

Summary: Investor Ownership and Influence in Healthcare Working Group | 9/24/2026

Date: September 24, 2026, 1:00 - 4:00 p.m.

Location: Amherst H. Wilder Foundation, Auditorium A

Meeting Summary and Key Themes

Alex Caldwell, Director of the Center for Health Care Affordability, opened the first Investor Ownership and Influence in Healthcare Working Group meeting. The group brings together members of the Health Care Affordability Advisory Task Force (HCAATF) and the Provider and Payer Advisory Task Force (PPATF) to investigate how investor ownership and business practices affect healthcare costs and affordability in Minnesota.

The first meeting focused on building a shared understanding of investor ownership in healthcare, with particular attention to private equity and outpatient care. Members discussed potential benefits of outside investment, concerns about how financial incentives may affect care and spending, what research shows about private equity, and what Minnesota-specific information the group will need before considering policy options.

Working Group Objectives and Roadmap

MDH defined “price” as the amount paid to a healthcare provider for a unit of service. This is different from a provider’s *cost* of delivering care, the *amount* listed on a bill or charge list, and *total* healthcare spending, which reflects both prices and the amount of care used.

The working group will initially focus on hospital inpatient and outpatient services. Its goal is to understand key commercial price issues, review policy options, and recommend a policy direction to the Health Care Affordability Advisory Task Force. The October 27 meeting will take a deeper look at related data and policies, and the December 2 meeting is intended to move toward recommendations.

Members said the group should continue refining the problem it is trying to address. They noted that focusing on high price levels, rapid price growth, or large price differences could lead to different policy approaches.

Investor Ownership and Influence in Healthcare

Julie Sonier of Mathematica described financialization as the growing role of financial companies, investors, and financial strategies in healthcare. This is different from corporatization, which refers to healthcare organizations becoming larger and more centrally controlled through mergers, acquisitions, and other forms of integration.

The presentation emphasized that outside investment may have benefits such as helping organizations pay for facilities and technology, supporting providers facing financial pressure, assisting ownership transitions when independent practice owners retire, supporting new models of care, and strengthening administrative and business systems.

At the same time, financial incentives can create affordability concerns when short-term revenue growth and investor returns become a stronger organizational priority. These concerns can include consolidation that increases negotiating power, efforts to increase the number or intensity of services, cost reductions that affect staffing or access to services, and financial arrangements that limit a provider's future flexibility.

In discussion, working group members highlighted the effects on patients and families as well as providers. They also raised questions about unnecessary testing, more frequent visits, changes in billing or coding, and other ways that financial incentives could increase spending. Members cautioned that management service organizations, or MSOs, vary widely and that the working group will need to take this into account.

Private Equity's Influence in the Healthcare Market

Erin Fuse Brown of Brown University reviewed how private equity operates in healthcare. Private equity firms raise money from investors, buy or gain control of companies, seek to increase their value, and later sell the investment. Compared with many other ownership models, private equity often uses more debt, provides less public information about its ownership and finances, and generally has a shorter investment period before sale.

In physician practices, private equity often uses a "platform and add-on" strategy. An investor first acquires or partners with a larger practice and then adds other practices in the same specialty or area. Building a larger organization can increase negotiating power with health plans and raise the value of the business when it is later sold.

In states that limit non-physician ownership of medical practices, private equity and other corporate investors may use an MSO to manage the business side of a practice. An MSO can provide services such as billing, staffing, contracting, finance, and operations. Members discussed the need to better understand which MSO arrangements support providers, and which may give outside investors too much control over business or clinical decisions.

Members also asked how Minnesota monitors compliance with its rules on who may own or control medical practices, what happens when a private equity-owned practice is sold to another investor, and how much financial return investors receive from healthcare investments. It was noted that limited transparency makes these questions difficult to answer.

Members asked why private equity investment activity increased around the COVID-19 period. Erin said low interest rates were likely an important factor because private equity acquisitions often use debt, making purchases less expensive when borrowing costs are low. Other healthcare-specific factors may also have contributed.

Impacts of Private Equity Ownership and Influence

Erin reviewed national research on private equity ownership and its effects on prices, spending, quality, staffing, and access. The strongest and most consistent evidence presented shows that prices and healthcare spending often increase after private equity acquisition. One study of dermatology, gastroenterology, and ophthalmology practices found that negotiated commercial prices increased by 11 percent after private equity acquisition compared with similar practices that were not acquired.

Other studies found changes in the number of services provided, the types of services offered, and use of higher-priced treatments. The specific strategy differs across specialties. For example, some practices may gain revenue by increasing patient volume, changing coding, using higher-priced drugs, or shifting toward more profitable services.

Evidence on quality is less consistent and depends on the type of provider. Studies of hospitals and nursing homes found some declines in staffing or quality after private equity acquisition. Studies of physician practices do not show a clear, consistent change in quality. Members also asked whether changes in the types of patients served could affect these results.

The group also discussed evidence that higher prices are not unique to private equity. Research presented at the meeting found that both hospital-affiliated and private equity-affiliated primary care practices had higher prices than independent practices. Members discussed whether future policy should focus on specific ownership types or on business practices that may increase affordability concerns regardless of who owns the organization.

Members also asked whether Minnesota's current healthcare transaction review law captures smaller physician-practice acquisitions and repeated "roll-up" transactions. Erin noted that some states use lower transaction thresholds, count the number of physicians involved, or review a series of smaller acquisitions together over time.

The group further discussed whether Minnesota should strengthen ownership reporting or its rules that limit non-physician control of medical practices. Erin noted that several states have recently changed these rules, but many of the policies are new and there is limited evidence about how well they work. She also noted that there is no single national database that reliably identifies private equity and other corporate ownership of physician and outpatient practices.

Understanding What Makes States More Attractive to Private Equity

Julie reviewed limited research on why private equity activity may differ across states. State laws on non-physician ownership and control of medical practices vary, and one study found more private equity hospital acquisitions after some states relaxed enforcement of these restrictions. However, the effects of newer ownership reporting and transaction review policies are not yet clear.

Research also suggests that private equity may be more likely to target larger practices or practices with stronger revenue opportunities. A national primary care study found lower measured private equity ownership in areas where more physicians were already affiliated with hospitals. The Upper Midwest showed this pattern, but the findings are limited to primary care, do not demonstrate causation, and do not support conclusions about whether Minnesota will attract future private equity investment in primary care or other specialties.

In looking to future meetings, members asked for a Minnesota-specific picture of health systems, independent practices, ownership types, MSO arrangements, and geographic differences. They also suggested looking beyond physicians to other outpatient settings and clinicians.

Closing and Next Steps

The November 6 meeting will focus on Minnesota-specific data on private equity ownership and affiliation and on Minnesota's current rules governing ownership and control of medical practices, including MSO arrangements.

The December 9 meeting will focus on policy options. The Commercial Healthcare Prices Working Group meets October 27, and the Health Care Affordability Advisory Task Force meets November 20.

ABOUT THE CENTER FOR HEALTH CARE AFFORDABILITY

The Minnesota Center for Health Care Affordability at the Minnesota Department of Health is committed to making health care more affordable for all Minnesotans.

The Center identifies cost drivers, provides transparent research, and advances solutions that stabilize health care spending so that Minnesotans can afford the high-quality care they need.

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