



Investor Ownership and Influence in Healthcare Working Group

September 24, 2026

Today's Objectives

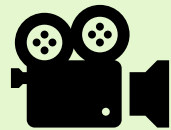
- Present the updated scope for the working group
- Outline the current and potential issues in the healthcare market related to financialization of healthcare and more specifically the impact and influence of corporate and private investors in the market
- Highlight problematic behaviors related to private equity and their impact on healthcare affordability
- Discuss why some states are more attractive to private equity than others

Today's Agenda

- Working Group Objectives and Roadmap – CHCA
- Introductions – CHCA
- What We Know About Investor Ownership and Influence in Healthcare – Mathematica
- Private Equity's Influence in the Healthcare Market – CAHPR
- Break
- Impacts of Private Equity Ownership and Influence – CAHPR
- Understanding What Makes States More Attractive to Private Equity – Mathematica
- Closing and Next Steps – CHCA

Housekeeping

- Slides will be available on the Center's website
- Bathrooms are outside the room at the end of the hallway
- Please remain on mute when not speaking
- Tech problems? Please try logging back in, or email Health.Affordability@state.mn.us.



This meeting is
being recorded.



Closed captioning
is available.

Working Group Objectives

- Develop a shared understanding of the affordability issues created by investor ownership and influence in Minnesota's healthcare system
- Identify gaps in Minnesota's current abilities to be aware of and monitor changes in ownership structure, and prevent or hold parties accountable for problematic outcomes resulting from these changes
- Potential areas of focus include:
 - Transparency of investor ownership and influence in Minnesota's healthcare system, specifically outpatient settings
 - Minnesota's corporate practice of medicine framework
- Propose a set of policy options and a recommended policy approach to the HCAATF

How We Got Here

- An early area of focus for the HCAATF was “**non value added spending**,” which included “investor-related spending that does not improve access, quality, or affordability” and included concerns that investor-backed entities have higher expectations of profit than non-profit entities
- In April, when HCAATF prioritized issues for future work, the top priority related to non value added spending was “developing options **to improve state visibility** into investor ownership of health care entities including private equity, REITs, and other ownership structures in health care, and **establishing safeguards to prevent unwanted practices**”
- Previous Task Force discussions have also noted the importance of:
 - Understanding the **upstream factors** that lead health care providers to enter into arrangements with investor-driven entities
 - **Avoiding unintended impacts** of policies to restrict investor-driven activity, especially in rural areas (e.g., losing access to services altogether)

Working Group Roadmap

- Today: Understand the current and potential issues associated with investor ownership and influence in the healthcare system and their impacts on affordability
- Meeting #2 (November 6): Review the Minnesota landscape and data
- Meeting #3 (December 9): Exploring policy options for consideration by the Health Care Affordability Advisory Task Force (HCAATF)

Working Group Objectives and Roadmap Discussion

- What questions do you have about the working group objectives and roadmap?



Working Group Introductions

Alex Caldwell | Director, Center for Health Care Affordability

Introductions

We will go around to each person in the room and you will have a minute to share:

1. Your name
2. What task force you are on

What We Know About Investor Ownership and Influence in Healthcare

Julie Sonier | Mathematica

Healthcare Has Become Increasingly Financialized

- Financialization is “the process by which the financial sector and financial actors become more involved in the healthcare system and use financial strategies to generate revenue.”
 - Includes activity by private equity (PE) firms, commercial/investment banks, venture capitalists, and other corporate entities
- The early stages of financialization can be traced back to shifts in the economy that occurred in the 1970s and 1980s spurred on by regulatory and policy changes that encouraged financial actors to get involved in the health care system
 - This occurred during a period where healthcare was also becoming more corporatized (e.g. horizontal and vertical integration) and privatized (e.g. private insurance involvement in Medicare)

There Are Two Different Types of Financialization

Financialization can be characterized in several ways:

“Outside-In”: Financial Actors Investing in Healthcare



Financial Ownership

Private and corporate ownership and/or governance of healthcare entities for the purpose of trading and sale.



Shareholder Value Maximization

Prioritizing profit to shareholders over the interests of communities, the healthcare workforce, and/or patients.



“Inside-Out”: Use of Financial Strategies by Healthcare Entities

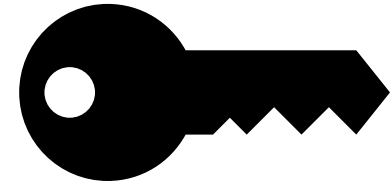
Mergers & acquisitions, consolidation, and investment actions by healthcare entities to sustain operations or finance new capital.

Investor Capital Can Provide Resources to Support Healthcare Delivery

- **Provide needed capital:** Support investments in facilities, technology, workforce, and service expansion
- **Support financially vulnerable providers:** Provide capital or partnership options that may help providers maintain operations or services
- **Support ownership transitions:** Provide succession and liquidity options when independent practices face challenges transferring ownership
- **Accelerate innovation:** Provide resources and expertise to adopt new technologies and scale new models of care,
- **Build operational capacity:** Strengthen capabilities such as analytics, IT, contracting, compliance, and administrative support

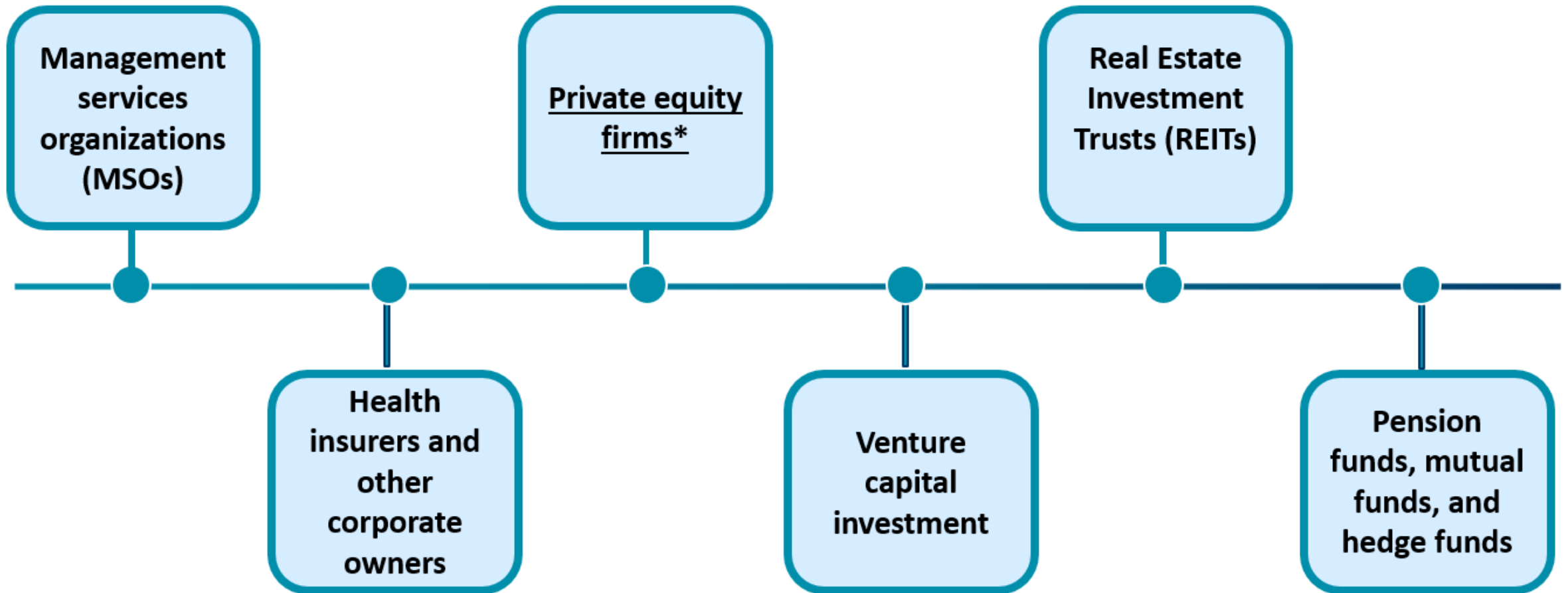
Financial Incentives Can Also Create Tension Between Investor Returns and Health System Goals

- **Financial return expectations can influence organizational priorities**, including emphasis on revenue growth, cost reduction, and distributions of returns to investors
- **Resources may be directed toward investor returns rather than reinvestment** in workforce, facilities, services, or other organizational needs
- **Consolidation can increase market power**, contributing to higher commercial prices and spending due to market leverage or lack of competition
- **Cost-reduction strategies may affect care delivery**, including staffing, service availability, and potentially quality
- Certain financial strategies, such as debt-financed acquisitions and sale-leasebacks, can create new **financial obligations or reduce provider financial flexibility**



How can we distinguish investment that **supports health system goals** from investment practices that **create affordability concerns**?

Who is Exerting Influence?



Definitions: Financial Actors in the Healthcare System

Entity	Definition
Management services organizations (MSOs)	Organizations that provide administrative and business services to health care practices, such as billing, staffing, contracting, finance, and operations. MSOs may be owned by physicians, health systems, or outside investors.
Health insurers and other corporate owners	Insurance companies and other corporations that own, acquire, or affiliate with health care providers or related businesses, often creating organizations that span multiple parts of the health care system.
Private equity firms	Investment firms that raise capital from investors to acquire ownership stakes in companies, typically with the goal of increasing their value and eventually selling the investment for a return.
Venture capital investors	Investors that provide financing to newer or rapidly growing companies, typically in exchange for an ownership stake and the potential for substantial future returns.
Real Estate Investment Trusts (REITs)	Companies that own or finance income-producing real estate. In health care, REITs may own hospitals, nursing facilities, medical offices, or other properties and lease them to health care operators.
Pension funds	Investment funds that manage assets to finance retirement benefits for workers. They may invest in health care companies directly or indirectly through private equity and other investment funds.
Mutual funds	Pooled investment vehicles that invest money from many investors in stocks, bonds, and other assets, including publicly traded health care companies.
Hedge funds	Privately managed investment funds that use a broad range of investment strategies to generate returns for their investors and may invest in or acquire stakes in health care companies.

