Regulating Financialization in the Healthcare System: A Toolkit for States

Prepared by Manatt Health

February 2025

Driving Innovation Across States

A grantee of the Robert Wood Johnson Foundation

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Questions? Email Heather Howard at heatherh@Princeton.edu.

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About Manatt Health

This toolkit was prepared by Patti Boozang, Eric Gold, and Michelle Savuto. Manatt Health, a division of Manatt, Phelps & Phillips, LLP, is an integrated legal and consulting practice with over 160 professionals in nine locations across the country. Manatt Health supports states, providers, and insurers with understanding and navigating the complex and rapidly evolving healthcare policy and regulatory landscape. Manatt Health brings deep subject matter expertise to its clients, helping them expand coverage, increase access, and create new ways of organizing, paying for, and delivering care. For more information, visit www.manatt.com/ManattHealth.aspx

Toolkit Objectives

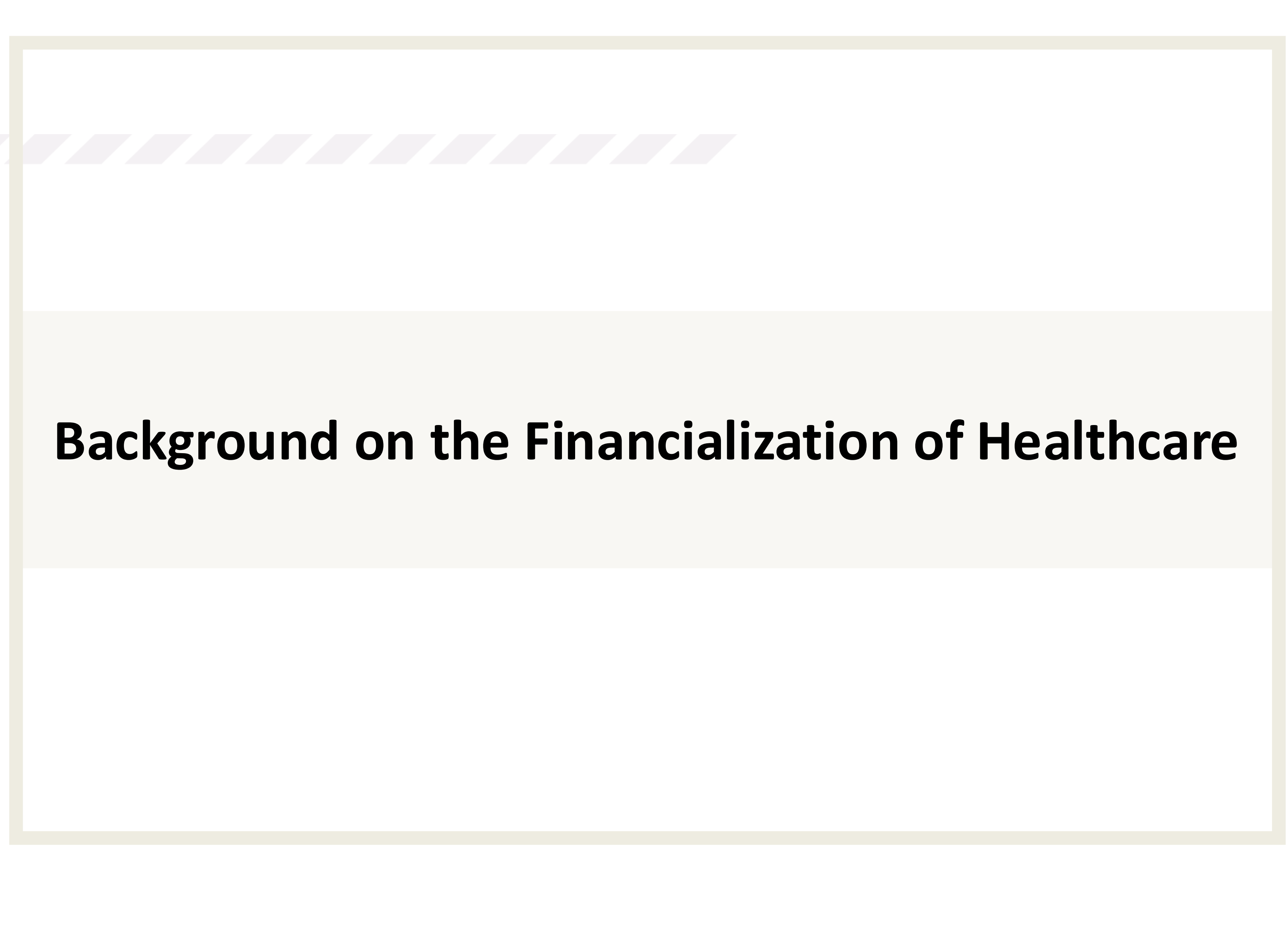
This toolkit is intended to support states in understanding the landscape of financial activity in the healthcare sector and opportunities to strengthen their regulatory framework to protect residents from the potential harms associated with financialization.

This toolkit:

Provides an overview of trends and a summary of the literature on the impact of financialization on the healthcare delivery system.

Describes recent federal action taken to study and regulate financial activity in the healthcare system.

Highlights recommendations and state best practices.


Background on the Financialization of Healthcare

What Is Financialization of Healthcare?

- The **process by which the financial sector and financial actors become more involved in the healthcare system** and use financial strategies to generate revenue.
- Inclusive of activity by **private equity (PE) firms, commercial/investment banks, venture capitalists, and other corporate entities**.

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 Maximation
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.

Sources: The Financialization of Health in the United States; Financialization in Health Care: The Transformation of US Hospital Systems.

What Motivates Private and Corporate Entities?

- **Investor-owned health service businesses vary** from large companies that own or operate many healthcare entities to independent institutions owned by local investors.

- The purpose of investor-owned corporations in general is to **make money for investors—to preserve and enhance the economic value of the invested capital. Healthcare is an attractive sector** as it is recession resistant and third-party government/private insurers guarantee payments.

