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ARTICLE

Private Equity and the Corporatization of Health Care

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Abstract. Private equity has rapidly enlarged its presence in the health care sector, expanding its investment targets from hospitals and nursing facilities to physician practices. The incursion of private equity is the latest manifestation of a long trend toward the corporatization and financialization of medicine. Private equity pools investments from large private investors to buy controlling stakes in companies through leveraged buyouts or similar arrangements that use the companies' own assets to finance debt. These investors seek to earn handsome profits by rapidly increasing revenues before selling off the investment.

Private equity's incursion into health care is especially concerning. The drive for quick revenue generation threatens to increase costs, lower health care quality, and contribute to physician burnout and moral distress. These harms stem from market consolidation, overutilization and upcoding, constraints on physicians' clinical autonomy, and compromises in patient care. Policymakers attempting to counter these threats can barely keep up. Like a cloud of locusts, private equity moves so quickly that by the time lawmakers become aware of the problem and researchers study the effects, private equity has moved on to other investment targets.

While it remains unclear whether private equity investment is fundamentally more threatening to health policy than other forms of acquisition and financial investment—

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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. The emphasis on short-term returns and exit, the heavy reliance on debt, and the insulation from professional and ethical norms make private equity investors more avid to exploit revenue opportunities than institutional repeat players. Thus, this Article's central claim is that the influx of private equity into health care poses sufficient risks to warrant an immediate legal and policy response. Public policy should primarily target market failures and payment loopholes and only secondarily curb private equity investment per se.

The good news is that we already have many tools under federal and state law with the potential to address the harms of commercialization. These can be used or sharpened to address the particular concerns raised by private equity's incursion into physician markets. Key tools include antitrust oversight, fraud and abuse enforcement, and state laws regulating the corporate practice of medicine and the terms of physician employment. In some instances, legislative or regulatory action may be needed to adapt existing laws. In other instances, new laws may be needed to close payment loopholes or correct market distortions. A leading example is the recent No Surprises Act, which curtails surprise out-of-network medical billing.

While the Article lays out a roadmap for additional legal and policy actions to protect the health system from the acute risks of private equity, these are patches rather than systemic solutions. If these patches fail to stave off the incessant march toward commercialization of health care, we may see renewed calls to fundamentally rethink the market orientation of the U.S. health system.

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Introduction

Policymakers and policy advocates are growing increasingly alarmed by private equity's (PE) investment influx into various sectors of the economy, especially health care. The alarm bells started ringing two decades ago when private equity companies began purchasing and selling hospitals and skilled nursing facilities. As PE has moved into physician practices, concerns have intensified about PE's effects on the quality and availability of patient care, physicians' clinical decisions, and rising health care costs.[1]

Private equity differs from other forms of health services investment in three critical ways. First, the investment comes from lay entities or individuals, meaning that investors lack professional and institutional obligations to promote the higher ethical goals of medical care.[2] Second, PE investment is heavily debt-financed. For example, a typical leveraged buyout (LBO) uses the assets of the underlying business to secure much of its purchase price.[3] Third, traditional PE investors aim to reap their profit rewards over a much shorter term than do conventional corporate investors or venture

1. For scholarly assessment of the risks posed by private equity's entry into health care markets, see, for example, Eileen Appelbaum & Rosemary Batt, *Private Equity Buyouts in Healthcare: Who Wins, Who Loses?*, at 5 (Ctr. for Econ. & Pol'y Rsch., Working Paper No. 118, 2020), https://perma.cc/Y66A-A8KS; John E. McDonough, *Termites in the House of Health Care*, MILBANK Q. OP., Nov. 2022, https://perma.cc/TL9V-YMZ9; RICHARD M. SCHEFFLER, LAURA ALEXANDER, BRENT D. FULTON, DANIEL R. ARNOLD & OLA A. ABDELHADI, MONETIZING MEDICINE: PRIVATE EQUITY AND COMPETITION IN PHYSICIAN PRACTICE MARKETS 9, 30 (2023), https://perma.cc/UFY8-XXZG; Jane M. Zhu & Daniel Polsky, *Private Equity and Physician Medical Practices—Navigating a Changing Ecosystem*, 384 NEW ENG. J. MED. 981, 982-83 (2021), https://perma.cc/S4DG-Y6YP.

   For journalistic coverage and opinion pieces expressing concerns over private equity investment in health care, see, for example, Reed Abelson & Margot Sanger-Katz, *Who Employs Your Doctor? Increasingly, a Private Equity Firm: A New Study Finds that Private Equity Firms Own More Than Half of All Specialists in Certain U.S. Markets*, N.Y. TIMES (July 10, 2023), https://perma.cc/NT3C-2PEL; Brendan Ballou, Opinion, *Private Equity Is Gutting America—And Getting Away with It*, N.Y. TIMES (Apr. 28, 2023), https://perma.cc/2F5Z-VDF3; Robert Pearl, *Private Equity and the Monopolization of Medical Care*, FORBES (Feb. 20, 2023, 4:00 AM EST), https://perma.cc/J3E3-BZS4; Yasmin Rafiei, *When Private Equity Takes Over a Nursing Home*, NEW YORKER (Aug. 25, 2022), https://perma.cc/2TEC-98Q8; Wendi C. Thomas, Maya Miller, Beena Raghavendran & Doris Burke, *This Doctors Group Is Owned by a Private Equity Firm and Repeatedly Sued the Poor Until We Called Them*, PROPUBLICA (Nov. 27, 2019, 1:00 PM EST), https://perma.cc/QER7-9TLX; Fred Schulte, *Sick Profit: Investigating Private Equity's Stealthy Takeover of Health Care Across Cities and Specialties*, KFF HEALTH NEWS (Nov. 14, 2022), https://perma.cc/5WAS-UMRA; Jeanne A. Markey & Raymond M. Sarola, Opinion, *Private Equity, Health Care, and Profits: It's Time to Protect Patients*, STAT (Mar. 24, 2022), https://perma.cc/SA27-PL9F.

2. Appelbaum & Batt, *supra* note 1, at 5, 7-8.

3. *Id.* at 6.

capital (VC) firms.[4] Accordingly, PE investors seek to generate substantial increases in the enterprise's operating profitability in just a few years before exiting the investment.[5]

PE's push for rapid revenue growth and quick exits generally means that PE is not adding value to patient care. Instead, PE seeks to strip the target's assets, load up the target with debt, slash costs (usually through staffing cuts), aggregate market power, and exploit payment loopholes to rapidly achieve investment returns without attendant quality improvements for patients. In this way, PE financializes health care, using health care entities as a means to extract wealth for investors, thereby prioritizing quick profits at the expense of patient care.[6]

PE investors in health services often find and exploit market vulnerabilities in a manner that raises significant public policy concerns. Public policy analysts can use PE firms' investment activities as a sentinel to identify dysfunctional markets that are being mined for profit. After initially targeting institutional entities such as hospitals and nursing homes about a decade ago, PE investors began to move into hospital-based physician-specialty markets such as emergency medicine and anesthesiology. PE investors found they could exploit the ability of these specialties to engage in surprise out-of-network billing to rapidly increase revenues.[7] More recently, PE has moved beyond the hospital-based specialties that can use surprise billing as a revenue strategy to procedural specialties (like gastroenterology, dermatology, ophthalmology, and orthopedics) that offer lucrative in-office procedures and ancillary services.[8] Private equity has also begun to invest in primary care

4. *Id.* at 7-8; Umar Ikram, Khin-Kyemon Aung & Zirui Song, Commentary, *Private Equity and Primary Care: Lessons from the Field*, NEJM CATALYST 2-3 (2021), https://perma.cc/3ZSC-9AZN; Atul Gupta, Sabrina T. Howell, Constantine Yannelis & Abhinav Gupta, *Owner Incentives and Performance in Healthcare: Private Equity Investment in Nursing Homes* 9-10 (Nat'l Bureau of Econ. Rsch., Working Paper No. 28474, 2023), https://perma.cc/K2M9-5V3F.

