But like many aspects of hospital operations, appropriate staffing levels likely depend on a number of circumstances that are difficult to define in advance and in the abstract and, therefore, hard to regulate effectively.

In short, like many other aspects of operations that are associated with harm in Steward hospitals, staffing levels and financial management depend on skill, experience, and focus on the right goals—quality, accessible patient care. And making tough calls about whether a hospital should change its staffing plans, its clinical service mix or even close (other than because of extreme quality concerns) is a task best left to private sector leaders, with state actors exercising oversight. Too much state authority to override the impact of private sector decisions and market forces could create other distortions and problems in the health care system.

Thus, although increased financial transparency and new kinds of monitoring such as litigation reviews might have helped in limiting some of the harms caused by Steward, and

[89] Goldstein & Agarwal, *supra* note 83.
[90] 105 CMR 130.311, 130.312.



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potential harms arising from PE investment in other circumstances, they would likely not have been sufficient to prevent them.

## IV. Proposed and Attempted Solutions

Federal and state lawmakers have taken steps to address the growing concern about PE, efforts that seek to mitigate PE's harmful effects on healthcare delivery by increasing transparency, oversight, and accountability of PE acquisitions and operations.[91] Nonetheless, scholars have argued that policy responses to PE in health care have been limited, unevenly enforced, or largely stalled[92] and, therefore, have proposed several additional legislative and regulatory changes to address ongoing problems.

First, for example, Senator Chris Murphy recently introduced federal legislation that would "prevent hospitals or skilled nursing facilities that are owned by certain firms from participating in the Medicare program."[93] The proposed legislation is broadly worded to prevent hospitals or skilled nursing facilities that participate in Medicare, Medicaid, and other federal health care programs from being controlled by, or owned by, PE funds and related entities as well as Real Estate Investment Trusts. Moreover, control includes the management of administrative functions. In short, if passed, the bill would preclude PE and REITs from the kind of activities described in this paper.

In addition, some states have passed new laws strictly limiting or heavily regulating PE health care deals. In the wake of the Steward debacle, Massachusetts enacted a law in January 2025, a comprehensive early state effort to regulate PE involvement in health care.[94] Although the law does not forbid PE transactions, it requires enhanced disclosure and advance notification of material transactions to state agencies, restrictions on high-risk financial practices such as REIT sale-leasebacks, and expanded investor liability for fraudulent billing under the state FCA.[95]

Since then, other states have passed laws with some more stringent terms. For example, in June 2025, Oregon adopted a law that is likely the country's most stringent. The law granted the Oregon Health Authority the power to impose conditions or entirely block health-related

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[91] *See, e.g.,* Mary Bugbee, Michael Fenne, & Chris Noble, *Recent Policy and Regulatory Initiatives to Address Private Equity's Negative Impacts in Healthcare*, PRIVATE EQUITY STAKEHOLDER PROJECT (Dec. 2024), https://pestakeholder.org/reports/2024-healthcare-policy-review.

[92] *See* Cai & Song, *supra* note 49.

[93] *Take Back Our Hospitals Act of 2026*, S. 4085, 119TH CONG. (2026); *see also* H.R. 7920, 119TH CONG. (2026) (companion bill); PRESS RELEASE, SEN. CHRIS MURPHY, *Murphy, Scanlon Introduce Bicameral Bill to Ban Private Equity From Owning Nurses and Hospitals* (Mar. 23, 2026), https://www.murphy.senate.gov/newsroom/press-releases/murphy-scanlon-introduce-bicameral-bill-to-ban-private-equity-from-owning-nurses-and-hospitals.

[94] Thomas C. Tsai, Gregg S. Meyer, & David Blumenthal, *Regulating Private Equity in Health Care—The Massachusetts Model*, 393 NEW ENG. J. MED. 731 (2025).

[95] *Id*.



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transactions by, in part, enhancing the state Corporate Practice of Medicine doctrine by limiting the ownership and control of medical practices by management services organizations. For example, it prevents an MSO from owning or controlling a majority of shares in or being on the board of directors of medical practices, and it largely blocks MSOs from forcing or preventing the sale of medical practices by their owners as well as prohibits MSOs from participating in clinical activities and operations.[96] The law regulates existing arrangements, but provides a multi-year grace period to allow existing arrangements to be reorganized or exit.

In addition, states are considering and enacting laws that will bring more scrutiny to transactions that liquidate the most significant assets of health care providers, notably their real estate and facilities[97]. Some states have gone farther and prohibited these transactions. Maine, for example, imposed a one-year moratorium on purchases of hospitals by PE or REITs, set to expire June 15, 2026.[98]

Second, scholars have called for increasing transparency to patients, the public, or various governments.[99] For example, Field argues for increased transparency about ownership of long-term care entities.[100] While we agree that transparency about ownership should be part of a response, it should not be an end in itself. What if patients were to know who owned their dental practice, hospital, or nursing home? Given the limited choices patients often face, perhaps because they are insured under policies that require or highly incentivize use of in-network