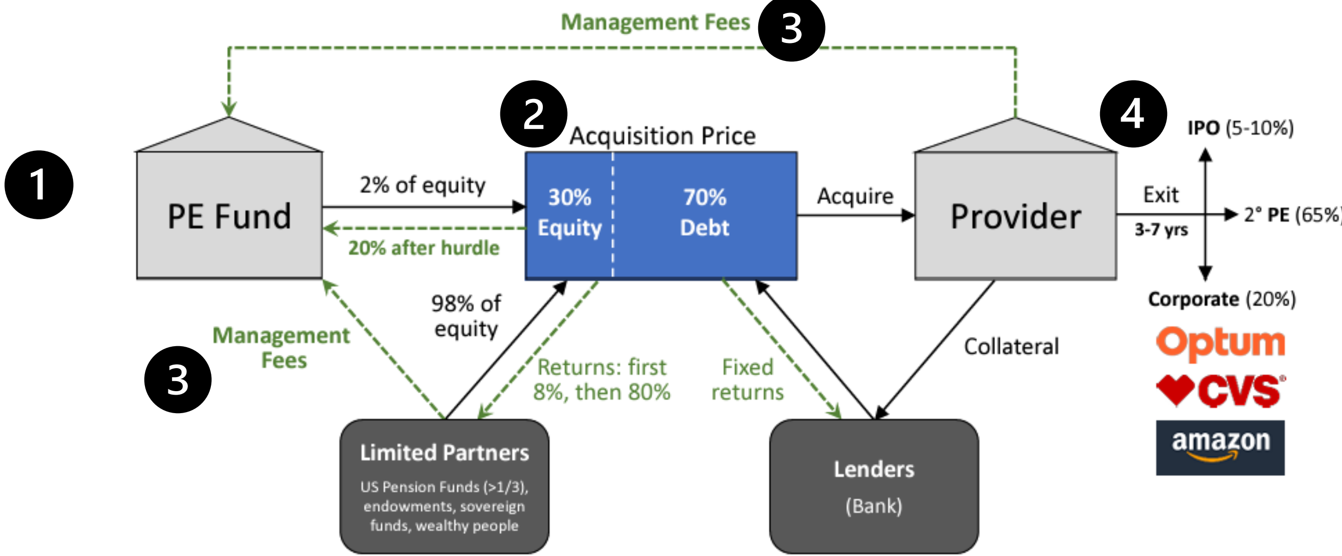
- Proponents of private and corporate investment point to the potential for increased access to capital, innovation, and operational efficiencies. **However, financialization often drives resource extraction without benefitting people, diversion of resources away from communities, and healthcare system inefficiencies.**

- **In particular, the PE business model is characterized by pursuit of significant profits over short periods of time and a reliance on debt to finance purchases (which can create moral hazards and encourage risk-taking). Some common financial tactics of PE firms include** *(see example on next slide)*:
  - "Roll-up" of multiple, small companies under one umbrella to consolidate market power and avoid federal transaction review.
  - Leveraged buyouts (i.e., heavy use of debt to privatize an organization).
  - Sale and leaseback of real estate (i.e., selling real estate to a third party and leasing it back).
  - Debt-funded dividends (i.e., acquisition of new debt to distribute a cash payout to investors).
  - Reduce costs or "asset stripping" (e.g., staffing cuts, reduce care for unprofitable patients or service lines).
  - Charge management fees to owned entities.

Sources: The Financialization of Health in the United States; Private Equity Hospital Tracker; Financialization in Health Care: The Transformation of US Hospital Systems.

Example PE Acquisition Model

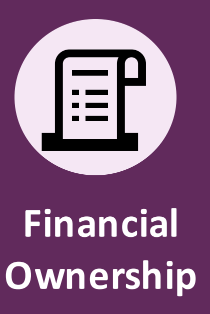
1. **A PE fund is typically set up as a limited liability company** that pools capital from institutional investors—pension funds, endowments, sovereign wealth funds—and high net worth individuals.
2. **PE funds purchase provider organizations using a significant amount of debt and only a small amount of their own equity. Debt is transferred to the acquired provider** by leveraging its physical assets (e.g., land, buildings) as collateral for the loan. The acquired provider must then **generate revenue or cut costs** to pay down the debt.
3. **The PE fund makes money through management fees**, typically 2% of assets under management that cover operational costs, and **performance-based fees** (also known as carried interest) that account for 20% of any investment gains above a certain threshold return.
4. **The PE fund invests for a short duration, typically three to seven years, before exiting** through selloffs, spin-offs, or initial public offerings.



Sources: Massachusetts Health Policy Commission, Board Meeting (December 2023). California Health Care Foundation, Private Equity in Health Care.

Summary of Financialization Trends (1/2)

The rise in financialization in the healthcare sector can be traced to economy-wide shifts that occurred in the 1970-80s.* A series of regulatory and policy changes empowered financial actors to make the U.S. healthcare system a core part of their growth strategy.



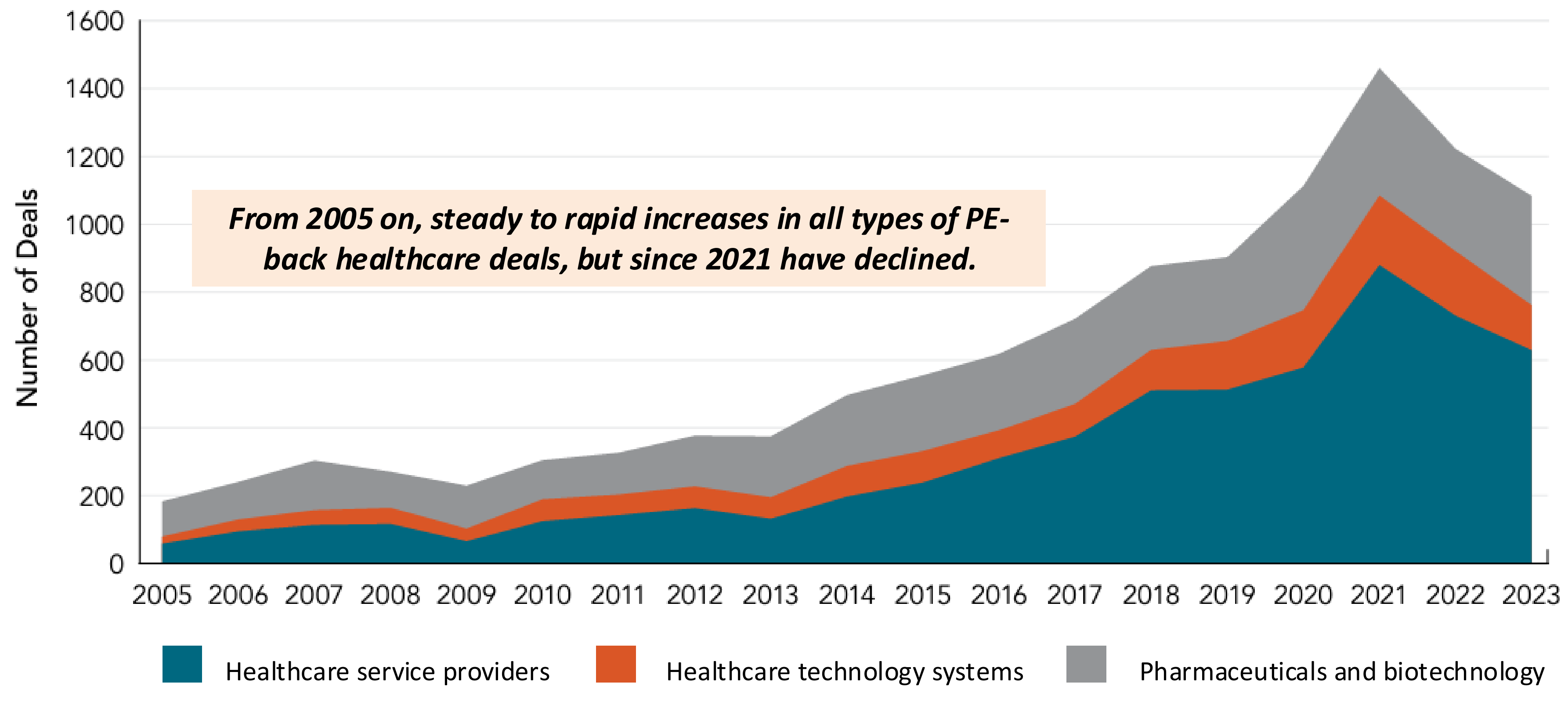
- In the past decade, **PE firms completed more than 8K transactions** involving healthcare entities ($1 trillion in value); however, recent federal and state regulatory scrutiny as well as broader economic factors have created a chilling effect.
- **Investment in physician specialties increased significantly**--more than 75% of doctors are employed by hospitals, health insurers, PE, or other corporate entities. Individual PE firms are acquiring competitively significant shares of local physician practice markets.
- **Though hospitals were once the primary focus of financial activity** (PE firms now own 4-6% of all acute care hospitals, focusing on for-profit hospitals in the mid-Atlantic/South and rural hospitals), **recently, there has been a shift toward more specialty markets** (e.g., in 2023, eye care, dental care, health information technology, medical technology, and home health were the five busiest sectors).