How Are They Exerting Influence?

- **Ownership and control:** Acquiring providers, taking equity stakes, or gaining governance rights
- **Consolidation:** Combining providers or acquiring additional practices to build scale and market power
- **Financial arrangements:** Debt, management agreements, real estate ownership, and other structures that influence organizational decisions
- **Business and financial strategies:** Pricing, service mix, coding, cost management, capital allocation, and pursuit of higher returns

What Are the Consequences?

- **Higher prices and spending:** Greater bargaining leverage as a result of market consolidation leads to increases in prices and/or increases in the volume of services provided
- **Changes in access and services:** Expansion of profitable services and potential reduction or exit from less profitable services
- **Workforce effects:** Cost reduction, changes in staffing models, or greater productivity expectations
- **Investor returns:** A portion of health care revenues may flow to investors through profits, dividends, management fees, or other financial arrangements rather than being retained or reinvested in care delivery
- **Changes in organizational priorities:** Greater emphasis on financial performance, potentially affecting clinical autonomy, quality, or long-term investment

Questions for Discussion – What We Know

- What questions does the group have?
- What stands out to you or was surprising to hear?
- When thinking about investor ownership and influence in healthcare in Minnesota, what do you think are the greatest opportunities and concerns for the healthcare system?



Private Equity's Influence in the Healthcare Market

Investor Ownership and Influence in Healthcare Working Group
2026-27

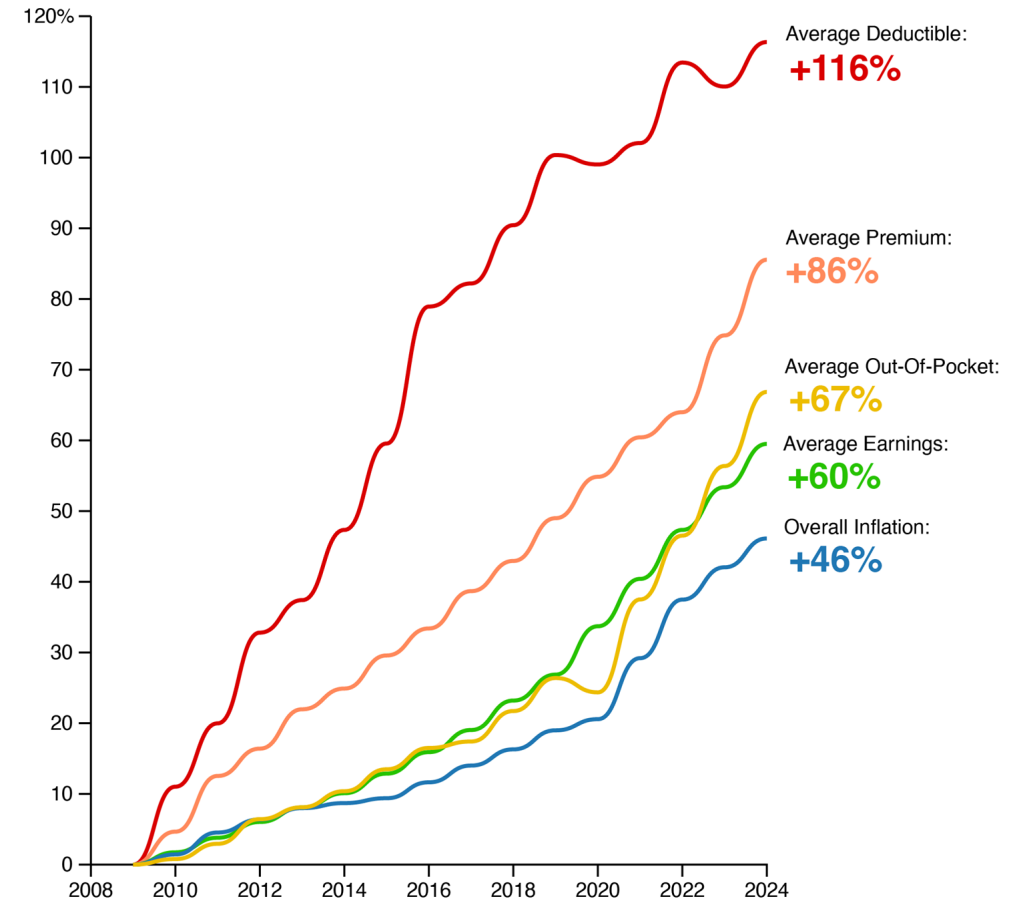
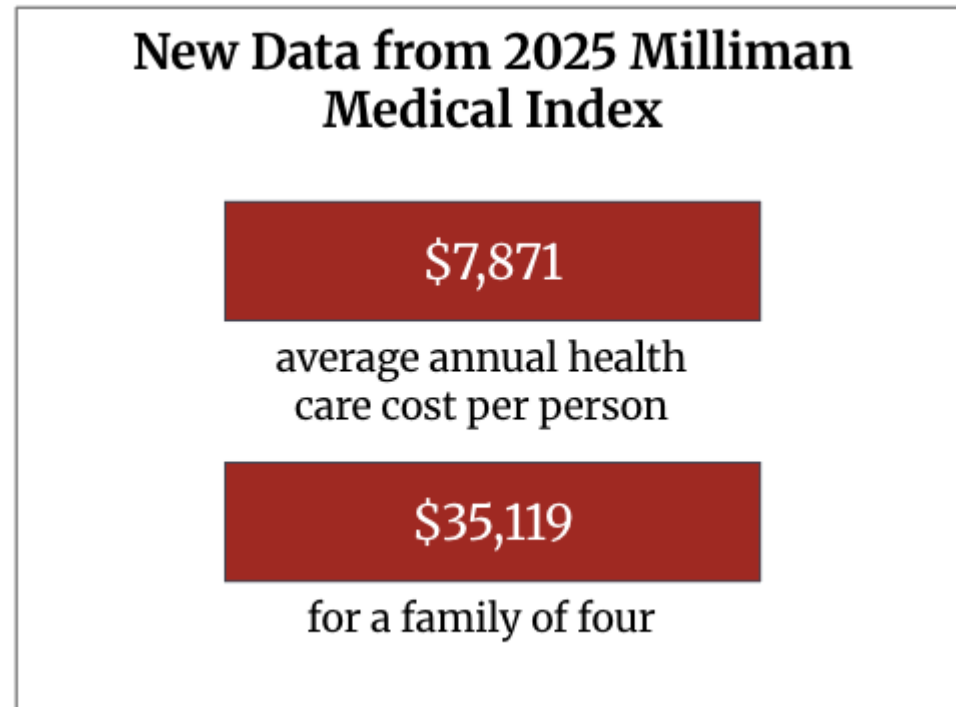
Erin Fuse Brown, JD, MPH
Brown University

September 24, 2026

Overview

- **Describing the landscape:** health care consolidation and private equity investment (i.e., corporatization)
- **What makes private equity (PE) different** than other forms of consolidation
- **The PE model** of investment health care facilities and physician groups
- **The evidence** of PE's impact on health care entities and **policy concerns**

Health care affordability declines as prices rise



Consolidation drives prices higher

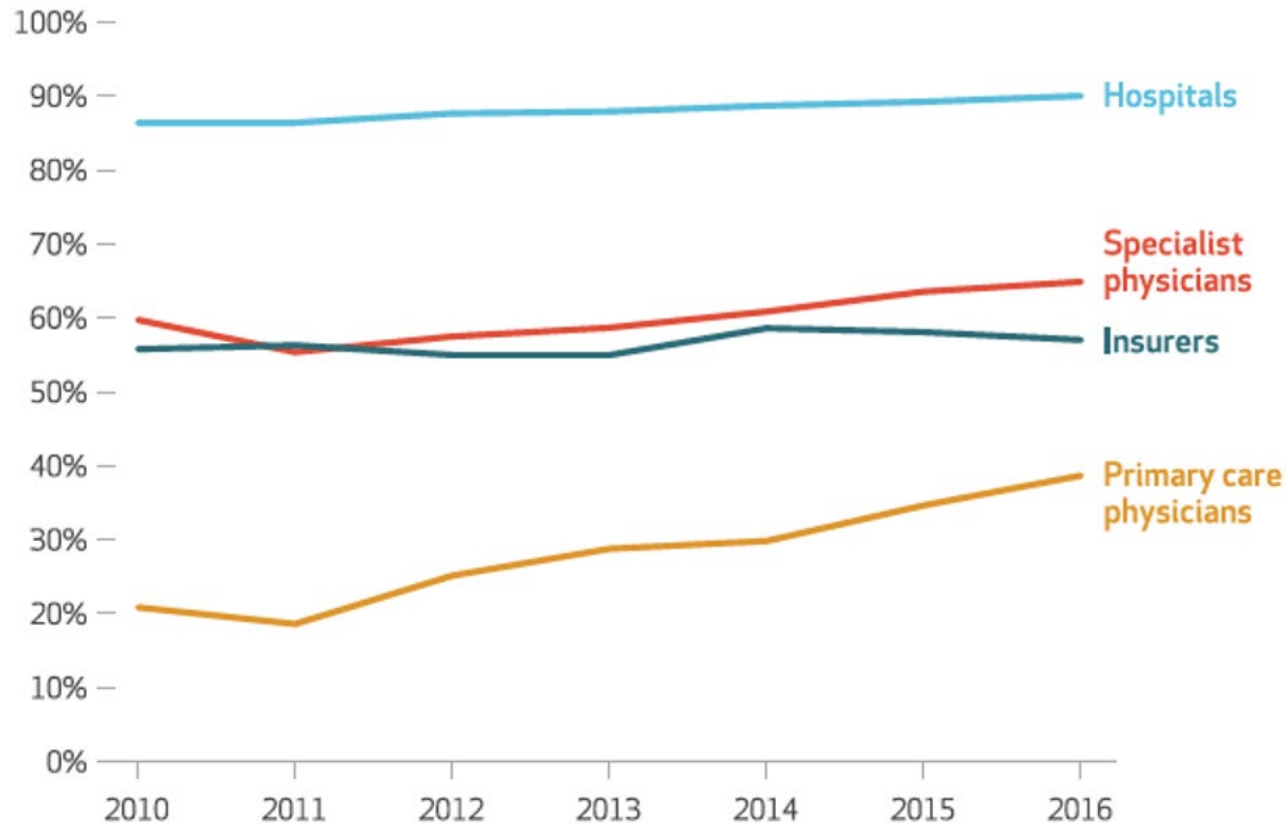
- It all comes down to **market power**
- Market power is amassed through **consolidation** (horizontal mergers, vertical consolidation, joint ventures, contractual affiliation)
- Higher priced providers are **not necessarily higher quality**
- High prices are paid for **workers**:
 - ↑ premiums and out-of-pocket costs
 - ↓ wages and jobs