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[96] Or. S.B. 951, 83d Leg. Assemb., Reg. Sess. (2025) (signed June 9, 2025) (codified as amended at Or. Rev. Stat. §§ 58.375, 58.376), as amended by Or. H.B. 3410 (2025) (signed July 24, 2025). SB 951 § 1(2)(a) prohibits a management services organization (and any "shareholder, director, member, manager, officer or employee" of the MSO) from, among other things, "[o]wning or controlling . . . a majority of [the] shares" in or "[s]erving as a director or officer" of "a professional medical entity with which the [MSO] has a contract for management services," and from "[c]ontrolling or entering into an agreement to control or restrict the sale or transfer" of the entity's shares, interests, or assets. Section 1(2)(b) further bars MSOs from exercising "de facto control over the . . . administrative, business or clinical operations of [a PME] in a manner that affects [its] clinical decision-making or the nature or quality of . . . medical care." Compliance is required by January 1, 2026 for entities formed on or after June 9, 2025, and by January 1, 2029 for existing entities. SB 951 § 9. For analysis, *see* DEBEVOISE & PLIMPTON, *Oregon Imposes Significant Restrictions on Private Equity Investment in Medical Practices* (June 2025), https://www.debevoise.com/-/media/files/insights/publications/2025/06/oregon-imposes-significant-restrictions-on-private.pdf.

[97] Whether real estate and facility sales are the only transactions that warrant this level of scrutiny and authority is an open question.

[98] An Act to Impose a Moratorium on the Ownership or Operation of Hospitals in the State by Private Equity Companies or Real Estate Investment Trusts, Me. P.L. 2025, ch. 401 (L.D. 985 / S.P. 416) (emergency enacted June 24, 2025; took effect without Governor's signature), codified at Me. Rev. Stat. tit. 22, § 1730-A. Section 1730-A(2) provides that "[a] private equity company or real estate investment trust may not acquire or increase a direct or indirect ownership interest or operational control or financial control" of a hospital in the State, with a limited exception for transactions for which a certificate-of-need application was filed before June 1, 2025. The moratorium is set to sunset on June 15, 2026.

[99] *See, e.g.,* Matthew Tracey et al., *What Are the Policy Options for Regulating Private Equity Involvement in Health Care? A Review of Policies Implemented or Considered in High-Income Countries*, HEALTH POL'Y, June 2025.

[100] Field et al., *supra* note 56 (proposing increased ownership transparency in long-term care); Field, *supra* note 48.



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providers who may be PE-owned or there are few providers able or willing to accept new patients, it is unclear what power patients have to reject PE-owned providers. The Steward experience is instructive. Steward complied with transaction notice and ownership disclosure, but it resisted the ongoing financial reporting required under state law (after its monitoring agreement with the Massachusetts Attorney General had expired), precisely the kind of post-transaction transparency that recent notification statutes do not impose.[101]

Other scholars have argued that physicians not only have a duty to consider how PE transactions may affect patient trust, continuity of care, costs, and quality, and to advocate for patients when conducting such transactions, but also, should they sell to PE, have an ethical obligation to inform their patients of the acquisition.[102] Given the realities of practice management under our complex health insurance structures, it is unclear how realistic it is for individual physicians and small groups to credibly demand that potential purchasers protect patients,[103] especially such large and powerful purchasers as PE. And it is even less clear what patients could do with this information since they are likely to have little or no choice in providers given that most Americans lack any meaningful choice of insurer, and are further limited by provider networks that may not provide for out-of-network coverage or charge prohibitively high prices and by an inability to find physicians willing to accept new patients.[104]

However, requiring various types of transparency to regulators, such as rules that would foreclose the kinds of stonewalling that precluded effective oversight of Steward Health Care in Massachusetts would be a step in the right direction.[105] Fortunately, some states have passed

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[101] *See* MASS. ATT'Y GEN., 2013 Monitoring Report, *supra* note 75 (describing the five-year post-transaction monitoring regime Steward agreed to, including financial reporting obligations); *see* MASS. ATT'Y GEN., 2015 Monitoring Report, *supra* note 76 (reflecting continued access to information from Steward); *see also,* Complaint, *Steward Health Care Sys., LLC v. Ctr. for Health Info. & Analysis*, No. 1784CV03481 *supra* note 87 (recounting Steward's subsequent refusal to file system-level financial statements with CHIA and its litigation challenging that obligation).

[102] Cheryl Erwin & Sheryl Tatar Dacso, *When and How Should Patients Be Informed About Clinicians' or Organizations' Sale of a Clinical Practice to a Private Equity Buyer?*, 27 AMA J. ETHICS 318 (2025). Others focus on clinical nurse specialists in safeguarding patient safety in PE-managed settings. Elizabeth Ann Scruth & Vanessa A. Martinez, *Private Equity Ownership in Healthcare*, 38 CLINICAL NURSE SPECIALIST 116 (2024).

[103] Indeed, in a survey of 5,000 U.S. physicians, only 42.2 % of physicians worked in private practices in 2024, a decline of 18 percentage points since 2012, meaning that private practices account for fewer than half of physicians across most specialties and showing significant consolidation of care delivery toward non-physician ownership structures. Carol K. Kane, *Physician Practice Characteristics in 2024: Private Practices Account for Less Than Half of Physicians in Most Specialties*, AMA (2025), https://www.ama-assn.org/system/files/2024-prp-pp-characteristics.pdf.

[104] *See* KFF, *2024 Employer Health Benefits Survey* (Oct. 9, 2024), https://www.kff.org/report-section/ehbs-2024-section-7-employee-cost-sharing/; KFF, *Survey of Consumer Experiences with Health Insurance* (June 2023), https://www.kff.org/report-section/kff-survey-of-consumer-experiences-with-health-insurance-findings/.