See graphs on next slides.

**More information on the history of regulatory and policy changes in the U.S. over time can be found here.*

PE Investment in Healthcare, 2005-2023

Number of Deals

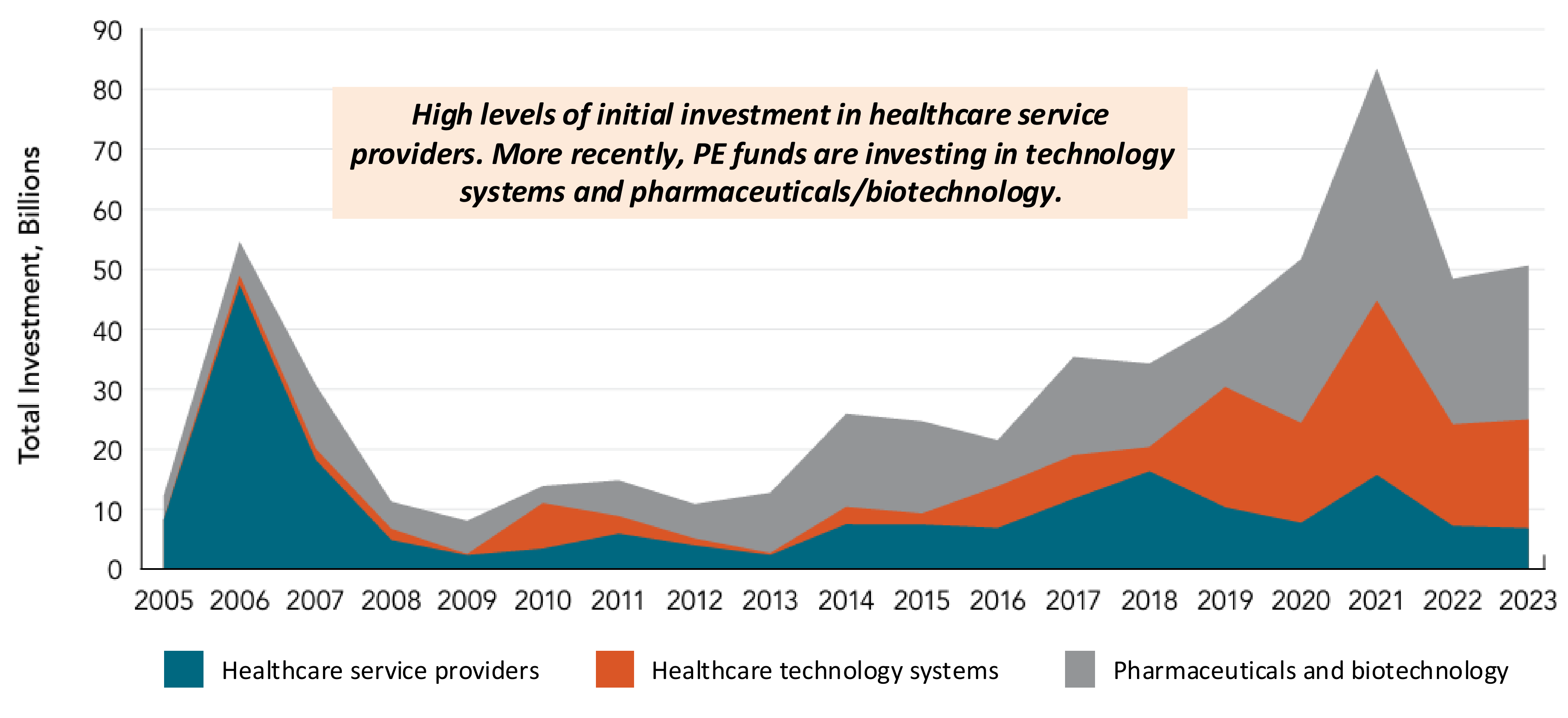


Notes: "Deals" include all buyouts, add-ons, and public-to-private deals. "Healthcare service providers" include hospitals/inpatient services, outpatient clinics, rehabilitation centers, and skilled nursing facilities. "Healthcare technology systems" include companies that provide revenue management, electronic medical records, or other technological services for healthcare providers and health systems. "Pharmaceuticals and biotechnology" include pharmaceutical manufacturers, drug discovery companies, and clinical trial management companies, among others.

Sources: California Health Care Foundation, Private Equity in Health Care: Prevalence, Impact, and Policy Options for California and the US.