Health care consolidation trends

EXHIBIT 2

Percentages of Metropolitan Statistical Areas (MSAs) whose Herfindahl-Hirschman Index (HHI) was above 2,500 for hospitals, physician organizations, and health insurers, 2010-16

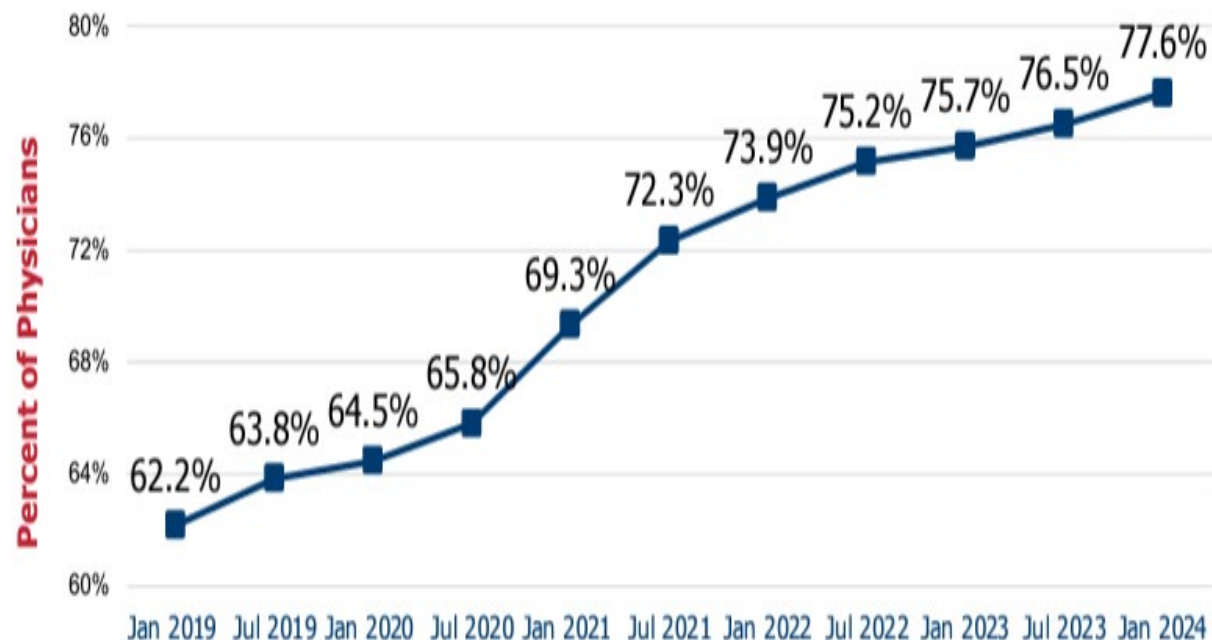


% of markets that are highly concentrated:

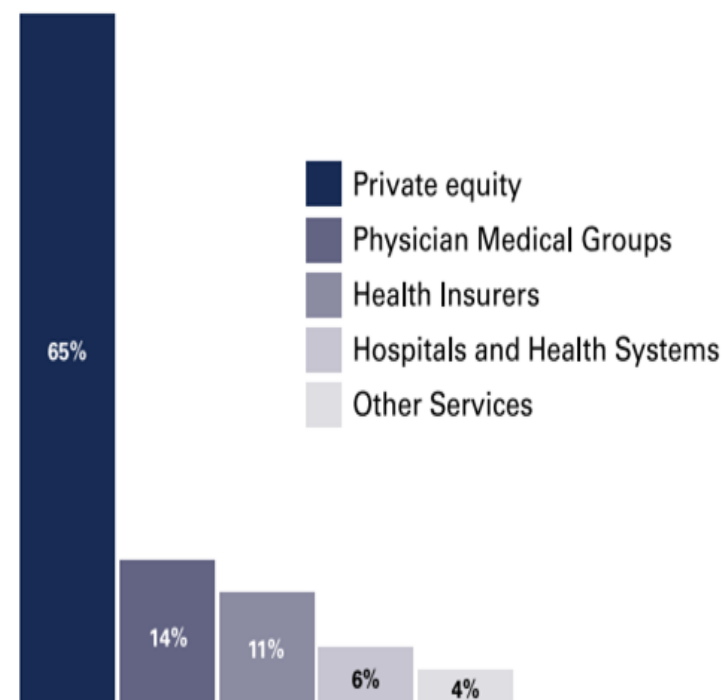
- 90% of hospital markets
- 65% of specialty physician markets
- 57% of insurer markets
- 39% of primary care markets

Context: Rapid changes to physician organizations

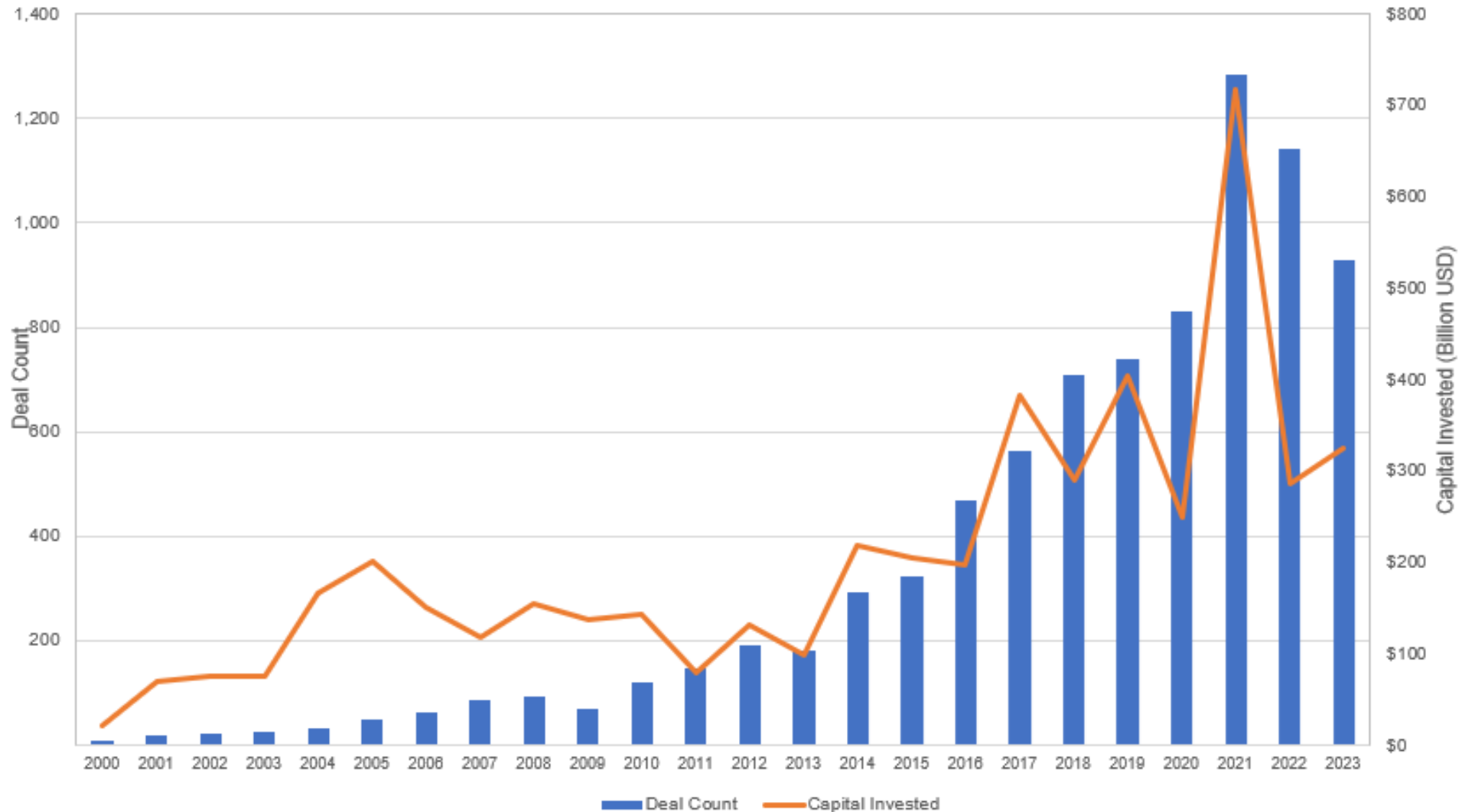
**PERCENT OF U.S. PHYSICIANS EMPLOYED
BY HOSPITALS OR CORPORATE ENTITIES IN 2019-23**



