Summary: Investor Ownership and Influence in Healthcare Working Group Meeting | 11/6/2026

Date: November 6, 2026

Location: Amherst H. Wilder Foundation, Auditorium A

Meeting Summary and Key Themes

Alex Caldwell, Director of the Center for Health Care Affordability, opened the second Investor Ownership and Influence in Healthcare Working Group meeting. The meeting focused on private equity investment in Minnesota outpatient care settings, the landscape of physician practices and other outpatient facilities in Minnesota, and potential state policies to improve oversight of investor influence. Working group members were asked to discuss policy choices and tradeoffs, not to select a policy or make final recommendations.

Working Group Status Update

Alex reviewed the September meeting, which introduced national research on private equity and other investor involvement in healthcare, including evidence of higher prices or spending in some settings. She emphasized that these findings were not uniform across specialties or facility types and noted that the group should consider actions and business practices that may cause issues, rather than assume all investors or transactions have the same effect.

Working group members discussed what practices might be considered “problematic” behaviors and whether evidence suggests that private equity investment can lead to useful new services or technology. The working group’s concerns include spending that does not improve care, pressure to provide services patients may not need, outside influence over medical decisions, and high prices. Members noted that these problems can occur under different types of ownership. They also recognized that outside investment may help clinics buy equipment, adopt new technology, or keep services available, especially in rural areas and communities with fewer resources.

Co-chairs Joel Beiswenger and Sheila Kiscaden encouraged members to consider future needs and possible risks without discouraging investments that could improve care. Alex outlined the meeting agenda and previewed several policy options, which included healthcare transaction oversight authority, strengthening the prohibition on corporate practice of medicine, ownership transparency, and site-neutral payment policies. In the upcoming meeting on December 9th, working group members will consider possible policy approaches and make recommendations to the Health Care Affordability Advisory Task Force.

What We Know, What We Can Track, and Current Oversight of Private Equity in Minnesota

Dr. Yashaswini Singh of Brown University's Center for Advancing Health Policy through Research (CAHPR) presented research on private equity purchases of outpatient specialties in Minnesota between 2015 and 2026. Researchers identified 56 acquired practice locations across four areas of care: 27 ophthalmology locations, 13 opioid use disorder treatment locations, nine autism therapy locations, and seven dermatology locations. The locations were spread across 16 counties. Forty-three were in the Twin Cities area, and seven were in rural counties.

Dr. Singh noted important limitations of their analysis and explained that the numbers presented include practice locations, not individual business deals, doctors, or patients. Researchers used PitchBook Data, Inc., business records, company announcements, and other public sources. However, because many small purchases are not made public, the study likely undercounts investor activity. The analysis also did not cover every type of healthcare practice. Members pointed to possible investor activity in other fields, including mental healthcare, radiology, obstetrics and gynecology, and dentistry.

Dr. Singh noted that practices can change hands again after an initial private equity acquisition. Her presentation described 27 of the 56 identified locations as having been resold or closed. Working group members asked how repeated sales or closures might affect patients, clinicians, and the availability of care. Dr. Singh explained that the effects of how long an investor owns a practice, and of later sales, have not been established for Minnesota.

Dr. Singh also reviewed national studies. Some research has linked private equity acquisitions to higher prices paid by commercial insurers and changes in the services provided, but results vary by specialty. One study found prices increased by about 11 percent across certain ophthalmology, dermatology, and gastroenterology practices. Other findings included fewer time-sensitive retina surgeries after acquisition. She also described unpublished research suggesting higher autism therapy prices. These studies do not show whether the same changes occurred in Minnesota.

Dr. Singh noted that there are currently significant limits to what Minnesota can track and understand when looking at private equity involvement and influence in healthcare. The state does not have a complete registry of who owns or controls outpatient practices. Additionally, transaction reports are generally not public, and investor relationships or management agreements can be difficult to track. Researchers also cannot easily connect ownership information with data on prices, quality, access to care, staffing, and wait times. These gaps limit the state's ability to assess the effects of private equity investment.

Landscape of Physician Practices and Other Outpatient Facilities in Minnesota

Julie Sonier of Mathematica reviewed Minnesota Department of Health (MDH) data on physician practices, freestanding surgery centers, and diagnostic imaging facilities. Minnesota collects information on clinic locations and their affiliations with medical groups but does not collect information about who ultimately owns each business, who has invested in it, or which outside companies help manage it.