PE Investment in Healthcare, 2005-2023

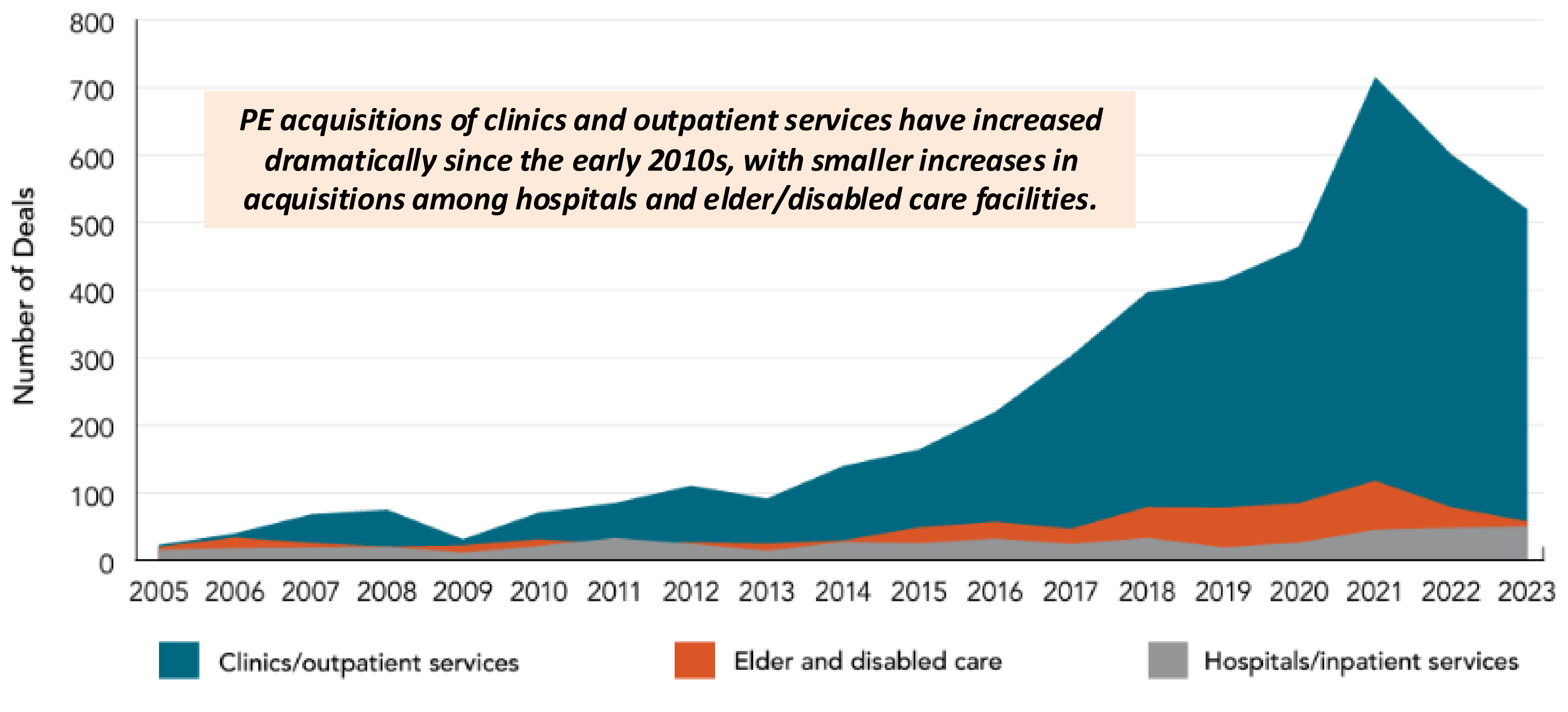
Total Investment ($)



Sources: California Health Care Foundation, Private Equity in Health Care: Prevalence, Impact, and Policy Options for California and the US.

PE Acquisitions of Healthcare Service Providers in the US, 2005-2023

Number of Deals



Sources: California Health Care Foundation, Private Equity in Health Care: Prevalence, Impact, and Policy Options for California and the US.

PE Acquisitions of Healthcare Service Providers in the US, 2005-2023

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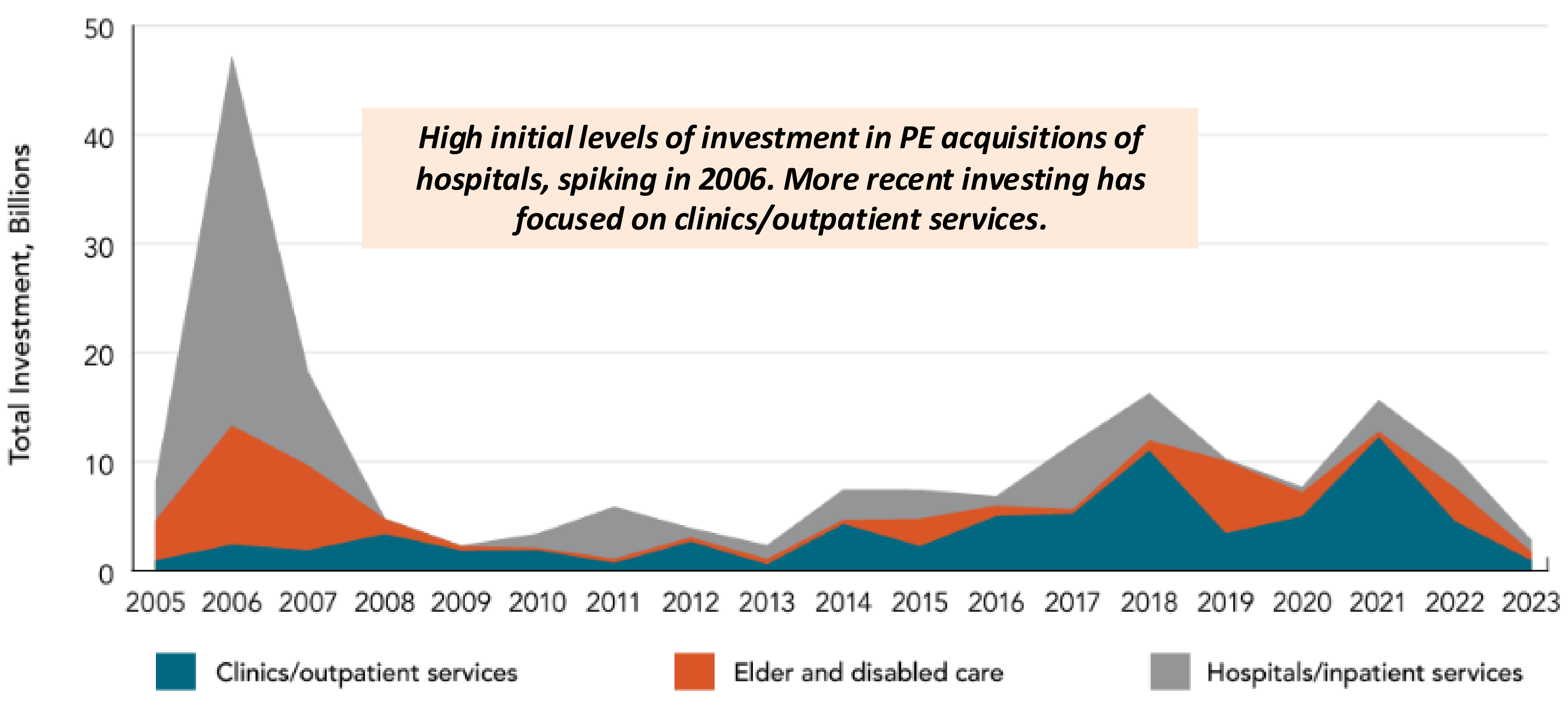

Sources: California Health Care Foundation, Private Equity in Health Care: Prevalence, Impact, and Policy Options for California and the US.