Percentage of acquired physicians by type, 2019 - 2023

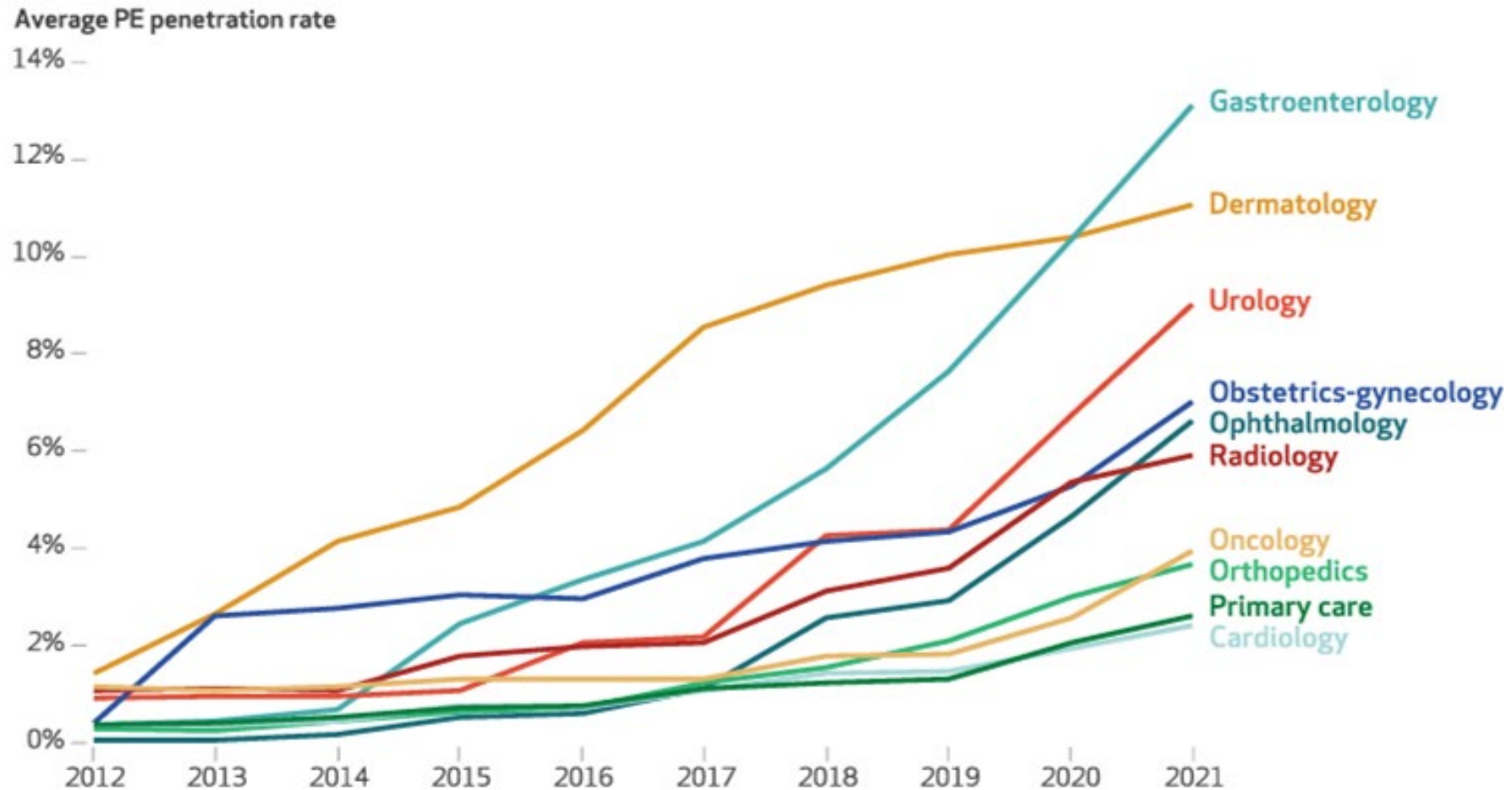


Private equity firms have invested \$1 trillion dollars in the US health care system in the last decade



A growing share of physicians are PE-affiliated nationally

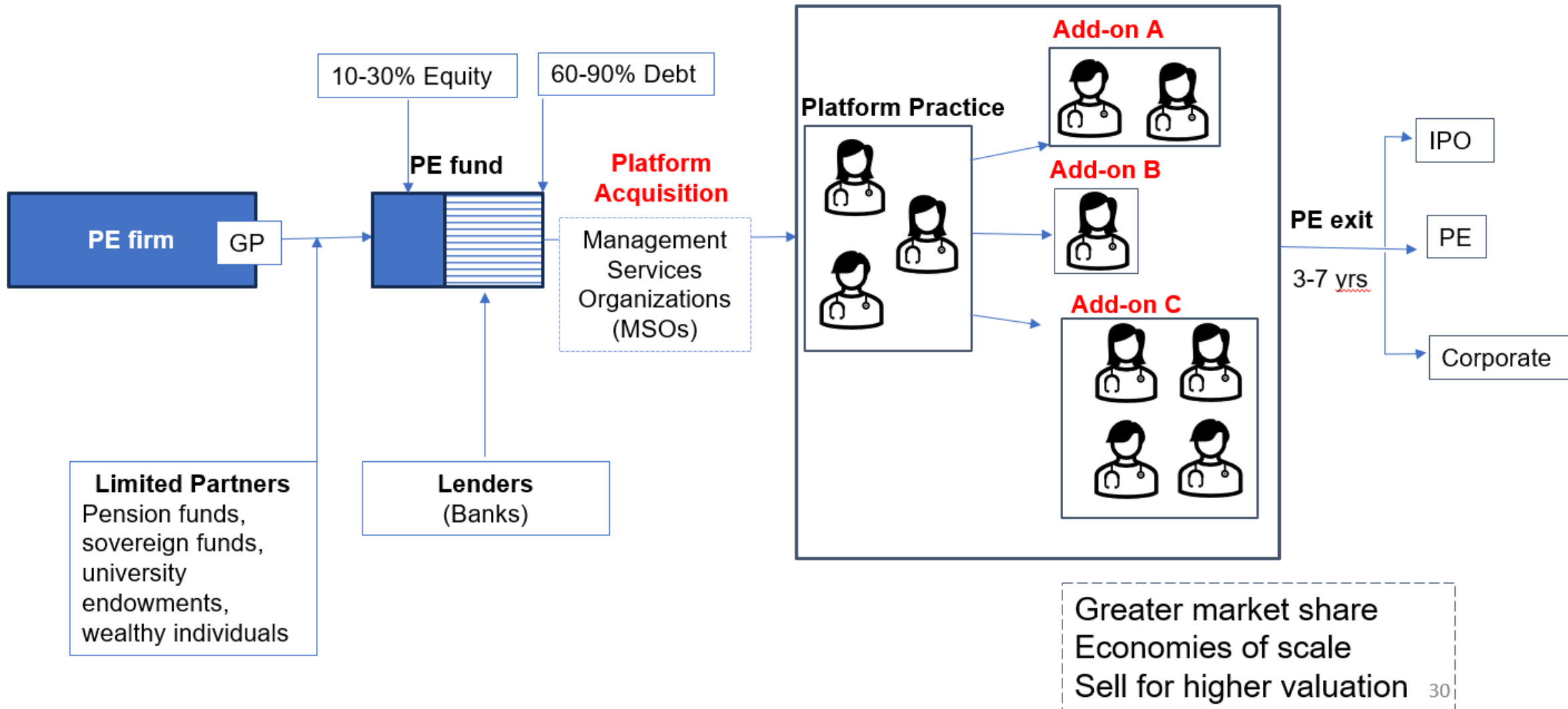
Trends in private equity (PE) penetration at the physician level in the US among 10 physician specialties, 2012-21



How PE differs from other private, for-profit health care entities

- **Limited transparency**
 - Few disclosure requirements on ownership structures, financing, or performance
 - Difficult for researchers, policymakers to identify trends and assess impacts
- **Incentive structure**
 - PE combines equity with substantial debt to acquire controlling stakes
 - Short investment horizon, typically 3–7 years
 - High target internal rates of return (often ~20% per year)
 - Emphasis on rapid value creation and exit rather than long-term investments
- **PE strategies are distinct across investment settings**
 - “Platform and add-on” consolidation in outpatient settings (common in physician practices)
 - Sale-leaseback arrangements that separate the property company (PropCo) from the clinical operating company (OpCo) (common in hospitals and nursing homes)

Classic model of private equity investment in physician practices

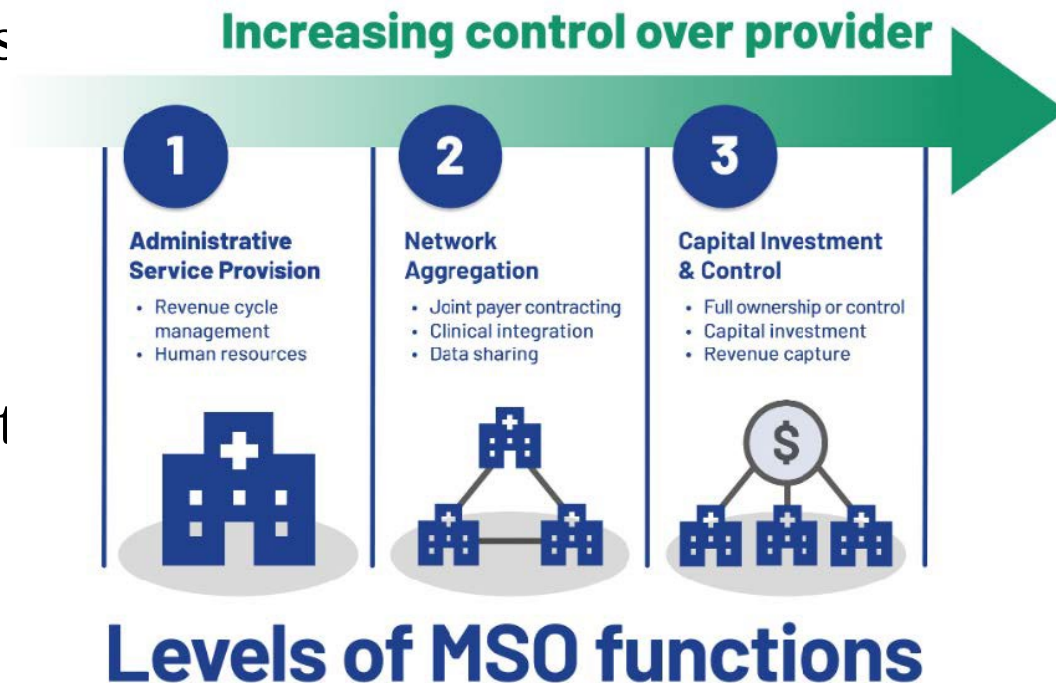


How PE firms control physician practices: management services organizations (MSOs)

Definition: An MSO is an entity that provides non-clinical services to physician practices. MSOs are the primary vehicle through which lay-corporations acquire control over medical practices.