5. Appelbaum & Batt, *supra* note 1, at 7.

6. *See* Eileen Appelbaum & Rosemary Batt, *Financialization in Health Care: The Transformation of US Hospital Systems* 69 (Ctr. for Econ. & Pol'y Rsch., Working Paper), https://perma.cc/UT5S-Q8RZ; Benjamin M. Hunter & Susan F. Murray, *Deconstructing the Financialization of Healthcare*, 50 DEV. & CHANGE 1263, 1270-72, 1279 (2019); Colleen M. Grogan & Miriam Laugesen, *Financialization of Health Politics* (unpublished manuscript at 2) (on file with authors).

7. For a description of surprise medical billing and the role of private equity investment, see Zack Cooper, Fiona Scott Morton & Nathan Shekita, *Surprise! Out-of-Network Billing for Emergency Care in the United States*, 128 J. POL. ECON. 3626, 3634 (2020); Erin C. Fuse Brown, *Stalled Federal Efforts to End Surprise Billing—The Role of Private Equity*, 382 NEW ENG. J. MED. 1189, 1189-90 (2020). *See also infra* Part I.B.

8. ERIN FUSE BROWN ET AL., USC-BROOKINGS SCHAEFFER INITIATIVE FOR HEALTH POL'Y, PRIVATE EQUITY INVESTMENT AS A DIVINING ROD FOR MARKET FAILURE: POLICY RESPONSES TO HARMFUL PHYSICIAN PRACTICE ACQUISITIONS 12-14 (2021),

footnote continued on next page

practices that can aggressively upcode[9] patient diagnoses to profit from Medicare's value-based and risk-adjusted payment policies.[10] And recent reports have noted PE's growing interest in other health care targets, including hospices[11] and behavioral health.[12]

While the revenue playbook for each health care market segment may differ, every playbook taps into one or more of a core set of public policy concerns: consolidation and attendant price increases; overutilization,[13] improper billing,[14] and upcoding; the shirking of unprofitable services or patients; interference with physicians' clinical decisions and independence; and compromised quality of patient care. In human terms, these harms manifest as

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https://perma.cc/SE4F-QWXN. Such ancillary services could include, for example, physician-administered drugs, diagnostic imaging, lab services, cosmetic dermatology, or rehabilitation services. *Id.* at 13.

9. "Upcoding" is a form of improper billing, where providers code higher levels of patient acuity than is justified or higher levels of service than were provided. It includes aggressively coding patient diagnoses or comorbidities to make an insured appear sicker to increase risk-adjusted payments from Medicare and other payers. It is also a form of fraud and abuse. *See* Michael Geruso & Timothy Layton, *Upcoding: Evidence from Medicare on Squishy Risk Adjustment*, 128 J. POL. ECON. 984, 985, 1021-24 (2020).

10. *Id.* at 14-15; *see also* Soleil Shah, Hayden Rooke-Ley & Erin C. Fuse Brown, *Corporate Investors in Primary Care—Profits, Progress, and Pitfalls*, 388 NEW ENG. J. MED. 99, 100 (2023); Reed Abelson, *Corporate Giants Buy Up Primary Care Practices at Rapid Pace*, N.Y. TIMES (updated May 12, 2023), https://perma.cc/ZR7B-5B2T (describing how investors are targeting primary care practices to capture and profit from Medicare Advantage patients by gaming the risk-adjusted and value-based payment formulas under these private Medicare plans).

11. *See, e.g.*, Joan M. Teno, *Hospice Acquisitions by Profit-Driven Private Equity Firms*, JAMA HEALTH F. e213745, at 1-2 (2021), https://perma.cc/U2LX-28CC (highlighting the potential repercussions of the recent influx of PE into hospice); Markian Hawryluk, *Hospices Have Become Big Business for Private Equity Firms, Raising Concerns About End-of-Life Care*, KFF HEALTH NEWS (July 29, 2022), https://perma.cc/VD45-TQZW (identifying and addressing the hindrances that PE has placed on hospice patients and the Medicare program).

12. *See, e.g.*, Benjamin Brown, Eloise O'Donnell & Lawrence P. Casalino, *Private Equity Investment in Behavioral Health Treatment Centers*, 77 JAMA PSYCHIATRY 229, 229 (2020) (providing data on and identifying the rationale behind PE's increasing presence in the behavioral health sector).

13. "Overutilization," or overuse, encompasses excess volume or intensity of health care and inappropriate health care. It is considered to be a major contributor to high and rising health care costs in the United States. *See* Ezekiel J. Emanuel & Victor R. Fuchs, *The Perfect Storm of Overutilization*, 299 JAMA 2789, 2789-90 (2008).

14. "Improper billing" is the act of billing a payer, such as Medicare or an insurer, for services not provided or more than is justified by the services provided. Improper billing is a form of health care fraud and abuse. *See* Paul E. Kalb, *Health Care Fraud and Abuse*, 282 JAMA 1163, 1165 (1999); CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP'T OF HEALTH & HUM. SERVS., NO. MLN4649244, MEDICARE FRAUD & ABUSE: PREVENT, DETECT, REPORT 11-13 (2021), https://perma.cc/NPE9-ANEV.

unmanageable medical bills and harsh collection practices,[15] clinicians experiencing moral distress and burnout under pressure to put profits over patients,[16] and—in extreme cases—declines in the quality of patient care.[17]

Increasing corporatization—or what others have termed "financialization"[18]—in health care is not a new phenomenon. Various aspects of corporatization in health care have drawn extensive scholarly attention for decades.[19] Recent private equity investment, however, takes these trends to a new extreme by targeting the heart of medical practice—physicians treating patients in their professional offices and clinics. Here, we offer an extended analysis of the heightened public policy challenges presented and a thorough review of the legal and regulatory tools needed and available to address the elevated concerns.

Health services research that systematically quantifies the effects of PE investment in health care is only beginning to emerge. A real question remains as to whether PE poses unique risks or whether such risks occur whenever a corporate investor controls a health care entity.[20] At bottom, all corporate investors—whether PE, retailers, conglomerate health systems, or health insurers—seek to maximize profits. Even if the risks of the corporatization of health care are not unique to PE, PE investment appears to heighten those risks by more adeptly or ruthlessly identifying profit opportunities and

15. *See, e.g.*, Appelbaum & Batt, *supra* note 1, at 76 (describing private equity's entry into "revenue cycle management"—medical billing and collection); Thomas et al., *supra* note 1 (describing 4,800 lawsuits by TeamHealth, a PE-backed physician-staffing firm).