PE Investment Trends by Area

- PE has accounted for more than **60% of all behavioral health deal flow** since 2018.
- **In 2022, 6.2% of mental health agencies and 7.1% of substance-use agencies were owned by PE firms.** In some states, PE ownership of behavioral health facilities is even higher (e.g., 25%).

- **PE ownership in nursing homes fell** to 5% of all U.S. facilities by 2022, down from a high of 8% in 2018. Now investment is centering on in-home care: from 2018 to 2019, PE was involved in nearly half of home healthcare industry deals.
- PE deals in **hospice** have risen 25% between 2011 and 2020.

- Since the mid-2010s, **PE firms have become dominant players in the market for autism services.** Between 2017 and 2022, PE firms completed 85% of all mergers and acquisitions in autism services.

- **More than 40% of the country's emergency rooms** are overseen by for-profit health care staffing companies owned by private equity firms.
- From 2009 to 2019, **PE-backed investment grew** from 3.2% and 8.6% of the national **anesthesia and emergency medicine markets**, respectively, to 18.8% and 22%.
- Between 2013 and 2023, **PE firms bought 41 cardiology practices in the U.S.,** with the vast majority of transactions (94.7%) occurring since 2021.

Additional information and resources can be found at the PE Stakeholder Project.

Summary of Financialization Trends (2/2)

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Investment and Protection of Shareholder Interests</td>
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- **Healthcare venture capital funds grew exponentially in the last decade**, exceeding $28 billion in 2021.
- **Real-estate investment trusts (REITs) are a growing share of U.S. healthcare real estate,** as financial analysts have identified that medical properties can yield higher returns for investors if they are separated from healthcare operations and sold.

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Use of Financial Strategies by Healthcare Entities</td>
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- **Hospitals have aggressively pursued mergers** (including vertical, horizontal, and cross-market mergers) to improve their negotiating position with insurers and create economies of scale.
- **Many non-profit hospitals have launched investment arms**, creating new financial risks.
- **Hospitals are increasing their focus on actions that improve or maintain their credit ratings** to ensure that financial investors purchase bonds to finance hospital construction or capital improvements.

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Research Findings

Emerging research highlights the impact of financialization on healthcare quality, costs, and access. These impacts create obstacles to state and federal action to improve population health outcomes.

Quality of Care

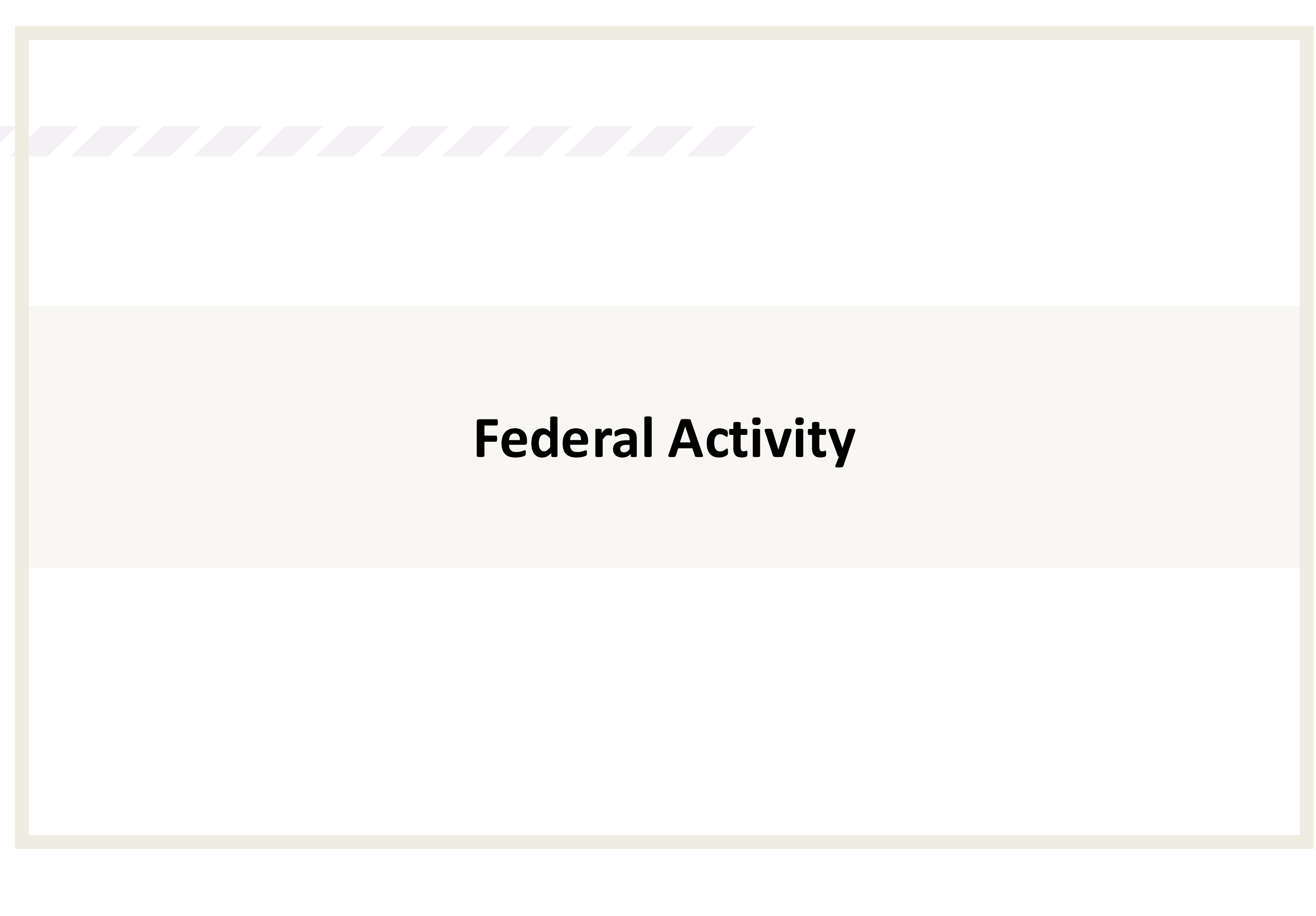
- **Hospitals**: Increased hospital-acquired adverse events (e.g., falls, infections), increased transfers to other hospitals, and decreased staffing.
- **Physician Practices**: Physicians report increased burnout and loss of autonomy over clinical decisions. Further, associations with higher prices and increased utilization, without requisite increases in quality.
- **Nursing Homes:** Associated with higher costs, acute care visits, lower patient mobility, and mortality rates than non-PE owned homes.
- **Other Healthcare Settings:** A broad literature review found mixed to harmful impacts on quality associated with PE ownership.