MSO Model: Corporate-owned MSO contracts to run the physician practice through a management services agreement

Friendly PC Model: MSO installs “friendly physician” to run, and often to exclusively own, the practice. The friendly physician is a licensed practice owner who works for the MSO, who may not provide any patient care in the practice.



Summary 1/2

- Health care **affordability is a problem**
- The main driver of rising health care prices is **consolidation**
- In recent years, consolidation has been amplified by **PE firms**
- There are some theoretical benefits, but **many concerns**, associated with PE acquisition
- **Research and policy is limited** by a lack of transparency
- **Next up**: we will discuss the **existing research** behind PE acquisitions in health care

Questions for Discussion – PE Influence

- What questions do you have?
- Are there any actions or behaviors that you think are of particular importance that the task force should consider addressing?
- What experience or perspective can you share about private equity's influence in Minnesota healthcare?



Break

Impacts of Private Equity Ownership and Influence

Investor Ownership and Influence in Healthcare Working Group
2026-27

Erin Fuse Brown, JD, MPH
Brown University

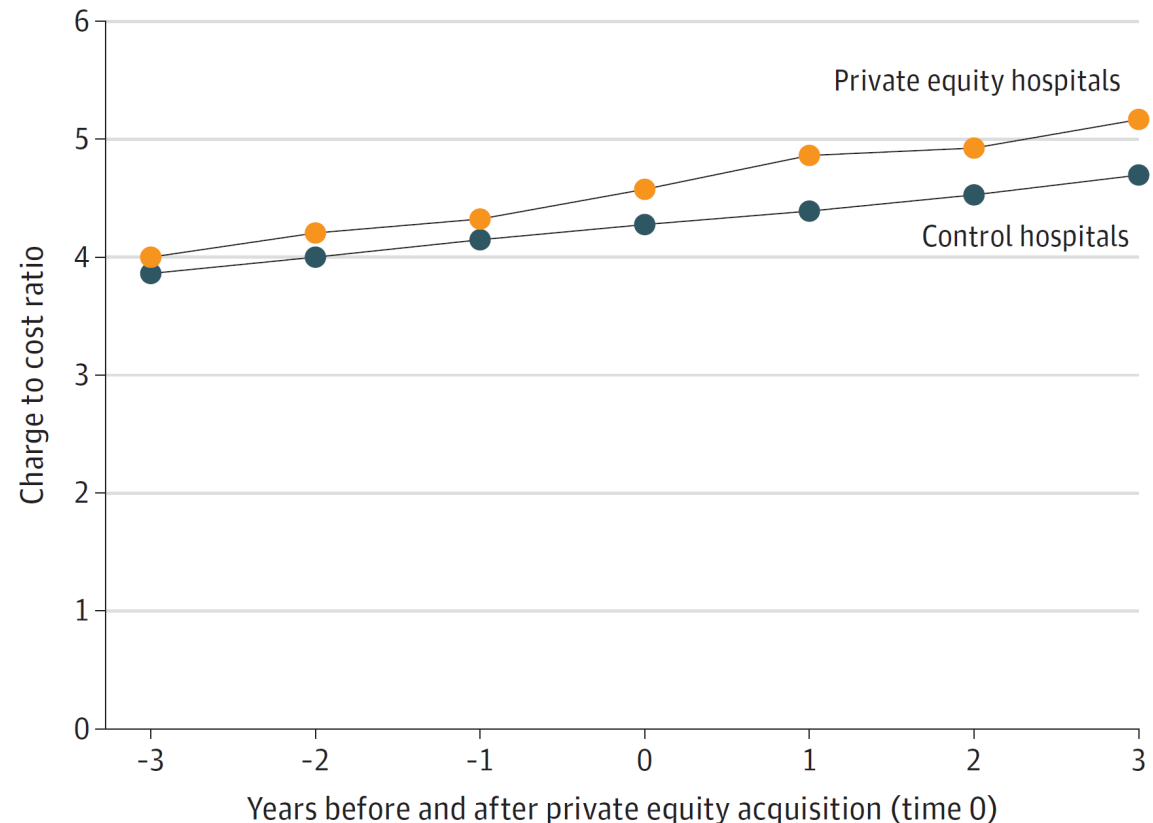
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PE acquisitions of hospitals increase charges, income, and decreased Medicare payer mix

Relative to control, PE acquisitions increased:

Net income	27%
Charges per day	7%
Charge/cost ratio	7%
Charge/cost ratio (ED)	16%
Case mix	1.4%
Medicare %	-2.4%

Figure. Total Charge to Cost Ratios Before and After Private Equity Acquisition

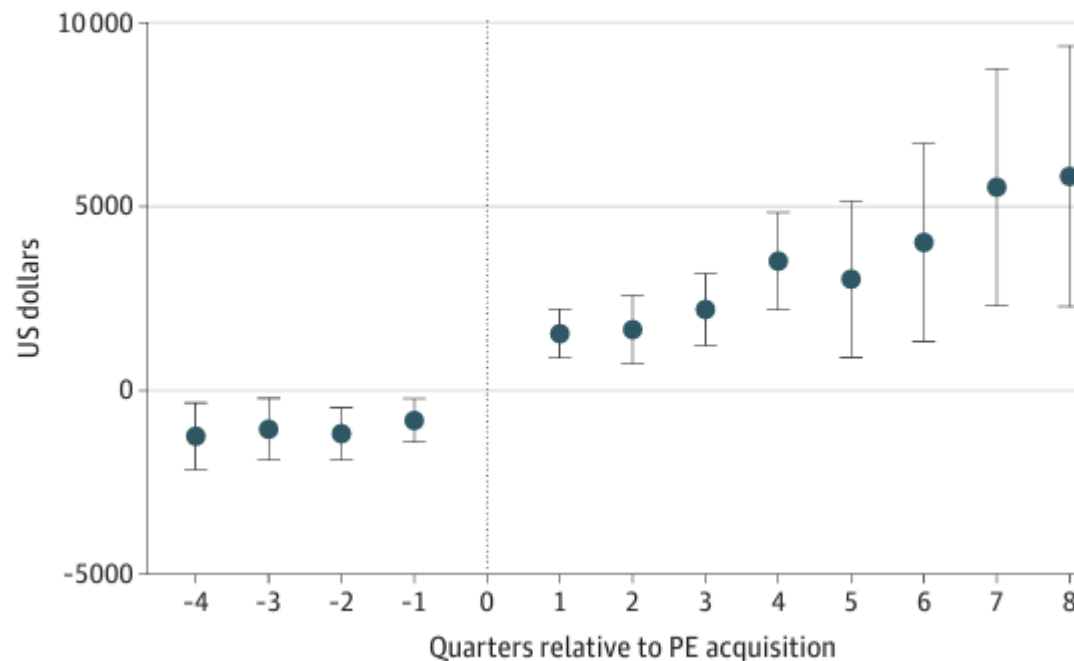


PE acquisitions of hospitals and nursing homes increase prices and spending, may spillover to local markets

- In **hospitals**, PE acquisition has led to an **11% increase in prices** negotiated between hospitals and private insurers. The price increase does not just affect the acquired hospital but also surrounding local hospitals ([Liu 2021](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3896410)
(https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3896410))
- In nursing homes, residents in PE-acquired nursing homes had **3.9% higher Medicare costs**, ~ **\$1080** annually per resident. ([Braun et al., 2022](https://doi.org/10.1001/jamahealthforum.2021.3817)
([doi:%2010.1001/jamahealthforum.2021.3817](https://doi.org/10.1001/jamahealthforum.2021.3817)))
- In PE-acquired nursing homes, the amount billed per nursing home stay per patient **increased by 8%** and **mortality increased by 11%** ([Gupta et al., 2024](https://doi.org/10.1093/rfs/hhdo82)
(<https://doi.org/10.1093/rfs/hhdo82>))

PE acquisitions of dermatology, gastroenterology, and ophthalmology practices increased commercial prices by 11%

Figure 1. Changes in Total Spending per Practice Associated With Private Equity Acquisition, by Quarter



Relative to controls, PE acquisitions increased:

- Charges by 20% (\$71 per claim)
- Prices by 11% (\$23 per claim)
- Visits by new patients by 38%
- Long (>30 min) visits by 9%

Other studies find PE-acquisitions increase prices and spending in physician practices

- PE-acquired retina practices **increased Medicare spending on higher-priced injectable drugs by 21%**, or \$13,028 per practice-quarter ([Singh et al., Ophthalmology, 2024 \(https://www.aaojournal.org/article/S0161-6420\(23\)00563-8/abstract\)](https://www.aaojournal.org/article/S0161-6420(23)00563-8/abstract))
- PE acquisitions of ophthalmology practices **decreased provision of critical but less-profitable retinal detachment surgeries by 20%**, relative to controls ([Singh et al., Health Affairs, 2025 \(https://doi.org/10.1377/hlthaff.2024.01204\)](https://doi.org/10.1377/hlthaff.2024.01204))
- PE-affiliated urologists had an **11.0% increase in Medicare payments** and a 12.5% increase in patient volume. Non-PE affiliated urologists had a 6% decline in Medicare payments and a 2.7% increase in patient volume. ([Nie et al., Urology, 2022 \(https://www.goldjournal.net/article/S0090-4295\(22\)00440-X/abstract\)](https://www.goldjournal.net/article/S0090-4295(22)00440-X/abstract))
- PE-affiliated neonatologists experienced a **70% increase in prices and 56% increase in spending**, compared with non-PE ([Yu et al., Pediatrics, 2023 \(https://doi.org/10.1542/peds.2022-057931\)](https://doi.org/10.1542/peds.2022-057931))