16. *See, e.g.*, Ryan Crowley, Omar Atiq & David Hilden, *Financial Profit in Medicine: A Position Paper from the American College of Physicians*, 174 ANNALS INTERNAL MED. 1447, 1448-49 (2021) (describing how private equity and other forms of corporate ownership might compromise physicians' clinical decisions); Gretchen Morgenson, *'Get That Money!' Dermatologist Says Patient Care Suffered After Private Equity-Backed Firm Bought Her Practice*, NBC NEWS (updated Dec. 20, 2021, 5:55 AM PST), https://perma.cc/L6NG-AX6F (describing how PE's pursuit of profits can harm patient care quality); Tara Bannow, *Parents and Clinicians Say Private Equity's Profit Fixation Is Short-Changing Kids with Autism*, STAT (Aug. 15, 2022), https://perma.cc/V595-L8QM (documenting the negative effects of PE's management strategies in behavioral health on quality of and access to patient care); Eyal Press, *The Moral Crisis of America's Doctors*, N.Y. TIMES MAG. (updated July 14, 2023), https://perma.cc/4HBE-JZA3 (describing how the corporatization of health care is causing moral injury and burnout among physicians).

17. *See* Rafiei, *supra* note 1 (describing abject conditions, minimal staffing, and deaths of residents at St. Joseph's Home for the Aged after it was acquired by a private equity firm); Gupta et al., *supra* note 4, at 18, 45 (finding that patients at private equity-owned nursing facilities suffered an 11% increase in 90-day mortality compared with control patients).

18. Appelbaum & Batt, *supra* note 6, at 4, 6, 17.

19. *See, e.g.*, JAMES C. ROBINSON, THE CORPORATE PRACTICE OF MEDICINE: COMPETITION AND INNOVATION IN HEALTH CARE (1999).

20. *See* FUSE BROWN ET AL., *supra* note 8, at 1.

consolidating previously fragmented providers. PE's short-term pursuit of revenue growth and use of debt financing means it may lack the reputational concerns and risk aversion of longer-term institutional players.[21] But if policymakers wait for more definitive answers from studies, it will be too late; PE investors will have entered, altered, and exited their health care investments. In its wake, PE will likely leave behind a health care system that is costlier, more concentrated, and less accessible. Thus, policymakers urgently need solutions to address PE's rapid incursion into health care. Because it is unclear if PE is uniquely harmful or just poses a heightened version of corporatization writ large, however, the current policy response has been to go after the market dysfunctions being exploited by PE and other corporate buyers rather than directly targeting PE.

The good news is that several legal and policy interventions already exist to address the risks posed by PE investment in health care. These include antitrust enforcement to address consolidation, fraud and abuse laws to go after improper billing and self-referrals, and the old state-law doctrine prohibiting the corporate practice of medicine. In some cases, such as fraud and abuse enforcement, the existing tools are already capable of policing the risks of PE investment and simply need to be trained on this current target.

In other cases, these existing legal tools should be sharpened and strengthened to better address PE investment. A leading example is antitrust authorities' failure to review many PE health care acquisitions that occur incrementally and thus are too small to trigger reporting under the Hart-Scott-Rodino (HSR) Act.[22] Some of this honing of legal tools can be done at the state level, which may be fertile ground for policy innovation.[23] For example, state

21. *See* Christopher Cai & Zirui Song, *A Policy Framework for the Growing Influence of Private Equity in Health Care Delivery*, 329 JAMA 1545, 1545-46 (2023).

22. *See infra* Part III.A.1.

23. Volumes have been written about federalism in health care and health policy. *See, e.g.*, Erin C. Fuse Brown & Elizabeth Y. McCuskey, *Federalism, ERISA, and State Single-Payer Health Care*, 168 U. PA. L. REV. 389, 446-48 (2020) (describing the federalism dynamics at play in state-based single-payer innovations); Abbe R. Gluck & Nicole Huberfeld, *What Is Federalism in Healthcare for?*, 70 STAN. L. REV. 1689, 1693 (2018) (describing federalism in health care); Kristin Madison, *Building a Better Laboratory: The Federal Role in Promoting Health System Experimentation*, 41 PEPP. L. REV. 765, 766 (2014) (same); Jerry L. Mashaw & Theodore R. Marmor, *The Case for Federalism and Health Care Reform*, 28 CONN. L. REV. 115, 116 (1995) (same); Richard P. Nathan, *Federalism and Health Policy*, 24 HEALTH AFFS. 1458, 1458-59 (2005) (same); Wendy E. Parmet, *Regulation and Federalism: Legal Impediments to State Health Care Reform*, 19 AM. J.L. & MED. 121, 121 (1993) (same); Lindsay F. Wiley, Elizabeth Y. McCuskey, Matthew B. Lawrence & Erin C. Fuse Brown, *Health Reform Reconstruction*, 55 U.C. DAVIS L. REV. 657, 703 (2021) (describing the federalism split between national and state spheres of regulation in health care); Patricia J. Zettler, *Pharmaceutical Federalism*, 92 IND. L.J. 845, 851 (2017) (describing federalism in pharmaceutical regulation).

laws prohibiting the corporate practice of medicine can be used to require that licensed physicians, rather than corporate investors or managers, retain control over the clinical and financial operations of the practice.[24] Other legal tools would require new federal legislation—for example, changing the federal tax treatment of PE investment income or closing Medicare payment loopholes being exploited to increase profits. The need for federal legislation makes enacting reforms more difficult but not impossible. A case in point is the passage of the No Surprises Act, which limits the market failure exploited by PE in the form of aggressive out-of-network billing.[25]

This Article's central claim is that the influx of PE into health care warrants an immediate legal and policy response—one that primarily targets the payment loopholes and market failures so adroitly leveraged by PE investors. This Article also argues that state policymakers have a vital role to play. Many of the available tools are creatures of state law (such as the corporate practice of medicine doctrine) or can be deployed by state enforcers (such as antitrust or fraud and abuse laws). State law innovations can inform the slower, more cumbersome federal policy response.

PE's incursion into health care continues a decades-long trend toward corporatization, financialization, and commercialization, which all prioritize profit maximization and financial returns for owners and investors of health care entities.[26] Concerns over the adverse effects of corporate financial incentives on patient care, professionalism in medical practice, and health care costs are as old as the U.S. health system.[27] Therefore, the legal tools previously developed to address these concerns, though archaic, remain useful today. Even so, existing tools have thus far failed to mitigate the steady march toward commercialization. Moreover, regulators and enforcement authorities may only be learning about the risks of PE's incursion into health care and therefore may be unaware of how to use the existing legal tools to address the problem. Thus, PE challenges policymakers to dust off existing legal tools to correct exploitable market dysfunctions. The PE incursion is also a signal that the U.S. health care system may be approaching an end stage of capitalism, requiring a more foundational renovation.

This Article describes the risks posed by PE investment in health care and then analyzes legal and policy interventions to mitigate these risks. Part I recounts the history of PE investment in health care and describes the problem

24. *See infra* Part III.A.2.

25. Sarah Kliff & Margot Sanger-Katz, *Surprise Medical Bills Cost Americans Millions. Congress Finally Banned Most of Them*, N.Y. TIMES (updated Sept. 30, 2021), https://perma.cc/LZR9-ZEQ5.

26. Appelbaum & Batt, *supra* note 1, at 4.

27. *See infra* Part II.C.1.

posed by PE's recent focus on physician practice acquisitions. Part II highlights the existing legal tools that could be used to address the adverse effects of PE investment in health care and assesses their strengths and limitations. Included are antitrust enforcement, fraud and abuse laws, the state corporate practice of medicine doctrine, and employment laws applicable to physicians. Part III identifies how existing tools may be sharpened and where additional policy reforms are needed.[28] The conclusion draws some lessons for the broader effort to counter the corporatization of medicine.