Anti-Competitive Behavior

- **Increased Consolidation** is a key driver of increased healthcare costs.
- **Increasing Charges and Negotiated Prices with Insurers:** Associated with increases in costs to patients and payers. Hospitals acquired by PE increased prices 7-16%; and PE-acquired physician practices increased prices by 4-20%.
- **Investor Pressure to Increase Revenues:** Increased exploitation of billing loopholes, overutilization, upcoding, aggressive risk coding, harming patients through unnecessary care, and excessive or surprise bills.

Access Barriers

- **Disrupting Continuity of Care:** Several recent PE-owned facility closures (e.g., Steward hospitals, Skyline nursing homes) have created major disruption for patients, particularly in areas with healthcare provider shortages (hospitals under PE ownership tend to be in lower income and rural areas).
- **Reducing Access to Preventive Care:** Closing facilities have been shown to reduce preventative treatment options resulting in communities of color experiencing higher rates of mental health crises and emergency department use.



Federal Activity

Activity Under the Biden Administration

Presidential Action

In July 2021, **President Biden issued an executive order promoting competition** in the economy, prompting agency action to enforce antitrust law and address "excessive" market consolidation.

Congressional Action

- **Congress has considered Democrat-sponsored legislation** to address potential adverse consequences from financialization (e.g., Corporate Crimes Against Health Care Act, Stop Wall Street Looting Act).
- **The Senate Budget Committee released a bipartisan staff report** on the harmful effects of PE on the healthcare system in January 2025 (*the report also recounts previous Congressional Committee work/hearings*).

Agency Action

- **The Department of Justice (DOJ) and the Federal Trade Commission (FTC) have aggressively investigated** the antitrust implications of some transactions and increased oversight over smaller acquisitions that previously avoided scrutiny. In December 2023, the FTC, with the DOJ, issued updated Merger Guidelines; and successfully sued to block a proposed acquisition of two hospitals under this new framework.

- **The U.S. Department of Health and Human Services (HHS) has focused on ownership transparency** for providers (e.g., nursing homes, federally qualified health centers). A final rule issued in 2023 required nursing homes to disclose ownership and management information to the Centers for Medicare & Medicaid Services (CMS). HHS recently released guidance to prevent surprise billing in accordance with the No Surprises Act (NSA).

- In March 2024, the **FTC, DOJ, and HHS jointly launched a cross-government public inquiry** into PE and other corporations' increasing control over healthcare, issuing a public request for information. Over 90 multi-issue local, state, and national organizations submitted comments. The full report is available here.

Spotlight: Current FTC Policy Levers

Impact/Level of Effort

Review and sue to block "acquisitions that substantially lessen competition."

Sue to stop "unfair methods of competition" or "unfair or deceptive acts or practices."

Issue rulemaking that identifies unfair competition or deceptive practices (e.g., billing practices, sale of facilities).

Conduct studies and issue public reports/statements.

Issue guidance on an array of health practices.

Submit amicus briefs in litigation.

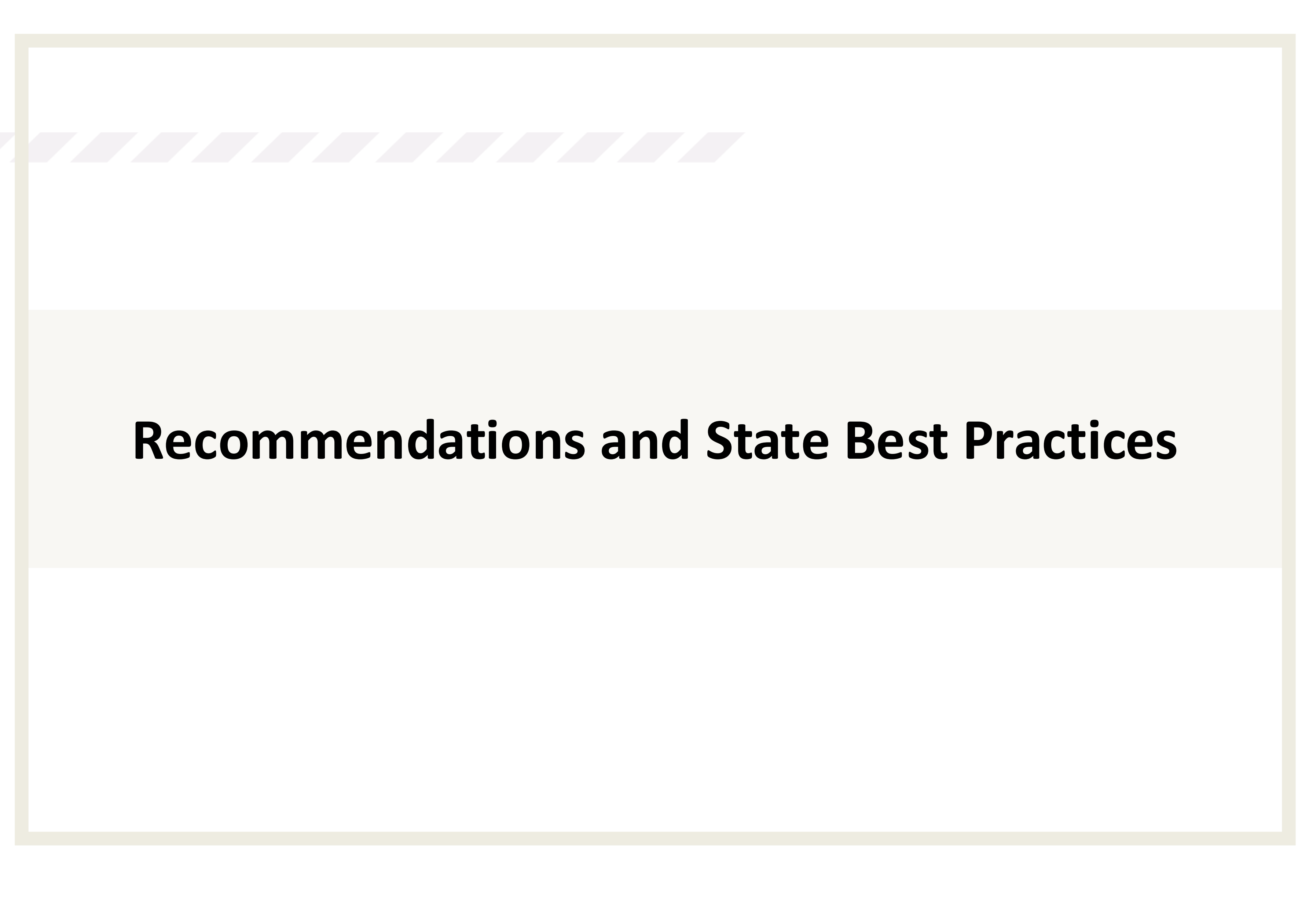
Make recommendations to Congress for legislation or testify in support of legislation.