Case: FTC v. US Anesthesia Partners

- In 2023, FTC sued USAP and PE firm, Welsh Carson alleging that USAP and WCAS used the roll-up strategy to monopolize the anesthesia market in Texas
- FTC alleges that USAP charged commercial prices that were **95% higher** than the average in-network rates for Texas and **65% higher** than the average in Houston.
- PE firm Welsh Carson was dismissed from the case, USAP has settled (terms not yet public)



FEDERAL TRADE COMMISSION
PROTECTING AMERICA'S CONSUMERS

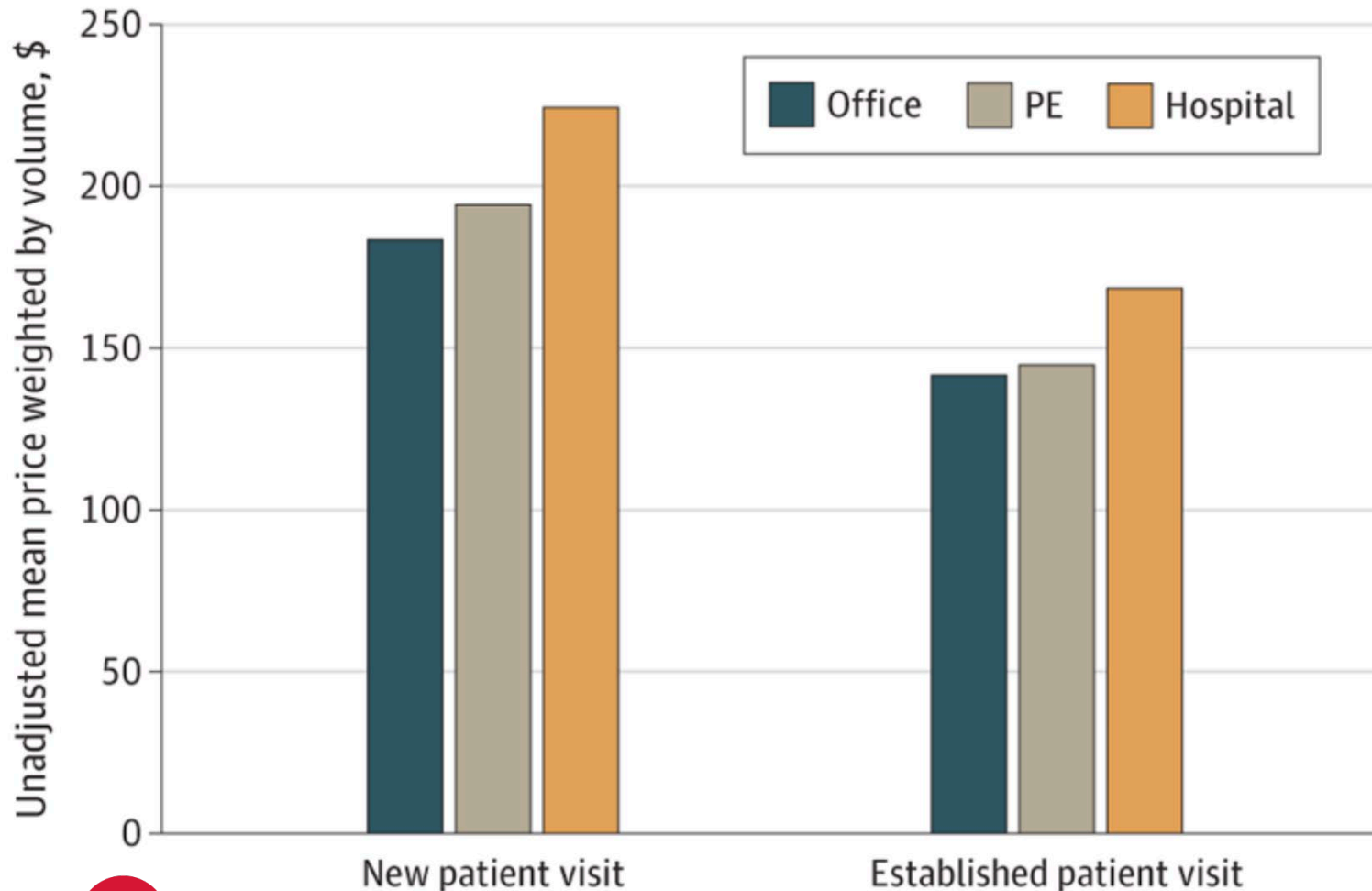
FTC Challenges Private Equity Firm's Scheme to Suppress Competition in Anesthesiology Practices Across Texas

U.S. Anesthesia Partners, Welsh Carson engaged in decade-long anticompetitive acquisition spree to suppress competition and unfairly drive-up prices for anesthesiology services

September 21, 2023 | [f](#) [X](#) [in](#)

But, PE is not the only ownership type that increases prices

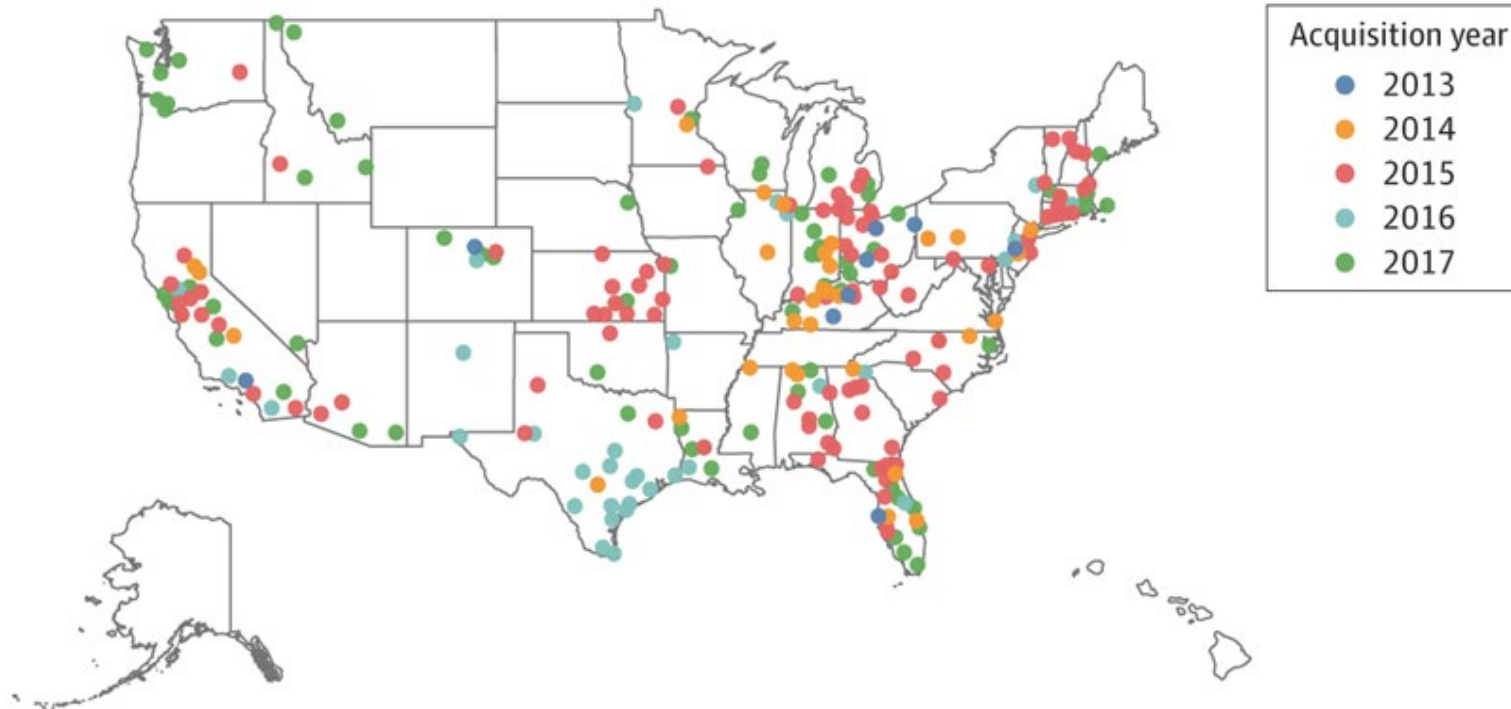
Figure 3. Unadjusted Mean Prices for Office Visits Across Ownership Type in 2022



Among primary care practices:

- Prices for office visits were 11% higher for hospital-affiliated than independents
- Prices were 8% higher for PE-affiliated than independents