I. The Problem of Private Equity in Health Care

Robbers rob banks because, as the saying goes, that is where the money is.[29] For that same reason, PE investment has surged in the health care industry, which, at more than $4 trillion in annual spending, represents nearly a fifth of the U.S. economy.[30] According to one estimate, PE investment in health care grew from less than $5 billion annually in 2000 to $100 billion in 2018.[31] Other sources estimate that PE investment in health care ranged from $750 billion to about $1 trillion over the past decade.[32] After slowing somewhat during the first year of the Covid-19 pandemic, PE investment accelerated again, reaching $77.5 billion and 733 deals in 2021.[33] In the past decade, PE investors have rapidly acquired physician practices, completing 39 such deals in 2010 and 221 deals in 2019, totaling 1,116 deals over that decade.[34]

Private equity investment in health care is the most acute manifestation of a larger trend toward the financialization of health care, in which financial investors and intermediaries (including PE) view health care organizations as

28. The legal and policy tools for addressing PE investment in health care and how they can be sharpened are depicted in the Appendix below.

29. *See Willie Sutton*, FBI, https://perma.cc/TA2K-SQMF (archived Jan. 19, 2024) (attributing the quote to famed bank robber Willie Sutton).

30. Ctrs. for Medicare & Medicaid Servs., National Health Expenditures 2021 Highlights 1 (n.d.), https://perma.cc/CZT6-YP7L; *see also* Appelbaum & Batt, *supra* note 1, at 14.

31. Appelbaum & Batt, *supra* note 1, at 14.

32. Schulte, *supra* note 1; RICHARD M. SCHEFFLER, LAURA M. ALEXANDER, & JAMES R. GODWIN, SOARING PRIVATE EQUITY INVESTMENT IN THE HEALTHCARE SECTOR: CONSOLIDATION ACCELERATED, COMPETITION UNDERMINED, AND PATIENTS AT RISK 39-42 (2021), https://perma.cc/G4LM-88YT.

33. PITCHBOOK, 2021 ANNUAL US PE BREAKDOWN 10 (2022), https://perma.cc/T963-XZ99.

34. FUSE BROWN et al., *supra* note 8, at 5 tbl.1.

sources for extracting wealth.[35] In a financialized market, profit making is the primary end, and the quality of the product—patient care—is secondary.[36]

This Article focuses on PE investment in physician practices, though some of the proposed regulatory channels and lessons apply to PE investment in hospitals, nursing homes, hospices, behavioral health, and other types of health care entities.[37] This Part describes the PE model, its history, and the risks posed by PE investment in health care.

A. The Private Equity Model

Private equity leverages private funds to purchase target companies from a wide array of industries. The target businesses are usually established and mature, and the PE investor seeks to substantially improve profitability through active management.[38] Private equity funds aim to sell the company for a large profit in a relatively short time, typically between three and seven years.[39] PE firms tend to use a LBO or similar model that finances the bulk of the purchase price with loans for which the business itself serves as security.[40] For the portion financed by equity, PE firms contribute only a small percentage as a general partner, yet retain a controlling interest in the target company.[41] Although a PE firm typically contributes only about 2% of the funds for a given deal, it reaps approximately 20% of the profits, known as carried interest.[42] The general partner of the PE fund only earns its 20% carried interest after clearing the hurdle rate (typically an 8% rate of return), which may further incentivize risk-taking to quickly maximize returns.[43] Private equity suffers from moral hazard because it bears comparatively little financial risk but earns outsized returns for rapid financial engineering tactics.[44]

35. *See* LAURA KATZ OLSON, ETHICALLY CHALLENGED: PRIVATE EQUITY STORMS US HEALTH CARE 2-3 (2022); Appelbaum & Batt, *supra* note 6, at 8; Hunter & Murray, *supra* note 6, at 1268-72; Grogan & Laugesen, *supra* note 6, at 1-2.

36. OLSON, *supra* note 35, at 3; Appelbaum & Batt, *supra* note 6, at 6.

37. For an in-depth legal and policy analysis of PE investment in nursing homes, see Robert I. Field, Barry Furrow, David R. Hoffman, Kevin Lownds & Hilary Pearsall, *Private Equity in Health Care: Barbarians at the Gate?*, 15 DREXEL L. REV. 821 (2023).

38. *See* Ikram et al., *supra* note 4, at 2-3.

39. *See id.*; Chris Morran & Daniel Petty, *What Private Equity Firms Are and How They Operate*, PROPUBLICA (Aug. 3, 2022, 5:00 AM EDT), https://perma.cc/TJ5W-R8U9.

40. Appelbaum & Batt, *supra* note 1, at 6.

41. *Id.*

42. MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: MEDICARE AND THE HEALTH CARE DELIVERY SYSTEM 80 (2021), https://perma.cc/XS92-QBQD.

43. *See* OLSON, *supra* note 35, at 21, 316.

44. Cai & Song, *supra* note 21, at 1545-46.

The PE firm typically restructures the target company to increase its profitability or to liquidate its most valuable assets (e.g., surplus real estate).[45] The PE investor also actively manages portfolio companies to rapidly grow revenues.[46] In health care, this financial engineering can involve using payment arbitrage, cutting staffing costs, consolidating market power, spiking prices, and pushing high-volume services.[47] The PE investment fund earns the bulk of its returns when it sells the company, so it typically looks to exit the investment in a short period of time rather than continue to hold or manage the acquired company.[48] Thus, PE investments are highly leveraged, actively managed, and short-term.[49]

PE investments in physician practices, in particular, often employ what is known as a "platform and add-on" or "roll-up" approach in which investors first purchase a large established practice (the "platform practice") and then acquire smaller "add-ons" to build market share and economies of scale and scope.[50] The PE firm then typically contracts out management of the business aspects of the practice.[51] In exchange for selling their practices, physician owners receive a sizeable buyout payment.[52] After the PE firm has grown the company, it will typically sell to another investor or a corporate buyer or take the company public.[53] The original physician owners, however, usually forfeit control over selecting subsequent buyers.[54] While PE is not the only type of corporate investor in health care, it poses heightened financial risks. Publicly traded companies may invest significant capital or use debt to finance

45. *See* Rosemary Batt & Eileen Appelbaum, *How Public Real Estate Investment Trusts Extract Wealth from Nursing Homes and Hospitals*, INST. FOR NEW ECON. THINKING (Aug. 1, 2022), https://perma.cc/DDZ2-A73D; David Blumenthal, *Private Equity's Role in Health Care*, COMMONWEALTH FUND (Nov. 17, 2023), https://perma.cc/2VEY-6PEB.

46. *See* Appelbaum & Batt, *supra* note 1, at 6-7.

47. *Id.*

48. Appelbaum & Batt, *supra* note 1, at 7.

49. Anaeze C. Offodile II, Marcelo Cerullo, Mohini Bindal, Jose Alejandro Rauh-Hain & Vivian Ho, *Private Equity Investments in Health Care: An Overview of Hospital and Health System Leveraged Buyouts, 2003-17*, 40 HEALTH AFFS. 719, 719-20 (2021).

50. *See* Zhu & Polsky, *supra* note 1, at 981-82; BRENDAN BALLOU, PLUNDER: PRIVATE EQUITY'S PLAN TO PILLAGE AMERICA 30-32 (2023) (describing private equity's roll-up strategy in health care and other industries); SCHEFFLER ET AL., *supra* note 32, at 29.