[105] *See* complaint*, supra* note 87 and accompanying text (demonstrating Steward's efforts to resist Massachusetts regulators' demands for information about its operations and financial health). For examples of approaches to securing transparency and methods of forcing sector participants to internalize costs *see supra* note *87* (discussing state contract with Stewart) *and infra* note 138 (discussing the Beth Israel-Lahey settlement agreement that included monitoring provisions).



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transparency laws that require more reporting and ongoing oversight.[106] Nonetheless, even if increased transparency alerts regulators to ownership changes, those regulators will need authority to hold actors accountable. Grundfast, for example, argues that notice and transparency alone is insufficient, and argues that approval power over transactions is needed.[107]

Moreover, it is unclear what standards should be used to determine whether a transaction should be approved. We note that regulators believed that the Steward transaction was good for Massachusetts at the time; under the transaction terms, it seemed that Massachusetts patients and Caritas retirees were set to receive significant benefits. Moreover, if the transaction had been blocked, the existing pensions would have gone unfunded and, according to experts at the time, at least one of the hospitals would have closed, and others were likely to deteriorate over time because of lack of maintenance.[108] Furthermore, although more transparency that allows regulators to better apply laws at the time of a transaction is necessary, ongoing transparency about financial conditions, clinical quality, and other aspects of operations is at least as important. Some regular reporting requirements are in place – including in Massachusetts, where Steward flouted and challenged the requirement. What is needed is broader authority for state regulators (e.g., provider licensing agencies) to obtain access to otherwise confidential business information and, with the help of experts, determine whether abuses are being committed or whether problems are the result of external factors. This broader authority could be triggered by certain "red flags" or could be invoked on a periodic "spot audit" basis. Accompanied by a statutory duty that those who directly or indirectly hold authority to direct operations must use

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[106] For example, Anna Claire Vollers, *New State Laws Tackle Private Equity's Growing Role in Health Care*, STATELINE (Nov. 21, 2025), https://stateline.org/2025/11/21/new-state-laws-tackle-private-equitys-growing-role-in-health-care/. Vollers reports that New Mexico expanded its 2024 Health Care Consolidation Oversight Act to make state regulator oversight permanent and more expansive while establishing penalties for non-compliance with reporting requirements, and that Washington state passed a transparency law creating a registry of all health care entities. *Id*.

[107] Jacqueline Grundfast, *Cutting the Corporate Puppet Strings Off Your Physician's Hands: How Approval Requirements for Material Health Care Transactions Will Improve Patient Outcomes*, 18 BROOK. J. CORP. FIN. & COM. L. 735 (2024). Grundfast analyzes state responses to PE's negative impact on the quality, access, and cost of patient care. *Id.* Using New York's Article 45-A of the Public Health Law as a case study, Grundfast argues that states' move toward notice requirements for material health care transactions increases transparency of PE transactions. *Id*. However, this increase in transparency does little to actually improve the quality, access, or cost of patient care. *Id.* Thus, Grundfast argues that state notice requirement laws for material health care transactions should also include an approval requirement. *Id*. By allowing regulators to block suspect PE transactions from closing, these approval requirements will mitigate the negative impacts of PE on patient health outcomes. *Id*.

[108] *Mass. Att'y Gen. Martha Coakley, Statement of the Attorney General as to the Caritas Christi Transaction 7 (Oct. 6, 2010)*, available at https://www.mass.gov/doc/complaintexhibitmpdf/download ("It is impracticable, if not impossible, for Caritas to continue to operate as a public charity. To do so would likely require (i) leaving the pensions of some 13,000 current and former employees substantially underfunded, uninsured, and at risk and (ii) closing at least one of the Caritas Hospitals."); *see also* Written Notice of Transaction from Caritas Christi to the Office of the Attorney General (May 2010), available at https://www.mass.gov/doc/complaintexhibitlpdf/download (describing worsening capital and pension under-funding problems and "deferred capital needs" addressed by Cerberus's commitment of $400 million in capital improvements over four years); Robert Weisman & Megan Woolhouse, Coakley Backs Caritas Sale to Cerberus, BOSTON GLOBE (Oct. 7, 2010).



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health care assets to advance their health care purpose, this kind of authority would provide a flexible tool and an enforcement mechanism to prevent "looting" and other abuses.

Third, many scholars have proposed increased application of or extensions to existing health care laws to address harms related to PE investing,[109] including most centrally antitrust, fraud and abuse laws, and the corporate practice of medicine doctrine. Because these are discussed in detail elsewhere, we touch on them only briefly.

Several scholars point to antitrust law,[110] as a potential method to allow regulators to limit PE activity. For example, McCarthy advocates pre-merger notification programs, arguing that they would allow regulators to deter PE practices that harm access to and quality of care.[111] Fuse Brown and Hall advocate for additional scrutiny to small acquisitions, like the sorts of incremental acquisitions of physician practices that result in higher prices, would be worthwhile.[112] Although application of antitrust law may provide a useful tool and the federal government made some moves toward reform,[113] like others,[114] we are skeptical that antitrust regulators can deter practices that harm access since existing antitrust law would not preclude small, yet harmful, acquisitions that allow companies to go up to and not beyond existing limits and the penalties are too minor to make a difference. Moreover, antitrust law is designed to promote competition. While it might be used to stop some transactions that would lead to excessive consolidation (whether or not PE was involved), it is not tailored to prevent the kind of financialization and resulting degradation in health care assets that has been observed in PE-acquired health care entities.