Quality: PE acquisitions lead to increased adverse outcomes at nursing homes

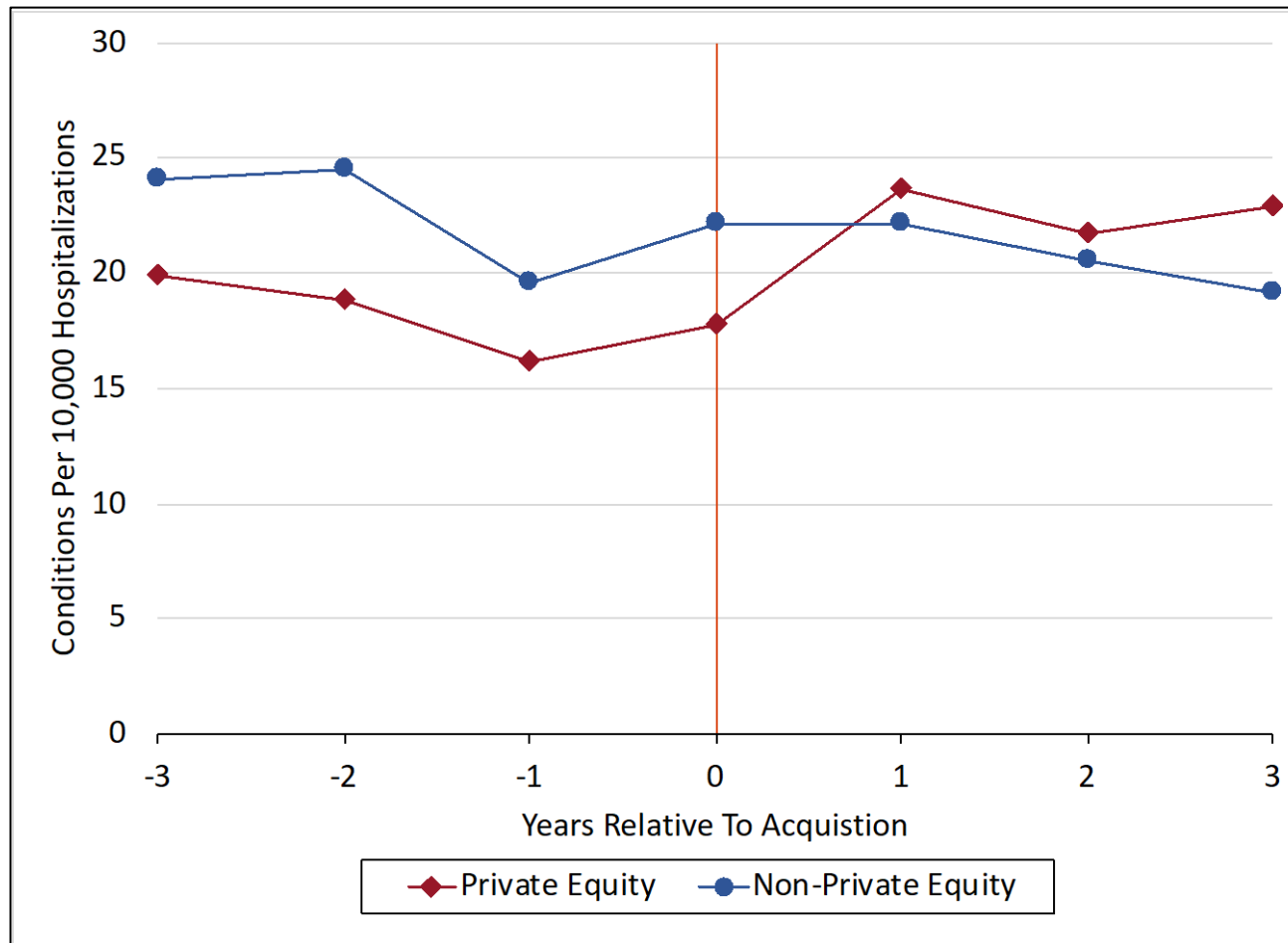


Relative to controls, PE-acquired nursing homes experienced:

- 11% increase in ED visits¹
- 9% increase in hospitalizations¹
- 11% increase in mortality²

Quality: PE acquisitions lead to increased hospital-acquired conditions

CMS Hospital-Acquired Conditions (HACs) – Composite



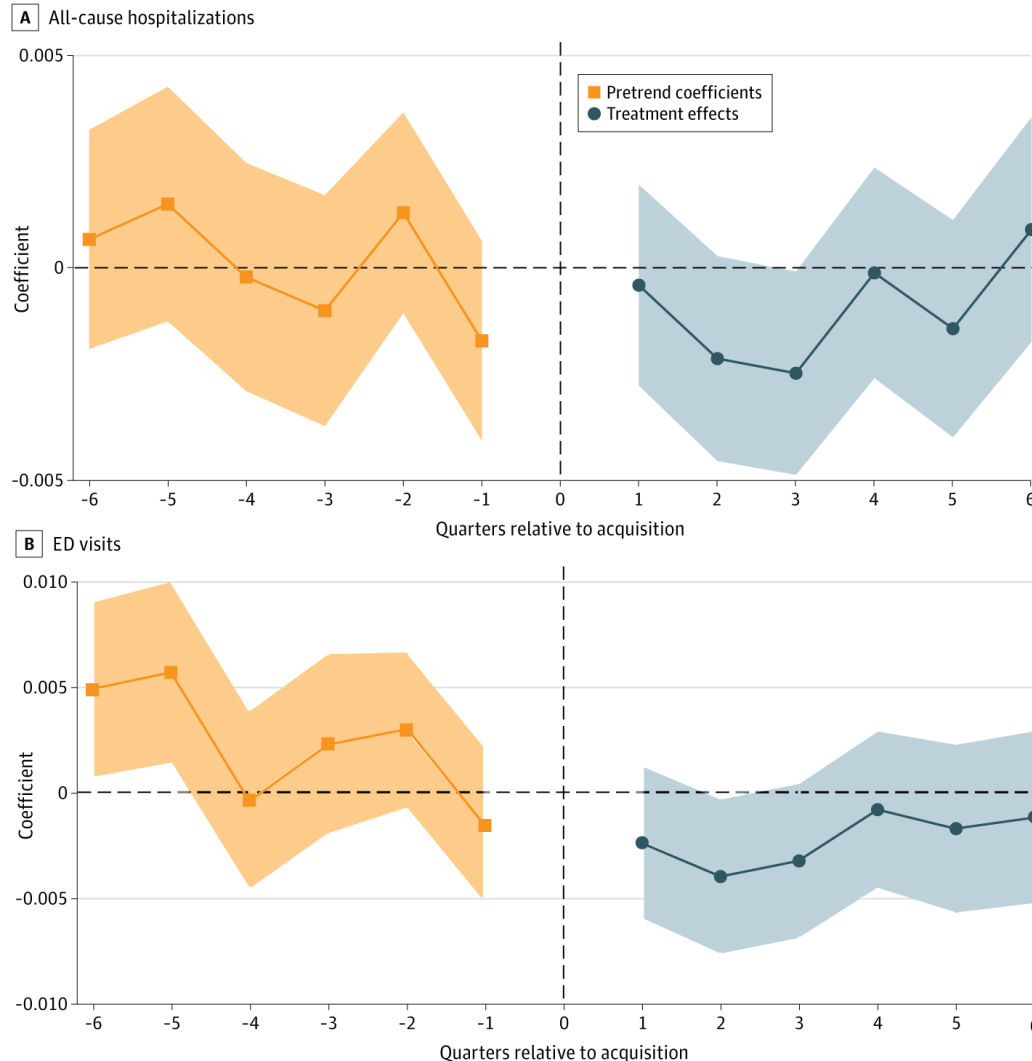
Relative to control, PE acquisitions increased:

Composite HACs	25%
Falls	27%
Central line infections	38%
(Despite 16% fewer central lines)	

Surgical site infections doubled at PE hospitals, while declining at controls.
(Despite 8% fewer surgeries performed)

Kannan S, Bruch JD, Song Z. Changes in Hospital Adverse Events and Patient Outcomes Associated With Private Equity Acquisition. *JAMA*. 2023;330(24):2365–2375.

Quality: PE acquisition of primary care practices was not associated with hospitalization



Relative to controls, PE-acquired primary care practices:

- Had no meaningful change to all-cause or preventable hospitalizations
- Experienced modest reductions in ED visits

Dixit MN, Philips AP, Trivedi AN, Whaley C, Singh Y. Private Equity Acquisition in Primary Care and Avoidable Hospitalizations. *JAMA Health Forum*. 2026;7(5):e261045

Conclusion of a review study by Borsa et al. in BMJ

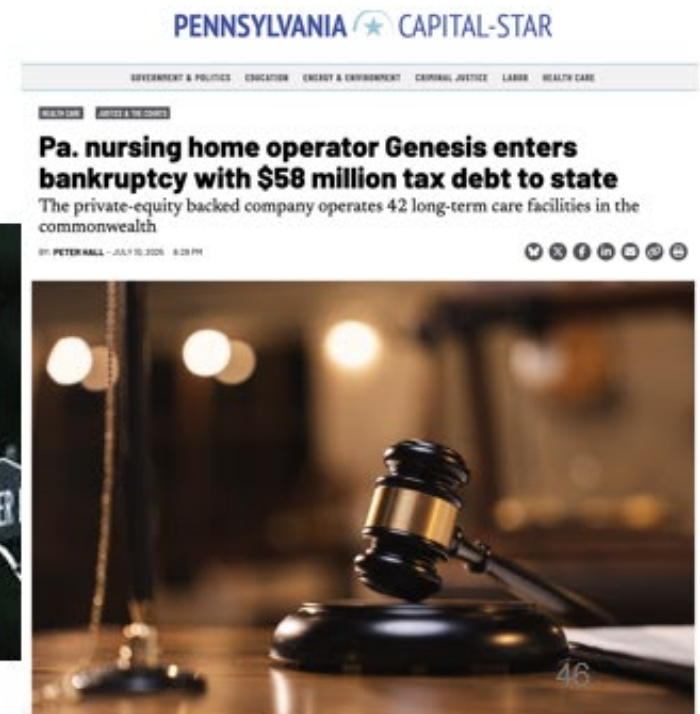
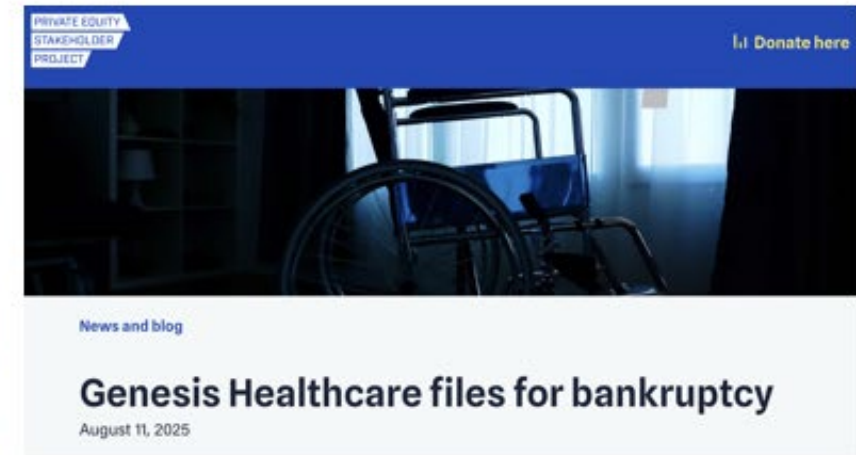
“Based on data from 55 empirical studies, we found that PE ownership in the healthcare sector has markedly increased ... [T]he most unequivocal evidence points to PE ownership being associated with an **increase in healthcare costs to patients or payers**, primarily by increased charges and negotiated higher rates with payers. **Evidence across studies also suggests mixed impacts of PE ownership on healthcare quality**, with greater evidence that PE ownership might degrade quality in some capacity rather than improve it.”