51. Patrick D. Souter & Andrew N. Meyercord, *Private Equity Investment in the Physician Practice: Has Its Time Finally Come or Will the Mistakes of the Past Be Repeated?*, 13 J. HEALTH & LIFE SCIS. L. (2020), https://perma.cc/3WML-FH7R.

52. Suhas Gondi & Zirui Song, *Potential Implications of Private Equity Investments in Health Care Delivery*, 321 JAMA 1047, 1047 (2019).

53. *See* Zhu & Polsky, *supra* note 1, at 981-82; Sarah Hershey et al., *Healthcare Exits: Corporate Buyers Step Up*, BAIN & CO. (Mar. 15, 2022), https://perma.cc/Q75D-HWNW.

54. *See* OLSON, *supra* note 35, at 81, 90.

health care acquisitions.[55] But public companies are subject to more regulation and disclosure requirements in offering securities to public investors, and the managers of publicly traded companies typically hold for longer periods of time.[56] VC is a specific form of PE that typically focuses on pure equity investments in early-stage businesses, such as technology or biosciences companies, with an eye to establishing and growing the company to the point where it can either go public or be sold to a larger, more mature company.[57] Unlike VC, PE tends to focus on more mature companies and is more heavily debt-financed.[58] Both investment styles can contribute to health care commercialization.[59] Yet, the combination of short-time horizons and moral hazard from highly leveraged acquisitions leads traditional PE to be more aggressive and risk-tolerant than other investors. This Article focuses on PE because it introduces heightened risks of corporatization to the U.S. health care system.

B. The History and Trends of Private Equity Investment in Health Care

Private equity investment in health care initially focused on facilities such as nursing homes and hospitals.[60] In recent years, however, PE investment in physician practices has dramatically accelerated because reduced returns from these earlier targets pushed private equity investors to seek more specialized providers.[61] By one estimate, from 2013 to 2016, PE acquired 355 physician practices encompassing 1,426 locations and 5,714 physicians.[62] The rate and volume of physician practice acquisitions have been increasing, from 75 deals in 2012 to 484 deals in 2021, a six-fold increase.[63]

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55. Prominent examples include Amazon's announcement that it would purchase primary care practice One Medical for $3.9 billion and CVS's announcement that it would purchase home health primary care provider Signify for $8 billion. *See* Rebecca Springer, *Walmart, Amazon and CVS Want to Disrupt Healthcare Services. Here's How PE and VC Could Benefit*, PITCHBOOK (Sept. 14, 2022), https://perma.cc/E6LS-5N6P. Also, private equity firms may sell their health care companies to publicly traded companies or take the companies public, such as Oak Street Health, which initially received VC funding, then PE funding in 2018, before going public in 2020. *Oak Street Health*, CRUNCHBASE, https://perma.cc/75VZ-QWFH (archived Feb. 28, 2022).

56. Appelbaum & Batt, *supra* note 1, at 7.

57. *See* Ikram et al., *supra* note 4, at 2.

58. *Id.* at 3 tbl.1.

59. Shah et al., *supra* note 10, at 99-100.

60. Appelbaum & Batt, *supra* note 1, at 4.

61. *Id.*; FUSE BROWN ET AL., *supra* note 8, at 3-4.

62. Jane M. Zhu, Lynn M. Hua & Daniel Polsky, *Private Equity Acquisitions of Physician Medical Groups Across Specialties, 2013-2016*, 323 JAMA 663, 663 (2020).

63. SCHEFFLER ET AL., *supra* note 1, at 4.

Private equity first targeted hospital-based specialties, such as emergency medicine and anesthesiology, based on their ability to use surprise medical billing as a revenue strategy.[64] Surprise medical bills occur when patients unexpectedly and involuntarily see an out-of-network provider, commonly in emergencies and where the facility is in-network, but the physician is out-of-network.[65] In all of these cases, the patient has no choice of provider due to an emergency or reasonable (but incorrect) assumption that the physicians at an in-network facility will also be in-network. Physician-staffing companies owned by PE and publicly traded firms have strategically used this market failure to increase revenues. They have intentionally stayed out-of-network to charge higher out-of-network rates, to "balance bill" patients for the difference between their list charges and what insurance paid, or to use the threat of surprise billing to demand higher in-network rates from health plans.[66]

Journalists have drawn attention to this phenomenon by documenting stories of surprise medical bills and their financial burden on patients, not all generated by PE-backed providers. Illustrative examples include a $108,951 surprise bill from an out-of-network hospital after a man suffered a massive heart attack,[67] a $52,112 surprise bill from an out-of-network air ambulance provider who transported an intubated 60-year-old woman suffering from Covid-19,[68] and a $117,000 surprise bill from an out-of-network assistant surgeon whom a patient did not even recall meeting.[69]

PE's exploitation of out-of-network surprise billing as a revenue strategy drew bipartisan ire, catapulting the issue onto the legislative agenda.[70] The effort to curb surprise medical bills generated considerable policy action—starting with dozens of state laws and culminating in the passage of the federal

64. FUSE BROWN ET AL., *supra* note 8, at 4, 5 tbl. 1.

65. MARK A. HALL ET AL., USC-BROOKINGS SCHAEFFER INITIATIVE FOR HEALTH POL'Y, SOLVING SURPRISE MEDICAL BILLS 5 (2016), https://perma.cc/AR6N-Y4LE.

66. *See, e.g.*, Cooper et al., *supra* note 7, at 3631, 3634; Julie Creswell, Reed Abelson & Margot Sanger-Katz, *The Company Behind Many Surprise Emergency Room Bills*, N.Y. TIMES (July 24, 2017), https://perma.cc/KSX8-PDJA.

67. Chad Terhune, *Life-Threatening Heart Attack Leaves Teacher with $108,951 Bill*, NPR (Aug. 27, 2018, 4:57 AM ET), https://perma.cc/X3YE-9JL6.

68. Sarah Kliff, *A $52,112 Air Ambulance Ride: Coronavirus Patients Battle Surprise Bills*, N.Y. TIMES (updated Oct. 22, 2021), https://perma.cc/WM5Q-8VJN.

69. Elisabeth Rosenthal, *After Surgery, Surprise $117,000 Medical Bill from Doctor He Didn't Know*, N.Y. TIMES (Sept. 20, 2014), https://perma.cc/4HVQ-LDKA.

70. *See* Fuse Brown, *supra* note 7, at 1189-90; Lunna Lopes, Audrey Kearney, Liz Hamel & Mollyann Brodie, *Data Note: Public Worries About and Experience with Surprise Medical Bills*, KFF (Feb. 28, 2020), https://perma.cc/72LH-A82F.

No Surprises Act at the end of 2020.[71] The saga continues as PE-backed physician-staffing firms, air ambulances, and other industry groups fight the implementation of the law or aggressively use the law's arbitration process to push for higher payments and preserve their profits.[72] Policymakers are right to wonder what loophole PE will exploit next and how to mount a preemptive policy response.[73]

PE investors are attracted to the areas of physician practice that offer the greatest profit potential due to their market structures or reimbursement rules.[74] Physicians are receptive to these investors because they offer substantial capital and relieve physicians from practice management responsibilities.[75] In addition to supplying capital, PE investment can provide economies of scale necessary for providers to successfully navigate the shift to value-based payment, assume financial risks, and take on more responsibility for population health management.[76]

Because individual physician practice acquisitions are too small to be reviewed by antitrust authorities, PE investors have stealthily amassed significant market shares in certain markets.[77] A 2022 study by Yashaswini Singh and colleagues found that in 2019, PE market penetration across six office-based specialties reached 30% in certain geographic areas.[78] Another study by Richard Scheffler and colleagues demonstrated that PE firms are

71. No Surprises Act, Pub. L. No. 116-260, 134 Stat. 2784, 2815, 2859, 2863 (2020) (codified at 26 U.S.C. § 9816); *see also* Kliff et al., *supra* note 25; Maanasa Kona, *State Balance-Billing Protections*, COMMONWEALTH FUND (Feb. 5, 2021), https://perma.cc/66MT-PZK7.