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[109] For a thorough discussion of many of these suggestions, in the context of acknowledging their limitations, *see* Fuse Brown & Hall, *supra* note 12.

[110] Cai & Song, *supra* note 49 (suggesting that the U.S. might follow the example of the European Union and strengthen oversight of mergers and acquisitions).

[111] Michael McCarthy, *Patients v. Profits: Addressing Private Equity's Incursion on Healthcare*, 82 WASH. & LEE L. REV. 1121 (2025).

[112] Fuse Brown & Hall, *supra* note 12, at 548.

[113] "The 2023 merger guidelines direct the agencies to examine the cumulative impact of smaller, serial acquisitions for anticompetitive effects under the Clayton Act." *See id.* at 550.

[114] Kevin T. White, Tammy W. Cowart, & Vivek Pandey, *A Finger in the Dike: Mobilizing State Health Care Transaction Notification and Corporate Practice of Medicine Laws to Scrutinize Private Equity Investment in Health Care*, 57 ARIZ. ST. L. J. 627 (2025) (arguing that federal antitrust enforcement often intervenes only after harm has occurred).



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A second common suggestion is increased enforcement of fraud and abuse laws such as [115] the False Claims Act.[116] As for-profit hospital ownership has been associated with upcoding[117] and other profit-seeking activities that may be legal but exploit government reimbursement loopholes[118], it would be reasonable to assume that PE is similarly associated with such behavior. If causation and knowledge of the falsity of claims can be shown, FCA enforcement could be useful.

Scholars have argued that FCA enforcement could be strengthened by applying cases in which for-profit parent and PE firms have been held liable for portfolio company's misconduct.[119] In some cases, PE owners or managers actively controlled or ordered behavior like understaffing or ignored specific warnings from staff about regulatory noncompliance.[120] In such cases it may be possible to show direct involvement or, where corporate structuring has not precluded it, to otherwise pierce a corporate veil.

But PE owners do not often meddle actively in the operations given how they can withhold resources or put pressure on it that results in problems like short staffing or regulatory short-cutting. Thus, meeting the FCA requirement that the defendant have knowledge of falsity of the claim could be difficult, and in such cases, PE owners can avoid liability.

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[115] Zack Buck, *Patients Versus Profits*, 97 TEMP. L. REV. 321 (2025) (arguing that the typical tool of using fraud and abuse statutes to curb PE pressures needs to be reimagined to adequately address provider pressure; he argues for a medical necessity standard, enforcement through *qui tam* whistleblowers, and the FCA's causation requirement, make fraud and abuse the wrong fit for addressing PE pressures on providers); *but see* White, Cowart & Pandey, *supra* note 114 (arguing that enforcement under the False Claims Act fails to address PE's effects on the quality of and access to care).

[116] For discussion of application of the Anti-Kickback Statute and Stark Law (governing physician self-referrals) *see* Fuse Brown & Hall, *supra* note 12, at 558 et seq.

[117] Gabriel Picone, Shin-Yi Chou & Frank Sloan, *Are For-Profit Hospital Conversions Harmful to Patients and to Medicare?*, 33 RAND J. ECON. 507 (2002).

[118] Atul Gupta, Ambar La Forgia & Adam Sacarny, *Turbocharging Profits? Contract Gaming and Revenue Allocation in Healthcare*, Am. Econ. J.: Applied Econ. (forthcoming), https://www.aeaweb.org/articles?id=10.1257/app.20240589; Cutler & Horwitz, *supra* note 66. *See also Cutler & Horwitz*, *Converting Hospitals from Not-for-Profit to For-Profit Status: Why and What Effects?*, NBER Working Paper No. 6672 (1998), http://www.nber.org/papers/w6672.

[119] Gregory F. Maczko, *Make Hay While the Sun Shines: Private Equity and the False Claims Act*, 74 VAND. L. REV. 797 (2021). Maczko's article examines the history of FCA enforcement against fraudulent PE investment in health care and argues that enforcement should evolve as PE ownership becomes more prevalent, particularly when wrongdoing is alleged at the portfolio company level. *Id.* He analyzes *United States ex rel. Medrano v. Diabetic Care RX, LLC* and *United States ex rel. Matrino-Flemming*, in which the DOJ and an FCA relator, respectively, sought to hold PE firms liable for their portfolio companies' misconduct. *Id*. Drawing on these cases, Maczko proposes adopting a "direct involvement in fraud causation" standard. *Id*. Under this approach, courts would treat a PE firm's direct involvement in fraudulent conduct as sufficient causation for FCA liability, thereby discouraging PE firms from incentivizing profit-driven fraud while attempting to shield themselves from liability by distancing themselves from claim submission. *Id.*

[120] *See United States ex rel. Martino-Fleming v. S. Bay Mental Health Ctrs., Inc.*, No. 15-cv-13065 (D. Mass. 2021) (Massachusetts mental health counseling case settled with a $25 million payment by the PE owners and former executives).