In 2023, the state's registry included more than 1,500 physician clinics: 599 primary care clinics and 925 specialty clinics. About 40 percent of primary care clinics were affiliated with Minnesota's five largest nonprofit health systems. Compared with 2012, more clinics were part of larger organizations, while fewer belonged to single-location practices or small groups with less than 10 facilities. Large health systems run many Minnesota clinics, but smaller physician groups still serve communities across the state. Some of these smaller clinics may later be candidates for or be purchased by health systems or companies backed by investors.

MDH also has information on more than 80 freestanding surgery centers and more than 250 diagnostic imaging facilities. These records do not include information about who has a financial interest in a facility or who influences how it operates.

State Policy Options to Improve Oversight of Investor Influence in Outpatient Clinics

Erin Fuse Brown of Brown University discussed four policy approaches that Minnesota could consider. Each focuses on a different concern, and the state could choose to pursue more than one.

Stronger Review of Healthcare Transactions

Minnesota law requires some larger healthcare businesses to notify the state before certain purchases or other changes in ownership. Fuse Brown explained that smaller deals, a series of small purchases, and complicated business arrangements may be difficult to track or may not have to be reported. The state could consider requiring reports on more types of deals and doing more to review investor conduct.

Stronger Corporate Practice of Medicine Prohibition

Minnesota law limits the ability of corporations to practice medicine or control doctors' medical decisions. Fuse Brown discussed how management companies or arrangements involving physician owners may still give outside investors significant influence over a practice. She reviewed a 2026 change to Minnesota law that made restrictions on corporations practicing medicine clearer. A separate proposal to address certain management service organization arrangements did not become law.

Fuse Brown also discussed Minnesota's rules on non-compete agreements, which generally prevent employers from making new agreements that limit where workers can take another job. Working group members raised questions about existing contracts, limits on non-compete agreements that restrict clinicians from changing jobs, and ways clinicians could report improper interference.

Clearer Information About Ownership and Control

Fuse Brown described how current data does not comprehensively record owners, parent companies, investors, and management organizations. One policy option would be a state registry that requires providers to report who owns or controls them and update the information when changes occur. Massachusetts' system for registering provider organizations was discussed as an example. Members asked what information

Massachusetts collects, how often organizations must report, which details are public, and whether the system has helped the state identify transactions of concern.

Site-Neutral Payment Policy

A site-neutral payment policy would seek to reduce payment differences when the same outpatient service can safely be provided in different settings, such as a hospital-owned clinic and an independent practice. Fuse Brown cited a national modeling study that estimated savings in Minnesota of $116.40 per commercially insured person each year if a particular policy option were put in place, based on 2022 data. This is an estimate, not a measured result from a specific Minnesota proposal. Members discussed potential savings as well as possible effects on hospital finances, practice affiliations, and the need for outside investment.

Discussion of Policy Choices and Tradeoffs

Working group members showed interest in all four policy options, with several members noting that improving ownership transparency could be a starting point for more effective oversight. Working group members explained that more transparent records could help Minnesota identify transactions of concern, evaluate effects on prices and quality of care, and help patients and employers understand who operates local services. Some working group members favored improving ownership reporting and transaction oversight together, while others cautioned against delaying action while collecting more data.

Working group members asked whether the state has the staffing and resources needed to review complicated business deals and contracts. They discussed whether the state should be able to see more agreements among insurers, healthcare providers, and management companies. They also asked how officials could track planned service closures and check whether businesses follow conditions placed on purchases. MDH noted that broader review would need a clear purpose, legal support, and staff who can examine the information.

Members also discussed whether site-neutral payment should be addressed by this working group or the Commercial Healthcare Prices Working Group. The policy relates more directly to hospital prices, but it could also affect decisions to buy or combine outpatient practices. Members did not remove any of the four policy options from consideration and will discuss key policy design decisions at their next meeting.

Closing and Next Steps

Alex outlined upcoming meetings. The Health Care Affordability Advisory Task Force will meet on November 20th to hear updates about the working groups. The Commercial Healthcare Prices Working Group will meet on December 2nd, and the Investor Ownership and Influence in Healthcare Working Group will meet again on December 9th to consider policy details and possible recommendations. CHCA indicated that meeting materials, the recording, and a public meeting summary would be available on its website.

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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