72. Katie Keith, *Latest in No Surprises Act Litigation and New Guidance*, HEALTH AFFS. (June 6, 2022), https://perma.cc/44DS-JTTN; Zachary L. Baron, *Latest Twists and Turns in No Surprises Act Litigation: What It Means for Consumers and Ongoing Implementation*, O'NEILL INST. FOR NAT'L AND GLOB. HEALTH L. (Aug. 31, 2023), https://perma.cc/2KVW-SGPD.

73. *See infra* Part III.A.

74. *See* Appelbaum & Batt, *supra* note 1, at 52-53.

75. Gondi et al., *supra* note 52, at 1047; Appelbaum & Batt, *supra* note 1, at 4-5.

76. *See* FUSE BROWN ET AL., *supra* note 8, at 1; Ikram et al., *supra* note 4, at 7 (pointing out that PE has provided "much-needed capital" for primary care practices to promote value-based care models and respond to the pandemic); Eloise May O'Donnell, Gary Joseph Lelli, Sami Bhidya & Lawrence P. Casalino, *The Growth Of Private Equity Investment in Health Care: Perspectives from Ophthalmology*, 39 HEALTH AFFS. 1026, 1027 (2020) (discussing economies of scale and scope in PE acquisitions of ophthalmology practices).

77. *See infra* Part II.A; *see also* Scheffler et al., *supra* note 1, at 4, 15 (arguing that many PE acquisitions in health care provider markets have anticompetitive effects but are too small to draw the attention of antitrust regulators).

78. Yashaswini Singh, Jane M. Zhu, Daniel Polsky & Zirui Song, *Geographic Variation in Private Equity Penetration Across Select Office-Based Physician Specialties in the US*, 3 JAMA HEALTH F. e220825, at 1-2 fig. 1 (2022), https://perma.cc/7SMA-2W6G.

amassing high market shares in an increasing number of local physician practice markets. In particular, they found that in 28% of metropolitan statistical areas (MSAs), a single PE firm controlled more than 30% of a physician market and that in 13% of MSAs, a single PE firm's market share exceeded 50%.[79] In a typical antitrust analysis, 30% market share is a competitively significant threshold.[80] Indeed, in these highly concentrated markets, PE-owned practices increased the cost of care by double digits.[81]

In previous decades, private investment in health services focused mainly on insurers or on hospitals and other health care facilities.[82] More recently, however, PE investments have gone to the very core of medical professional practice by directly targeting physicians' care of patients.[83] Commercialization of physicians' office practices has been seen only once before, a generation ago, in physician practice management companies (PPMCs), but that form of investment differed in meaningful ways.[84] The market value of for-profit PPMCs rose rapidly but then crashed spectacularly only a few years after they emerged.[85] PPMCs were often publicly traded and thus less leveraged, with physicians usually maintaining a majority equity stake.[86] Initial valuations ended up being far off the mark, however, because PPMCs failed to achieve anticipated cost reductions and lacked business strategies to substantially increase profit margins.[87] PPMCs, hungry for revenue growth, financed further acquisitions by diluting existing share values, ultimately leading to an implosion in the market that observers likened to the collapse of a pyramid scheme.[88]

PE investors have avoided this fate so far—perhaps because they have targeted areas of physician practice ripe for substantial profit growth.[89] PE

79. SCHEFFLER ET AL., *supra* note 1, at 6, 19, 20 fig.3.

80. *See id.* at 17.

81. *Id.* at 4; Abelson et al., *supra* note 1.

82. *See* FUSE BROWN ET AL., *supra* note 8, at 3-4.

83. *See id.*

84. *See generally* Lawton R. Burns, *Physician Practice Management Companies*, 22 HEALTH CARE MGMT. REV. 32 (1997) (providing an overview of PPMCs); Souter et al., *supra* note 51 (comparing PE's interest in the health care market to PPMCs in the 1990s).

85. Uwe E. Reinhardt, *The Rise and Fall of the Physician Practice Management Industry: Can Wall Street Efficiently Value Health Care?*, 19 HEALTH AFFS. 42, 44 (2000); *see also* Burns, *supra* note 84, at 41-42; Bill Frack & Nurry Hong, *Physician Practice Management—A New Chapter*, BECKER'S HOSP. REV. (Feb. 19, 2014), https://perma.cc/NKV6-MTS9; Souter et al., *supra* note 51.

86. *See* Burns, *supra* note 84.

87. *See* Souter et al., *supra* note 51; *see also* Reinhardt, *supra* note 85, at 51-52 (arguing that PPMCs failed because they took on too much debt).

88. *See* Reinhardt, *supra* note 85, at 44, 46-50.

89. *See* Appelbaum & Batt, *supra* note 1, at 94.

investors have also assumed more control over business strategies by reducing physicians' role in management aspects to minority status.[90] However, it is too soon to tell whether current PE investment models will likewise collapse once easy revenue generation opportunities are exhausted.

C. The Risks of Private Equity Investment in Health Care

Many public policy analysts are worried that PE investment in health care contributes to its commercialization, fuels consolidation and rising costs, and worsens patient access, outcomes, and professional practice.[91]

Private equity is exceptionally adept at identifying and exploiting market failures that can be turned into profit for investors. PE investors are not the only investors who capitalize on these market failures. However, they are more likely to find opportunities to profit from payment loopholes or market dysfunctions and to move aggressively into that space.[92] PE investors' heightened risk tolerance stems from their desire to generate high returns quickly, and the LBO model effectively requires companies to significantly grow revenues or cut costs to shoulder the debt burden.[93] Hence, as we have argued elsewhere, PE functions as a divining rod for finding market failures; where PE has penetrated, there is likely a profit opportunity ripe for exploitation.[94]

PE investment poses three main risks to patients, medical professionals, and the health care market overall. First, PE investment spurs health care consolidation, which increases prices and potentially reduces quality and access.[95] Second, the pressure from PE investors to increase revenue can lead to exploitation of billing loopholes, overutilization, upcoding, aggressive risk-coding, harming patients through unnecessary care, excessive bills, and

90. *See* FUSE BROWN ET AL., *supra* note 8, at 7; Robert Tyler Braun, Amelia M. Bond, Yuting Qian, Manyao Zhang & Lawrence P. Casalino, *Private Equity in Dermatology: Effect on Price, Utilization, and Spending*, 40 HEALTH AFFS. 727, 728 (2021).

91. For academic commenters, see Appelbaum & Batt, *supra* note 1; Cai & Song, *supra* note 21; Field et al., *supra* note 37; McDonough, *supra* note 1; SCHEFFLER ET AL., *supra* note 1. Policymakers have also expressed these concerns. *See, e.g.*, Press Release, S. Comm. on Fin., Wyden Statement at Finance Committee Hearing on Corporatization and Consolidation in Health Care (June 8, 2023), https://perma.cc/JF5U-DGDE.