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A third common suggestion is more stringent application of state corporate practice of medicine laws that, roughly summarized, forbids lay ownership of medical practice.[121] White et al. argue that these laws coupled with health care transaction notification laws can be mobilized to address the structural features and opacity of PE ownership in health care.[122] Although some form of the doctrine exists in most states, even where it still exists some states have so many exceptions to the law and in others corporate structuring can make evading it relatively easy. California, for example, exempts certain 501(c)(3) nonprofit clinics and charitable institutions from its CPOM regime, leaving room for entities organized in those forms to employ physicians directly even where the doctrine would otherwise bar lay ownership.[123]

Nonetheless, the doctrine may be particularly useful in the context of PE acquisition of physician practices where structuring may be difficult. Some laws, such as the Oregon CPOM, define decisions that might seem to be administrative in nature as part of "the practice of medicine," thereby making it hard to separate the administrative activities typically conducted by PE owners or managers from medical practice.[124] Finally, as we argue below, without the right orientation toward providing care, owners, including physicians, will seek profits over care.

In addition, some scholars advocate for payment reform as a solution.[125] Of course, the history of health policy is largely the history of solving the market failures that make it difficult

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[121] Fuse Brown & Hall, *supra* note 12. There are other approaches to shielding physicians from profit-seeking behavior. Zack Buck, for example, focuses specifically on the pressures PE ownership places on providers in an article discussing legal frameworks designed to shield clinical decision-making from profit driven influence, especially when profit interests directly control, own, and pressure the decision-making of the providers. Buck, *supra* note 115. Buck argues the typical tool of using fraud and abuse statues to curb PE pressures needs to be reimagined to adequately address provider pressure. *Id.* Specifically, Buck suggests that the medical necessity standard, enforcement through *qui tam* whistleblowers, and the FCA's causation requirement, make fraud and abuse the wrong fit for addressing PE pressures on providers. *Id.*

[122] White, Cowart & Pandey, *supra* note 114.

[123] It is notable that California exempts certain nonprofits from the corporate-practice-of-medicine restrictions. *See* Cal. Bus. & Prof. Code § 2400 (West 2025) (prohibiting corporations from holding professional rights but authorizing the Division of Licensing to approve employment of licensees by "licensed charitable institutions, foundations, or clinics, if no charge for professional services rendered patients is made"); *id*. § 2401(b) (authorizing employment of licensees by clinics operating under Cal. Health & Safety Code § 1206(p)); *see also* Cal. Health & Safety Code § 1206(l) (West 2025) (defining a parallel clinic-licensure exemption for 501(c)(3) nonprofit clinics providing care through groups of 40 or more independent-contractor physicians representing at least 10 board-certified specialties).

[124] OR. S.B. 951, *supra* note 96. SB 951 prohibits MSOs from exercising "de facto control over administrative, business or clinical operations of a professional medical entity in a manner that affects the professional medical entity's clinical decision making or the nature or quality of medical care that the professional medical entity delivers," defining de facto control to include, inter alia, "hiring or terminating, setting work schedules or compensation for . . . medical licensees," "setting clinical staffing levels," "making diagnostic coding decisions," and "negotiating, executing, performing, enforcing, or terminating contracts with third-party payors." *Id.* § 1(2)(a)(G), (H). For a detailed analysis, *see* Andrew L. Bab et al., *Oregon Imposes Significant Restrictions on Private Equity Investment in Healthcare*, DEBEVOISE & PLIMPTON LLP (June 12, 2025), https://www.debevoise.com/insights/publications/2025/06/oregon-imposes-significant-restrictions-on-private.

[125] *See, e.g.,* Fuse Brown & Hall, *supra* note 12, at 584–88 (arguing that public policy should primarily target payment loopholes exploited by private equity, including Medicare Part B drug payment incentives and



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to align payments with optimal service provision. We have yet to see how payment reforms can produce incentives that would preclude determined actors from seeking profits at the expense of patients.[126]

Finally, some scholars have argued for changes in governance models. More specifically, Fuse Brown and Rooke-Ley have advocated for shifting governance back to physicians and community members rather than PE investors.[127] This approach, however, has some of the same assumptions underlying the CPOM doctrine, that physicians in the role of administrators will not be unduly motivated by profit-seeking. Moreover, in many organizations, physicians do not want to run a complex business; they want to practice medicine. Additionally, although including community views in decision-making is important, local input can be biased toward maintaining organizations or service lines that are not financially sustainable or even medically desirable. For example, some service lines should not be provided by small entities given the relationship between quality and volume, but patients and community representatives typically will advocate for maintaining services. As we argue below, the problem with PE is not that they're not doctors or that they are from out of town.

The problem with PE is that their objective is generating profits, not the provision of health care.[128]

## V. What can be done?

In 1963, Nobel Prize winner Ken Arrow published "Uncertainty and the Welfare Economics of Medical Care," which set out the multiple market failures in the medical care industry.[129] These failures, such as the endemic agency problems associated with health insurance, mean that health care markets are bound to provide suboptimal care to patients. Given

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Medicare Advantage risk-adjustment gaming); Cai & Song, *supra* note 49, at 666–73 (proposing policy interventions including price regulation to mitigate the arbitrage incentives created by consolidation).

[126] Closing payment loopholes is one prominent payment-reform proposal. *See* Fuse Brown & Hall, *supra* note 12, at 584. We note that absent a prohibition on PE entry, payment reforms that stabilize hospital finances may also make hospitals more attractive PE acquisition targets.

[127] Fuse Brown & Rooke-Ley, *supra* note 80.