Submit comments on other agencies' proposed regulations.

Sources: FTC, The FTC's Health Care Work. For more information regarding how FTC and DOJ work together to address anticompetitive activity, see here.

Initial Actions Taken by the Trump Administration

- **The second Trump administration's policies related to antitrust enforcement and mergers/deal-making are still emerging, but the focus so far has centered on "Big Tech."**
- On January 30th, 2025, the Trump administration **took its first antitrust action**, announcing a lawsuit to block a proposed $14 billion **tech industry deal**.
- **President Trump's choice for AG, Pam Bondi (former Florida AG), has promised to continue to pursue antitrust enforcement.** It remains to be seen how Bondi will approach ongoing litigation begun under the Biden administration (e.g., UnitedHealth's acquisition of the health and hospice provider Amedisys) or whether she may withdraw the DOJ/FTC 2023 Merger Guidelines.
- **Gail Slater, an antitrust veteran and economic advisor for Vice President JD Vance, will lead the DOJ's antitrust division.** JD Vance has said antitrust officials should take a broader approach to enforcement.
- **The FTC commissioners under the Trump administration will be led by three Republicans and two Democrats.** The new chairman, Andrew N. Ferguson, has been a vocal opponent of the Biden administration's approach to FTC rulemaking.

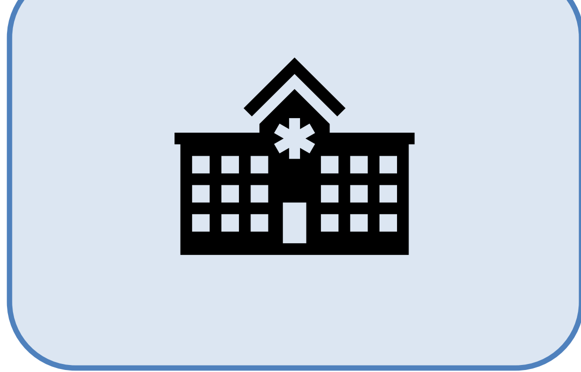


Recommendations and State Best Practices

Recommendations Overview

The following are recommendations for states on how to leverage their authority to regulate financial activity in the healthcare system and conduct ongoing oversight to protect patients and communities.

Strengthen Transparency, Promote Competition, and Prevent Market Abuses



Support Community-Based Care

Enhance Quality and Safety Protections

Strengthen Transparency, Promote Competition, and Prevent Market Abuses

Recommendation	State Examples
Adopt a new, or revise the existing, transaction notice and transparency framework to cover a broad range of healthcare entities and types of transactions.	**30 states and the District of Columbia (DC)** require notification of healthcare transactions to a state's department of health, AG, and/or other state entity. The timeline for notice, required submissions, level of detail, and requirements for public posting vary by state. **CT** requires a **30-day notice** to the AG before a company acquires a physician practice or hospital. **NY** requires notice **detailing a "material transaction"** involving a healthcare entity, including listing of the parties' names, copies of definitive agreements, and locations impacted by the transaction. **OR** requires any corporate mergers or acquisitions made up of providers, hospitals, or provider organizations to **submit notice to the State Health Policy Commission or AG if the corporation had an average annual revenue of $25 million or more in the three most recent years.**

The state may want to **review their definitions for key terms** (e.g., control, material change transaction, ownership or investment interest) for opportunities to strengthen existing regulations/legislation; or consider these definitions for new regulations/legislation.

Strengthen Transparency, Promote Competition, and Prevent Market Abuses

Recommendation	State Examples
Require a state entity or AG to review and approve all transactions involving private or corporate entities in the state's delivery system.	**14 states** have enacted healthcare transaction oversight laws that require pre-closing review. Each state operates a distinct review process with varying requirements on which parties must file, what information must be provided, how much notice parties must give, and what authority a regulator has to modify or block a transaction. **RI requires certain transfers in ownership, assets, membership interest, authority or control of a hospital in the state to gain approval by both the Department of Health and the Rhode Island Department of the AG** under the authority of the Hospital Conversions Act (which covers any transaction involving the transfer of 20% or more of any ownership interests or assets of a hospital). The RI AG and Department of Health may take over **180 days to approve** such transactions before the parties are permitted to close. **Parties must provide a broad set of information** on the relevant hospitals in the notice, including organizational, financial and operational documents; board minutes; and patient statistics for the prior three years. **OR,** through its "Health Care Market Oversight" program, **reviews proposed healthcare transactions to assess their potential impacts on healthcare costs and access for Oregon residents**, essentially acting as the entity responsible for reviewing these transactions instead of the State Health Policy Commission or AG.

Strengthen Transparency, Promote Competition, and Prevent Market Abuses

Recommendation	State Examples
Use licensing and/or regulatory authority to ensure operators continue to be in good standing.	Currently, **35 states/DC** operate certificate or determination of need (CON/DON)* programs, with wide variation by state. **Some states (DE, NC, VA) require health facilities to establish financial assistance policies** and provide **discounted care** to certain patients (e.g., low-income, elderly) as a condition for CON approval. **MA requires that before approving a new DON project that the Department has consulted with "all Government Agencies"** and determined that the entity applying for the new project is in "compliance and good standing with federal, state and local laws and regulations."

*CON/DON laws are state regulatory mechanisms for approving major capital expenditures and projects for certain healthcare facilities. In a state with a CON/DON program, a health planning agency or other entity must approve the creation of new healthcare facilities or the expansion of an existing facility's services in a specified area. CON/DON programs primarily aim to control healthcare costs by restricting duplicative services and determining whether new capital expenditures meet a community need.

Strengthen Transparency, Promote Competition, and Prevent Market Abuses

Recommendation	State Examples
Ensure the AG has authority, health policy expertise, and political support to bring suit to enforce antitrust or other state merger laws.	**States can bring legal challenges** to proposed hospital and provider mergers under federal and state antitrust law or to enforce conditions on non-profit conversions, some examples include: **CA's** AG joined a lawsuit in 2018 initiated on behalf of some group health plans against Sutter Health, a large nonprofit health system in the state. The parties argued that Sutter had used **anticompetitive contract clauses**—such as all-or-nothing and anti-tiering provisions—to increase prices. In 2019, Sutter agreed to a settlement agreement that required the system to abandon the relevant contract clauses and to pay $575 million in damages, among other things. **PA** filed a lawsuit against Prospect Medical Holdings, Inc., regarding years of the **company's mismanagement and neglect** of Delaware County-based Crozer Health System, **which resulted in closures of facilities.** The lawsuit also sought a preliminary injunction to preserve existing service lines, the appointment of a receiver to manage the Crozer Health System for the immediate future to avoid additional closures and cuts to services.