92. FUSE BROWN ET AL., *supra* note 8, at 2, 17.

93. Cai & Song, *supra* note 21, at 1545.

94. *See* FUSE BROWN ET AL., *supra* note 8, at 16.

95. Claire E. O'Hanlon, Christopher M. Whaley & Deborah Freund, *Medical Practice Consolidation and Physician Shared Patient Network Size, Strength, and Stability*, 57 MED. CARE 680, 680 (2019); *see also* Jon B. Christianson, Caroline S. Carlin & Louise H. Warrick, *The Dynamics of Community Health Care Consolidation: Acquisition of Physician Practices*, 92 MILBANK Q. 542, 543-44 (2014) (noting the more general point that health care consolidation can lead to higher prices for consumers).

increasing overall health spending.[96] Third, physicians acquired by PE companies may be subject to onerous employment terms and lose autonomy over clinical decisions.[97]

Although the data are still being developed, early evidence supports several of these concerns. In the hospital context, PE acquisition has been associated with decreases in staffing ratios and increases in charges, markups over costs, and the proportion of privately insured patients.[98] The quality of patient care also appears to suffer after a PE firm acquires a hospital, perhaps due to reduced staffing. One study found that PE-acquired hospitals experienced a 25.4% increase in hospital-acquired adverse events (central line infections, falls, and surgical site infections) among Medicare beneficiaries, compared with non-PE hospital controls.[99] Among nursing homes, evidence of the impact of PE on patient outcomes is particularly troubling. Researchers found that Medicare patients in PE-owned nursing facilities suffered a 11% increase in ninety-day mortality between 2004 and 2016 and that this increased risk of death may have been due to reduced staffing levels.[100] Other quality measures also declined following acquisition, even as per-patient spending increased.[101] Another study found that residents in PE-owned nursing homes had higher rates of hospitalizations and emergency room visits as well as

96. Appelbaum & Batt, *supra* note 1, at 5; FUSE BROWN ET AL., *supra* note 8, at 2-3; *see also* Harris Meyer, *More Orthopedic Physicians Sell Out to Private Equity Firms, Raising Alarms About Costs and Quality*, KFF (Jan. 6, 2023), https://perma.cc/QM56-79UL (describing how PE investment in orthopedic practices has generated concerns over increased prices and utilization, unnecessary care, and quality concerns).

97. *See* Sally Tan, Kira Seiger, Peter Renehan & Arash Mostaghimi, *Trends in Private Equity Acquisition of Dermatology Practices in the United States*, 155 JAMA DERMATOLOGY 1013, 1019 (2019); Zhu & Polsky, *supra* note 1, at 982; Jack S. Resneck Jr., *Dermatology Practice Consolidation Fueled by Private Equity Investment: Potential Consequences for the Specialty and Patients*, 154 JAMA DERMATOLOGY 13, 13-14 (2018); Harris Meyer, *Banning Noncompete Contracts for Medical Staff Riles Hospitals*, KFF (Mar. 27, 2023), https://perma.cc/LUM2-JJME.

98. Joseph D. Bruch, Suhas Gondi & Zirui Song, *Changes in Hospital Income, Use, and Quality Associated with Private Equity Acquisition*, 180 JAMA INTERNAL MED. 1428, 1432-33 (2020); Offodile et al., *supra* note 49, at 724-25.

99. Sneha Kannan, Joseph D. Bruch & Zirui Song, *Changes in Hospital Adverse Events and Patient Outcomes Associated with Private Equity Acquisition*, 330 JAMA 2365, 2368, 2371 (2023).

100. Atul Gupta, Sabrina T. Howell, Constantine Yannelis & Abhinav Gupta, *Owner Incentives and Performance in Healthcare: Private Equity Investment in Nursing Homes* 18 (Nat'l Bureau of Econ. Rsch., Working Paper No. 28,474, 2021), https://perma.cc/QE92-TWRL.

101. *Id.* at 3, 18.

higher Medicare costs compared to non-PE-owned nursing homes.[102] And a review of studies of PE's effect on various health care settings (hospitals, nursing homes, physicians) across eight countries found "mixed impacts of PE ownership on health care quality, with greater evidence that PE ownership might degrade quality in some capacity rather than improve it."[103]

The impact of PE investment in physician practices shows similar risks of higher prices, increased health spending (which reflects higher utilization), and reduced staffing levels. One study documented that hospitals that contracted with either of two large PE-backed physician-staffing companies for emergency services experienced substantially higher prices, increased testing and hospital admissions, and more aggressive billing practices.[104] Another study found that PE-acquired physician practices specializing in dermatology, gastroenterology, and ophthalmology increased health spending and utilization.[105] A separate study of dermatology practices found that PE targeted larger practices for acquisition (which poses consolidation concerns) and that PE acquisition led to higher prices and patient volumes.[106] PE investment in anesthesia practices yielded similar price increases.[107] A study across multiple specialties found evidence that physician price increases from PE acquisitions were driven by market consolidation, and price increases tended to be higher in areas where a single PE firm controls more than 30% of the market.[108]

In terms of staffing impacts, PE ownership of surgical dermatology practices is associated with higher ratios of nonphysician providers to physicians and lower staffing levels overall, particularly for non-revenue-generating staff.[109] Compared to non-PE-acquired practices, PE-owned

102. Robert Tyler Braun, Hye-Young Jung & Lawrence P. Casalino, *Association of Private Equity Investment in US Nursing Homes with the Quality and Cost of Care for Long-Stay Residents*, 2 JAMA HEALTH F. e213817, at 1 (2021), https://perma.cc/MVW8-UMJ2.

103. Alexander Borsa, Geronimo Bejarano, Moriah Ellen & Joseph Dov Bruch, *Evaluating Trends in Private Equity Ownership and Impacts on Health Outcomes, Costs, and Quality: Systematic Review*, 382 BMJ e075244, at 13 (2023), https://perma.cc/B8RA-YEKQ.

104. Cooper et al., *supra* note 7, at 3656, 3672-73.

105. Yashaswini Singh, Zirui Song, Daniel Polsky, Joseph D. Bruch & Jane M. Zhu, *Association of Private Equity Acquisition of Physician Practices with Changes in Health Care Spending and Utilization*, 3 JAMA HEALTH F. e222886, at 1 (2022), https://perma.cc/GR7R-RNU6.

106. Braun et al., *supra* note 90, at 733-34.

107. 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, 397, 402 (2022).

108. SCHEFFLER ET AL., *supra* note 1, at 30 tbl.3.

109. Alexander L. Fogel, Sara Hogan & Jeffrey Dover, *Surgical Dermatology and Private Equity: A Review of the Literature and Discussion*, 48 DERMATOLOGIC SURGERY 339, 339 (2022).

dermatology, ophthalmology, and gastroenterology practices showed higher physician turnover and the addition of more advanced practice providers.[110] These findings suggest that physician satisfaction may be lower in PE-owned practices and that PE-driven practice growth may rely on midlevel practitioners rather than hiring new physicians.

To be sure, not all studies have shown clear adverse effects.[111] Physicians may perceive certain benefits of PE ownership, such as the access to capital, the stability of salaried employment, and the ability to offload the administrative burden of practice management.[112] Yet no study has found significant improvements to health care quality, efficiency, costs, or access as a result of PE acquisition.