[128] Another approach is to decrease the incentives of nonprofit, tax-exempt organizations to sell to private equity, thus keeping assets in the health care sector and, in addition, to decrease the incentive of nonprofits to invest portfolios in PE. *See, e.g.,* James R. Repetti, *Private Equity, Health Calamity: How Our Tax Laws Aid Private Equity Investment in Hospitals and Nursing Homes* (Dec. 15, 2025) (unpublished manuscript), https://ssrn.com/abstract=5924964 If the approach would work to keep some assets in nursing homes, it would impose penalties on assets that are legally restricted to be used for other charitable health purposes rather than on PE buyers. Moreover, it may be difficult to impossible to separate PE investment from other kinds of investments as PE becomes part of standard investment portfolios. *See, e.g.,* William W. Clayton & Elisabeth de Fontenay, Private Equity for All: The Paradoxical Push to Democratize Private Markets Clayton (Jan. 30, 2026), European Corporate Governance Institute - Law Working Paper No. 898/2026, BYU Law Research Paper No. 26-02, Duke Law School Public Law & Legal Theory Series No. 2026-10, available at https://ssrn.com/abstract=6157128 (discussing efforts to open private equity to retail investors and the associated risks).

[129] Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963).



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the massive amount of money at stake, recently hovering between 16 and 19% of GDP,[130] providers will find ways to profit, including by exploiting these market failures to the detriment of patients and the country. Consider, for example, the ability of PE investors to concentrate on specialties in which they could profit from "surprise out-of-network billing to rapidly increase revenues"[131] or use arbitration processes to protect profits.[132]

This has always been true. Profit-seeking entities find ways to profit as water finds cracks. But PE and associated pressures make the water flow faster. The proposals for new laws, including more transparency, transaction review and approval, and more—all have some merit, and all fall short of stopping the pillage of health care. Although private equity offers needed capital investment to an industry that is sometimes starving for it, it is laser-focused on its own need to obtain outsized returns in a short period of time.

Fuse Brown and Hall are right,[133] PE moves faster than any remedial policy lawmakers can devise to mitigate its effects. While they call for an immediate legal and policy response aimed at market failures and payment loopholes, rather than PE investment itself, we think that won't do the trick. PE will find a way to do that within the new laws, or it will walk away from health care—leaving providers with even fewer options for accessing capital.

Our prescription is primarily structural: rather than patching the rules under which profit-maximizing owners operate, we would change who is permitted to own and govern health care providers in the first place. Providers already hold ethical obligations to preserve clinical autonomy and advance patient needs above business interests.[134] But the needs for capital and the power of private equity that has been well documented are certainly too strong to be limited by reminders to providers that they must put patients first. We are calling for something else. Changes to governance are required.[135]

Providers not only need the right orientation—one that prioritizes obligations—those obligations must be legally enforceable. The only model we know of that provides for corporate leaders to hold enforceable duties to advance a general purpose other than serving the financial

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[130] Peterson-KFF Health System Tracker, *How Does Health Spending in the U.S. Compare to Other Countries?*, https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/ (last visited Apr. 2026).

[131] Fuse Brown & Hall, *supra* note 12, at 531; *see also* Bain & Co., *Global Healthcare Private Equity Report 2026*: Record Highs, Renewed Momentum, Ready for More, https://www.bain.com/insights/topics/global-healthcare-private-equity-report/; Yashaswini Singh, Erin Fuse Brown & Irene Papanicolas, *The Rise of Private Equity in Health Care—Not a Uniquely American Phenomenon*, 392 NEW ENG. J. MED. 627 (2025).

[132] Fuse Brown & Hall, *supra* note 12, at 541.

[133] *Id*.

[134] Some scholars call on physicians to adhere to those obligations when engaging with private equity. *See, e.g.,* Amber R. Comer & Jake Young, *Physician Engagement with Private Equity Firms*, 27 AMA J. ETHICS 341 (2025).

[135] Fuse Brown & Rooke-Ley, *supra* note 80 (arguing for governance requirements as part of a multitiered approach to reshape the market through structural separation, nondiscrimination, and governance).



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interests of owners and investors is the nonprofit form.[136] We note that we are not naïve to the problems with nonprofits in health care. To many observers, nonprofit providers, especially hospitals, seem indistinguishable from for-profits. This is not surprising given that nonprofit providers, like hospitals, exist in the same ecosystem as for-profits and must compete against them. Moreover, scholars and regulators have missed key differences among ownership forms because they have focused on the outcomes easiest to measure, spending money on uncompensated care, rather than activities that are more central to health care providers yet hard to measure.[137]

We conclude that learning from the nonprofit governance structures, imposing on leaders of all health care organizations fiduciary duties to advance health and health care should be a minimum requirement for holding such leadership (or ownership) positions. Without having an appropriate goal, advancing patient and community health, money-making will always be prioritized. This is a problem of degree for traditional for-profit providers, whose business model treats profit as the goal for which care is delivered, but too often becomes a problem of kind for private equity, where care is the means by which profit is extracted, or worse, a side activity while focusing on liquidating assets.

What will this look like? If the unlikely coupling of PE and providers can be made to work well, it will be because all parties are committed to advancing the goal of providing good care in as efficient a manner as possible. What's needed to encourage pursuit of that goal with ingenuity and sustained commitment is a serious and flexible oversight system, run by state government and enacted through statute with realistic standards of proof and meaningful penalties, that combines respect for private sector expertise, commitment to the public good, and public accountability on all sides. The state insurance system offers the closest parallel: the agency retains supervisory and enforcement authority while drawing on outside experts for the technical work.