Alexander Borsa et al. BMJ 2023;382:bmj-2023-075244

	Impacts			
	Health outcomes	Costs to patients or payers	Costs to operator	Quality
Borsa and Bruch 2022 ³⁶	Neutral			Neutral
Bos and Harrington 2017 ³⁷				Harmful
Bos et al 2020 ³⁸				Harmful
Braun et al 2021 ³⁹		Harmful		
Braun et al 2021 ⁶⁰	Harmful	Harmful		Neutral
Braun et al 2020 ⁶⁰	Harmful			Mixed
Broms et al 2023 ⁶¹				Harmful
Bruch et al 2023 ⁶²				Harmful
Bruch et al 2022 ⁶³	Neutral	Neutral		
Bruch et al 2021 ⁴¹		Neutral		Harmful
Bruch et al 2020 ⁴²		Harmful		Beneficial
Cerullo et al 2022 ⁴³			Beneficial	Harmful
Cerullo et al 2022 ⁴⁴	Beneficial	Neutral		Neutral
Cerullo et al 2021 ⁴⁵				Mixed
Creadore et al 2021 ⁴⁶				Beneficial
Gandhi et al 2020 ²²				Mixed
Gandhi et al 2020 ⁴⁷	Beneficial			Beneficial
Gupta et al 2021 ⁴⁸	Harmful	Harmful	Harmful	Harmful
Harrington et al 2012 ⁴⁹				Harmful
Huang and Bowblis 2019 ⁵⁰				Mixed
La Forgia et al 2022 ⁵¹		Harmful		
La France et al 2021 ⁵²				Harmful
Liu 2021 ⁵³	Neutral	Harmful	Beneficial	Mixed
Nie et al 2022 ⁶⁶		Harmful		Harmful
Nie et al 2022 ⁵⁴				Mixed
Offodile et al 2021 ⁵⁵		Harmful	Beneficial	Harmful
Patwardhan et al 2022 ⁶⁴				Harmful
Pradhan et al 2014 ⁵⁶				Mixed
Pradhan et al 2013 ⁵⁷			Harmful	
Singh et al 2022 ⁶⁵		Harmful		
Stevenson and Grabowski 2008 ⁵⁸				Mixed
Winblad et al 2017 ⁵⁹				Mixed

Prominent PE-backed provider bankruptcies



Summary 2/2

- PE investments in health care reflect a **broader trend of health care corporatization and financialization**
 - Strong evidence that PE-ownership leads to **higher prices and spending** across health care settings and specialties
 - **Quality effects are mixed and setting-specific**: in facilities, staffing cuts can lead to worse quality, but not in practices
 - Concerns over heightened risk for **bankruptcy and closure**, degrading access
- PE strategy is **sector-specific**; there are differences in the impact across payers, patients, and workers
- **State-specific studies are sparse**, reinforcing a need for state-specific evidence to inform policymakers about the extent and impact of PE penetration in the market
- Key regulatory challenge: balance need for capital investment with protections for patients and health care workers

Questions for Discussion – Impacts of PE

- What if anything stood out or surprised you?
- In order to accomplish the working group's objectives, what else do you need to know about the impacts of private equity ownership and influence?



Understanding What Makes States Attractive to Private Equity

Julie Sonier | Mathematica

State Policy May Play a Role in Private Equity Interest

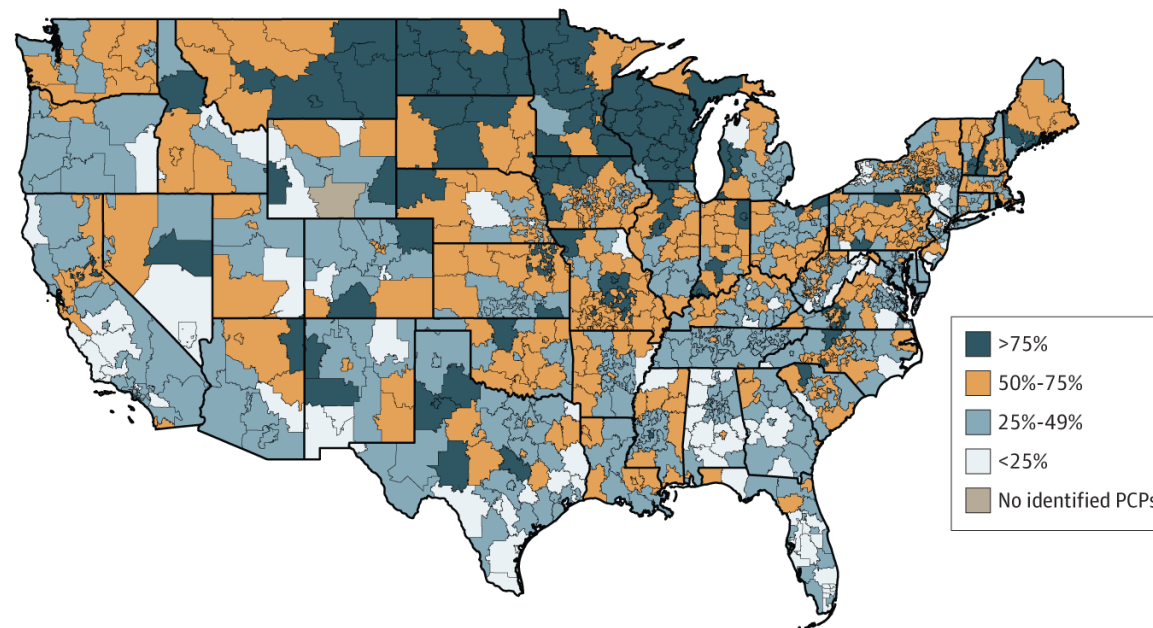
- **Corporate Practice of Medicine (CPOM) restrictions vary by state:** States differ in how they restrict and regulate nonphysician ownership or control of health care providers
- **Some evidence links CPOM rollbacks to changes in PE investment:** One study found that PE hospital acquisitions increased after states relaxed enforcement of corporate practice of medicine restrictions
- **Effects of new oversight policies are unclear:** Notification, review, and ownership disclosure requirements can create additional scrutiny or transaction requirements, but their effect on PE investment patterns is not yet well established

PE Investment May Target Specific Markets

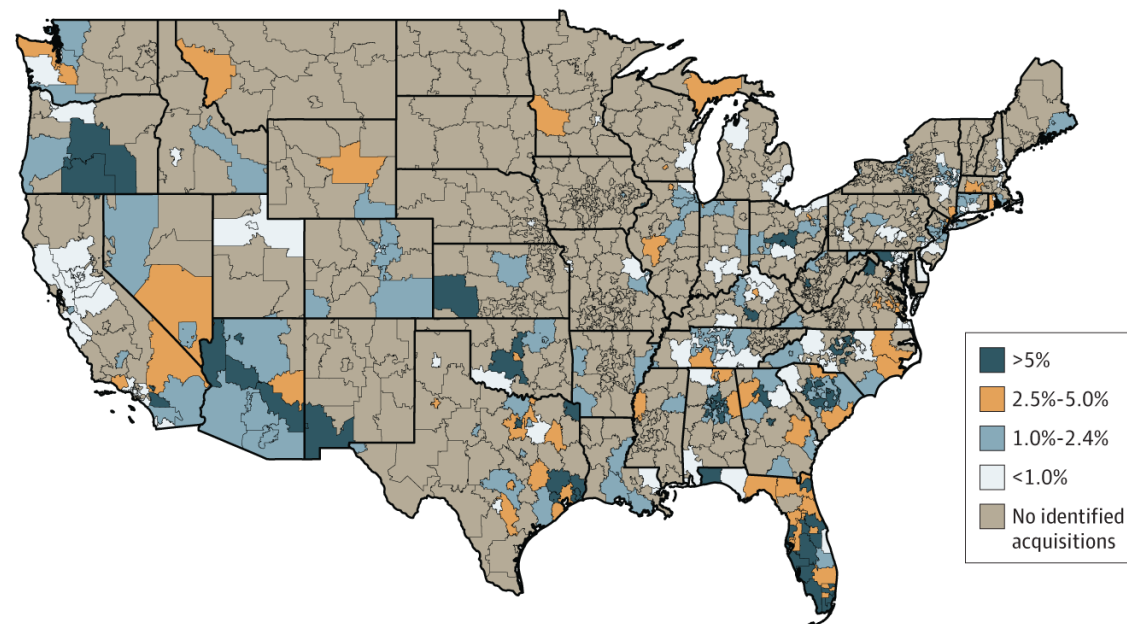
- **Availability of independent practices may play a role:** One study found that states with a high percentage of primary care practices that are affiliated with hospitals tended to have lower PE affiliation, but this evidence was descriptive not causal
- **PE has targeted larger practices:** Dermatology and urology studies found PE disproportionately targeted larger practices. Urology platforms also acquired smaller practices after establishing an initial platform
- **Practice revenue opportunities may matter:** Studies have found PE targeting practices with characteristics such as more commercially insured patients or ownership of ancillary services. However, the studies do not establish that these characteristics cause PE investment or that they predict investment at the state level

Share of Hospital and PE-affiliated Primary Care Physicians in 2022

A Share of hospital-affiliated PCPs



B Share of PE-affiliated PCPs



Questions for Discussion – Next Steps

- What additional questions do you have?
- Which component of investor ownership and influence should we focus on considering that our goal is to improve affordability?
- Do you have any additional comments on the focus and direction of the workgroup after today's presentations and discussion?



Next Steps



What: Commercial Healthcare
Prices Working Group

When: October 27, 1:30 – 4:30
pm

Where: Wilder Foundation,
Auditorium A



Stay tuned for:

- HCAATF meeting on
affordability standards
(meeting date TBD)

Thank You!

Center for Health Care Affordability

Health.Affordability@state.mn.us

References

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