Support Community-Based Care

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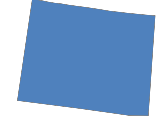
<tr><td>Revise and/or strengthen the state's enforcement of corporate practice of medicine (CPOM) laws* and regulate exemptions and workarounds (e.g., <u>Friendly Private Corporations</u>).

*CPOM laws are regulations that prohibit standard corporations (or other non-physician entities) from practicing medicine or employing practicing physicians.</td><td><u>33</u> states have CPOM laws (more detail available <u>here</u>). In 22 states, nonprofit entities are exempt from the oversight of CPOM laws (four states allow exemptions if the physicians have decision-making autonomy). 11 states have no non-profit exemptions.

<u>CA</u> has one of the strongest prohibitions on the CPOM, with more active enforcement than most other states. Corporations may not practice medicine nor facilitate the practice of medicine. The ban extends to other licensed clinical professions (e.g., dentists, psychologists). Corporations may not “indirectly” practice medicine by unduly controlling a physician's work. Consequences of CPOM violations include criminal sentencing, exposure to lawsuits, risk of insurance claw backs, or claims denials.


In <u>CO</u>, corporations can conduct the practice of medicine only if the shareholders of the corporations are actively licensed physicians or physician assistants. There are no exemptions for this law, including for nonprofit organizations.

<u>NY</u> enforces one of the strictest prohibitions (relative to other states). NY law prevents for-profit publicly traded companies from operating hospitals. The state has strict rules on CPOM, including governing the type of management fee(s) that a professional corporation can pay an affiliated management service organization, as well as strict naming rules and requirements.</td></tr>
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Support Community-Based Care

Recommendation	State Examples
Prohibit leasing land from REITs.	**MA** passed a **new market oversight law** in 2024 that, among other provisions, adds new authorities related to REITs. The Department of Health is prohibited from issuing or renewing a license to an acute-care hospital if the main campus of the hospital is leased from a healthcare REIT. **MN** introduced a bill in 2024 whereby PE companies and REITs would be **prohibited from acquiring or increasing ownership interest in individuals or entities that provide healthcare services in the state.**
Invest in improving access to care in healthcare shortage areas.	**GA** created the **Rural Hospital Stabilization Grant Program** in 2016, which provides **funding to rural hospitals to improve financial and operational stability.** Hospitals participating in the program are required to evaluate community and hospital needs, assess current service lines, and submit funding proposals designed to strengthen the hospital's financial base.

Enhance Quality and Safety Protections

Recommendation	State Examples
Implement minimum staffing requirements and quality standards above federal standards.	**CA** set **minimum requirements for skilled nursing facilities** in 2017, however, the state has struggled to achieve universal compliance. **OR** passed legislation in 2023 to **adopt mandatory nurse staffing ratios** and is the first state to **memorialize these ratios in statute**. The law also provides for wall-to-wall staffing committees, investigations, and enforcement when hospitals fail to follow the law.
Limit surprise medical billing above federal standards and monitor price increases.	**Several states** have surprise billing laws that include protections beyond the federal NSA requirements: **WA** enacted legislation that **expands protections to medical specialties** not previously covered (e.g., behavioral health providers) and to coverage of post-stabilization services. **WV** and **MD** passed laws giving their **insurance commissioners authority to enforce** the NSA. **States like DE, CT, MA, OR, RI and WA** have established commissions to **monitor healthcare costs and/or set cost growth targets.**

The state may also consider establishing a task force (e.g., regulatory agencies, legislators, and community stakeholders) to develop policy recommendations related to (1) promoting non-profit ownership of healthcare facilities; and/or (2) ensuring access to care in rural and under-resourced communities.

Key Questions to Ask Healthcare Entities Applying for Licensure

Application Section	Questions and Considerations
Administration and Ownership Information	• Require identification of "each beneficial owner" of the company, their full name, date of birth, and current address (Note: states may define "beneficial owner" as anyone who has "substantial control" over the company OR owns at least 25% of the company). • Management company information, as applicable, and any adverse actions against the company. • Require background checks on all administrators and beneficial owners. • Require a copy of the lease or financing arrangement for facilities/properties.

Qualifications	• Include in application forms questions and assessments regarding:
	   o Operating history (e.g., denial, suspension, or revocation of provider license in the state/other state).
	   o Criminal convictions (e.g., assaults, patient/elder abuse, health and safety violations, controlled substances).
	   o Financial health (e.g., debt, bankruptcies, revenues, costs, facility closings or phasedowns, projected patient days, occupancy rate, mortgages, line of credit).
	• Establish clear thresholds/circumstances under which the state would deny licensure for each qualification question or criterion (e.g., debt threshold).

For example applications, see CA, MA, and WI.

Model State Legislation

States may consult the National Academy for State Health Policy model legislation, which provides draft language to address issues of corporate and PE entry into healthcare markets, healthcare consolidation, and closures of key service lines or facilities.

The model legislation includes language that:

- Updates definitions to reflect current market conditions.
- Extends healthcare market and transaction oversight to corporate changes of control of healthcare provider groups (including management services organizations), real estate sale-leasebacks involving healthcare entities, and planned closures of facility or service lines.
- Strengthens laws regulating CPOM and physician non-competes.
- Requires transparency of healthcare ownership and control structures.

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Committed to improving the health and well-being of all people across every state.

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UPDATED ON 07-26-2024

Comprehensive Consolidation Model Addressing Transaction Oversight, Corporate Practice of Medicine and Transparency

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Summary: Model legislation for states to address the issues of corporate and private equity entry into health care markets, health care consolidation, and closures of key service lines or facilities. Key provisions include measures that (1) update definitions that reflect current market conditions; (2) extend health care market and transaction oversight to corporate changes of control of health care provider groups (including management services organizations, or MSOs), real estate sale-leasebacks involving health care entities, and planned closures of facility or service lines; (3) strengthen laws regulating the corporate practice of medicine and physician non-competes; and (4) require transparency of health care ownership and control structures.

Definitions: As used in [this Act], the following words shall have the following meanings:

"Affiliate" means:

a. A person, entity, or organization that directly, indirectly, or through one or more intermediaries, controls, is controlled by, or is under common control or ownership of another person, entity, or organization;

b. A person whose business is operated under a lease, management, or operating agreement by another entity, or a person substantially all of whose property is operated under a management or operating agreement with that other entity;

c. An entity that operates the business or substantially all the property of another entity under a lease, management, or operating agreement; or

d. Any out-of-state operations and corporate affiliates of an affiliate as defined in a, b, or c herein, including significant equity investors, health care real estate investment trusts and management services organizations.

"Control," including the terms "controlling," "controlled by," and "under common control with," means the direct or indirect power through ownership, contractual agreement, or otherwise:

a. to vote more than [10 percent] or more of any class of voting shares of a health care entity; or

b. to direct the actions or policies of the specified entity.

Sources: NASHP, Comprehensive Consolidation Model Addressing Transaction Oversight, Corporate Practice of Medicine and Transparency.