By way of example, state health departments that license the provider types seeking investment, sale or other significant involvement from PE (or any other investor) could require,

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[136] Hybrid forms such as the benefit corporation and certified B Corp do not impose enforceable affirmative duties to deliver public benefits. State benefit-corporation statutes generally authorize directors to consider stakeholder interests and require disclosure of progress against a stated public benefit, but enforcement is limited to a derivative "benefit enforcement proceeding" brought by shareholders, and courts have not developed a meaningful body of doctrine policing the duty. *See* Model Benefit Corp. Legislation § 305 (B Lab 2017); J. Haskell Murray, *Defending Patagonia: Mergers and Acquisitions with Benefit Corporations*, 9 HASTINGS BUS. L.J. 485, 511–14 (2013). B Corp certification is a private contractual standard administered by B Lab, not a statutory regime, and lapsing certification carries no legal consequence beyond loss of the mark.

[137] *See, e.g.,* Statement of Jill R. Horwitz, Trobman Family Innovation Professor, Northwestern Pritzker School of Law, Before the U.S. House Comm. on Ways and Means, Subcomm. on Oversight (Sept. 16, 2025), https://waysandmeans.house.gov/wp-content/uploads/2025/09/Statement-of-Jill-R.-Horwitz-September-16-2025.pdf (discussing how nonprofit hospitals provide a different mix of services than for-profits and explaining why uncompensated-care metrics fail to capture the central differences); *see also* Jill R. Horwitz & Austin Nichols, *Hospital Service Offerings (Still) Differ Substantially by Ownership Type*, 41 HEALTH AFFS. 331 (2022).



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as a condition of transaction approval or license transfer, that the new entity (or the lender or other source of funds and control) agree to a monitoring regime with escalating levels of access to otherwise confidential clinical and business information, depending on the level and area of concern; engagement with state agency retained experts in the area of concern; agency authority to impose additional reporting requirements or substantive remediation steps to address problems; and public reporting about investigations and steps taken in response. The sector should provide the funds necessary to implement such a regime—for example, by funding a reserve with an assessment imposed on all organizations seeking review and approval of transactions, or on all licensees in the sector.

This type of flexible and serious review has relevant precedent in the Steward Monitoring Agreement that applied during the first five years of Steward's operation in Massachusetts and in the Lahey-Beth Israel consolidation agreement that followed. In each, the Attorney General contracted with outside experts to perform the data collection and analysis while retaining oversight authority within the office.[138] State insurance industry oversight incorporates many of these features (e.g., solvency monitoring, market conduct examinations, levels of agency supervision up to and including receivership where serious problems are identified). Both precedents have limits. The Steward Monitoring Agreement was time-limited and could not constrain post-window behavior; insurance oversight is largely financial in focus rather than directed at clinical operations. Even within their respective scopes, the precedents had operational shortcomings: the Steward monitoring period closed in 2015 with a compliance finding even as the AGO's own report documented consecutive years of substantial losses. The regime proposed here builds on these models while addressing those limits, particularly the temporal cutoff that allowed Steward's most damaging actions to follow expiration of the monitoring authority.

States should explore approaches to this kind of flexible oversight that could be imposed through conditions on transactions that applicants would agree to as a condition of approval. Successful approaches could be incorporated into statutory regimes based on experience.

At its core, such an oversight system would be grounded in a common commitment to advance the purposes of the health care providers at the heart of concern and opportunity. Managers clearly following that goal would have little to fear from agreeing to it. Those whose true goals lie elsewhere would never agree to it.

What if fiduciary duties to purposes, enforceable by state attorneys general or a designated state health agency, were imposed? Some might find such an imposition at odds with the wide-

[138] *See* MASS. ATT'Y GEN., *supra* note 39; MASS. ATT'Y GEN., *supra* note 75. On the Lahey–Beth Israel consolidation, *see* Assurance of Discontinuance, *Commonwealth v. Beth Israel Lahey Health, Inc.*, No. 2018-3703 (Mass. Super. Ct. Suffolk Cnty. Nov. 29, 2018); Press Release, Mass. Off. of the Att'y Gen., AG Healey Reaches Settlement with Beth Israel, Lahey Health Over Proposed Merger (Nov. 29, 2018), https://www.mass.gov/news/ag-healey-reaches-settlement-with-beth-israel-lahey-health-over-proposed-merger.



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spread belief that the U.S. health care system is fundamentally based upon private, for-profit economic activity. This view, however, is grounded in deep misconceptions. First, federal and state government funds account for almost half of all health care spending in the United States.[139] The sector would not survive with this funding. Moreover, the elderly, children, people with disabilities, and those living in poverty rely on it. Second, there is plenty of precedent for treating health care as a special, nonmarket good, even as a public utility. [140]

Is it realistic to think such fiduciary duties could be enforced? After all, derivative suits by board minority members seeking to enforce fiduciary duties are few and far between.

We believe that fiduciary duties can and do substantial work even if not litigated: the obligation, backed by personal financial liability, shapes board deliberation in ways infrequent enforcement does not capture. In an industry so powerful, if the regulated entities were forced to pay the costs of enforcement necessary to protect patients, then oversight could have sharper teeth. Consider what could happen if not only every conversion from nonprofit to for-profit, but every major PE investment in critical health care infrastructure, came with a fee that regulators could use to hire experts to assist them in monitoring the operations of the providers most likely to seek profits at the expense of patients and communities. Such experts could include law firms, accounting firms with specialties in health care and fiduciary obligations, or others. Unlike small state offices, these experts have the resources and experience that make them more likely to spot problems. Coupled with the more liberal appointment of relators−private parties authorized to bring a claim on behalf of a the government−private parties could succeed in constraining the ill-effects of private equity whereas government regulators alone, no matter how sophisticated, have not.

We acknowledge limits to our approach. For example, because state law supplies the most plausible vehicle for these reforms, a regime adopted in one state alone leaves PE free to redeploy capital elsewhere. Coordinated state action will be a necessary companion: the Interstate Compact on Mental Health has organized cross-state cooperation on patient care for decades, and states routinely coordinate on vaccine purchasing and distribution. A parallel

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[139] Sean P. Keehan et al., National Health Expenditure Projections, 2024–33: Despite Insurance Coverage Declines, Health to Grow as Share Of GDP, 44 HEALTH AFFAIRS 776, 776–87 (July 2025).

[140] For a detailed history of the role of public utility regulation in the administrative state and how it has shaped health law, for good and bad, *see* Nicholas Bagley, *Medicine as a Public Calling*, 114 MICH. L. REV. 57 (2015). More broadly, our approach may be in harmony with some ideas proposed by other scholars urging adoption of regulatory tools from so-called "regulated industries" or "public utilities" area of law aimed at curbing the exercise of private control over "infrastructure goods." K. Sabeel Rahman, *The New Utilities: Private Power, Social Infrastructure, and the Revival of the Public Utility Concept*, 39 CARDOZO L. REV. 1621 (Apr. 2018). However, our suggestion to impose a fiduciary duty to further the purposes of those "infrastructure goods" (here, health care assets and organizations) upon those private actors who control them is rooted in the law of public charities rather than public utilities. Nonetheless, pursuing the public good is behind both approaches.



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compact for health care ownership oversight, through which states share information on PE acquirers and harmonize transaction-review standards, would close the redeployment loophole.

Moreover, funding gaps may need to be filled. As government leaders consider measures to impose new duties on investors, they should also examine the role public program payment policy may play in widespread capital shortfalls and possible interventions should PE no longer be an available source—either because it is prohibited or because conditions imposed on its participation in health care make it unattractive—and hospitals confront institutional deterioration or financial collapse.

## VI. Conclusion

In some respects, the seemingly endless demand for capital is good news. For example, we continue to make technological advances that provide relief from suffering and allow people to live healthy lives. There is even recent evidence that the growth in health care spending has slowed, that we have not only improved care but that we have begun to do what seemed to be impossible; we have begun to "bend the cost curve" for various reasons, including technological improvement, lower prices, and a healthier population.[141]

But large amounts of capital will continue to be needed. Health care providers will need it to adopt new and expensive technologies and to provide care to an aging population. At the same time, in a system that is the most expensive in the developed world, capital is also needed to reach the almost half of the U.S. adult population who find it "difficult to afford health care costs."[142] With rising uninsurance, not only will these people fail to get needed care, but the organizations that provide it will fail more frequently leaving ever larger shares of the population without care. We can ill-afford to leave health care providers to rely on financial resources that are likely to increase prices and carry the risk of liquidating health care assets.

Short of what we see as two unrealistic approaches—1) adoption of a European-style public system that would centralize capital provision, at least for major health care providers, or 2) banning of specific kinds of funding like PE, which is politically infeasible and would likely leave capital needs unmet or, at least, lead to games of whack-a-mole where new products that evade regulation appear—we think aligning corporate objectives with health care for all providers is a minimum requirement for avoiding catastrophes like the Steward bankruptcies.

In short, all health care providers must have health care as their first objective. Putting health and service to patients rather than profits would reorient business goals to the long term,

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[141] David M. Cutler & Lev Klarnet, *Has the United States Bent the Health Care Cost Curve?*, Brookings Papers on Econ. Activity (Spring 2026 Conference Draft), https://www.brookings.edu/wp-content/uploads/2026/03/5_Cutler-Klarnet_unembargoed.pdf (last accessed May 31, 2026).

[142] KFF, *Americans' Challenges with Health Care Costs*, https://www.kff.org/health-costs/americans-challenges-with-health-care-costs/ (last visited Apr. 2026).



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ensuring that maintenance of value in a company is part of the plan, rather than quick earnings and exits.

Moreover, there need to be enforcement mechanisms as well as enforcement, funded by the parties, that are not only focused on transactions but also on ongoing operations. This system may preclude investment that is focused on the short term. But capital seeking longer term returns should be available under such a system and, although we cannot know what might have happened if PE were not available, it is possible such capital was crowded out with PE as an option and would fill the need.

Although we believe that for-profit ownership of large health care organizations, with its duty to return value to owners, is inferior to nonprofit, at a minimum, the sector should borrow from the nonprofit form in terms of adopting substantive objectives and making them enforceable. People who are determined to seek profits above care can always evade a protective system and can undermine regulations, but adopting legally-enforceable goals could provide an important lever for enforcement. As our health care system increasingly splinters into better access and care for a smaller percentage of the population, we should at least demand that major health care organizations promise to focus on what they should—quality, accessible care.

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