Taken together, the emerging evidence of PE's adverse effects on health care appear to outweigh evidence of its benefits. There is strong evidence that PE acquisition appears to increase heath care prices and spending, depress quality, and negatively alter staffing. Moreover, anecdotal and journalistic accounts link the PE corporatization with physicians' deep moral and mental health crises.[113] In contrast, there is little support that PE improves efficiency or patient care. Based on these findings and the speed of PE's incursion, policymakers and enforcers should urgently mount a policy response to counter the risks to patient care, health care spending, and physicians' clinical autonomy posed by rampant PE investment in health care.[114]

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110. Joseph Dov Bruch et al., *Workforce Composition in Private Equity-Acquired Versus Non-Private Equity-Acquired Physician Practices*, 42 HEALTH AFFS. 121, 126-27 (2023).

111. *See, e.g.*, Marcelo Cerullo et al., *Association Between Hospital Private Equity Acquisition and Outcomes of Acute Medical Conditions Among Medicare Beneficiaries,* 5 JAMA NETWORK OPEN e229581, at 10 (2022), https://perma.cc/3R7Y-NTVJ (reporting no increase in hospital mortality following private equity acquisition).

112. Lawrence P. Casalino, *Private Equity, Women's Health, and the Corporate Transformation of American Medicine*, 180 JAMA INTERNAL MED. 1545, 1545 (2020) (summarizing conceptual arguments for and against PE acquisition of physician practices); Gondi & Song, *supra* note 52, at 1047 (describing why physicians may be attracted to private equity buyouts); FUSE BROWN ET AL., *supra* note 8, at 6.

113. *See* Press, *supra* note 16 (quoting a physician who estimates that staffing in 30% of all ERs is now overseen by PE-owned firms that, once in charge, "start squeezing the doctors to see more patients per hour, cutting staff"); *infra* note 334 and accompanying text.

114. For examples of contemporary regulatory and policy responses to PE's entry into health care, see Anastassia Gliadkovskaya, *The FTC and DOJ Have Vowed to Scrutinize Private Equity Deals. Here's What It Means for Healthcare*, FIERCE HEALTHCARE (Oct. 21, 2022, 7:45 AM), https://perma.cc/CRS3-SPUK; Press Release, S. Comm. on Fin., Wyden Statement at Finance Committee Hearing on Corporatization and Consolidation in Health Care (June 8, 2023), https://perma.cc/JF5U-DGDE; Press Release, Rep. Pramila Jayapal, Jayapal Introduces Bill To Improve Transparency in Health Care (Mar. 23, 2023), https://perma.cc/X324-C7S7.

II. Regulating Private Equity in Health Care: Current Legal Tools

In their quest to maximize profits, PE investors exploit various market dysfunctions and payment loopholes. Although similar critiques could be leveled against other acquirers of physician practices, such as health systems, public companies, or insurance companies, PE's entry into a physician-specialty market serves as a divining rod to identify regulatory gaps and market dysfunctions that merit correction.[115] Because of its short-term pursuit of large returns and heavy reliance on debt, PE poses heightened risks to the health care system. While not unique to PE, the problems of consolidation, overutilization, upcoding, corporate control over medical practice, and anticompetitive physician employment practices are intensified.

An array of existing laws passed in response to the perennial threat of profit-seeking in the U.S. health care system could be trained on this latest (and most egregious) manifestation of the problem. Enforcement of existing laws can address market vulnerabilities to some extent, but the aggressiveness of PE makes honing and adapting these legal tools even more urgent, to address old threats by new actors.

This Part reviews existing legal mechanisms to address the key harms posed by PE in health care: (A) antitrust enforcement to address consolidation; (B) fraud and abuse enforcement to address improper self-referrals, overbilling, and upcoding; (C) state prohibitions on the corporate practice of medicine and fee splitting to address threats to professionalism from improper lay control over physicians' practices; and (D) state employment laws to curb PE's use of restrictive covenants and gag clauses against physicians. The Appendix summarizes these legal tools, the policy concerns they address, their source (state or federal), and what could be done to sharpen them to address the risks of PE investment in health care.

A. Antitrust Law

Antitrust review for PE roll-up transactions is a tool for addressing the risk that PE investment in physician practices contributes to the horizontal market consolidation of these physician specialties.[116] This concern is particularly strong for PE investments that fit the "platform add-on" model, in which an existing practice with market clout grows substantially by acquiring smaller and less recognized groups.[117] Regional dominance allows the combined

115. FUSE BROWN ET AL., *supra* note 8, at 2.

116. SCHEFFLER ET AL., *supra* note 32, at 39-42; Zhu & Polsky, *supra* note 1, at 981-83; *see also* Resneck Jr., *supra* note 97, at 13-14.

117. FUSE BROWN ET AL., *supra* note 8, at 18-19; SCHEFFLER ET AL., *supra* note 32, at 29; Resneck Jr., *supra* note 97, at 13; Gondi & Song, *supra* note 52, at 1047; Zhu & Polsky, *supra* note 1, at 981-82.

practice to demand higher prices from payers.[118] Moreover, PE's use of debt to finance its acquisitions strongly incentivizes consolidation because one way to quickly grow the revenues of a portfolio company is to buy other companies. The availability of debt financing increases with the size of the company, and there is some evidence that larger companies trade at higher EBITDA (earnings before interest, taxes, depreciation, and amortization) multiples than smaller companies, all other things being equal—especially important given PE firms seek to exit their investment.[119] Consumers may be the losers: Studies find that horizontal consolidation of physician practices results in higher prices.[120] And horizontal physician consolidation may lead to worse patient outcomes when it is not possible to increase prices, as under Medicare.[121]

One legal solution to address PE's use of the platform add-on model to amass market power would be to increase antitrust scrutiny of these incremental acquisitions. Under Section 7 of the Clayton Act, federal antitrust authorities—the Federal Trade Commission (FTC) and the Department of Justice (DOJ)—can sue to block mergers and acquisitions where the effect of the transaction may be "substantially to lessen competition, or to tend to create a monopoly."[122] To determine whether a transaction may threaten competition, antitrust agencies analyze whether the transaction will enhance the market power of the transacting parties in a given geographic and product market.[123] The amassed market power allows the merging entity to increase prices to consumers and can lead to adverse "non-price" effects such as diminished

118. SCHEFFLER et al., *supra* note 32, at 29, 41-42.

119. *Id.* at 30; Casalino et al., *supra* note 50, at 114 (describing how acquiring smaller practices "provides a major arbitrage opportunity" because rolling up smaller practices allows the PE fund to resell the larger entity at the a higher multiple without any change in the underlying assets).

120. Laurence C. Baker, M. Kate Bundorf, Anne B. Royalty & Zachary Levin, *Physician Practice Competition and Prices Paid by Private Insurers for Office Visits*, 312 JAMA 1653, 1654-61 (2014); Daniel R. Austin & Laurence C. Baker, *Less Physician Practice Competition Is Associated with Higher Prices Paid for Common Procedures*, 34 HEALTH AFFS. 1753, 1753-59 (2015); Eric Sun & Laurence C. Baker, *Concentration in Orthopedic Markets Was Associated with a 7 Percent Increase in Physician Fees for Total Knee Replacements,* 34 HEALTH AFFS. 916, 916-920 (2015); Thomas Koch & Shawn W. Ulrick, *Price Effects of a Merger: Evidence from a Physicians' Market*, 59 ECON. INQUIRY 790, 790-91 (2021).

121. Thomas Koch, Brett Wendling & Nathan E. Wilson, *Physician Market Structure, Patient Outcomes, and Spending: An Examination of Medicare Beneficiaries*, 53 HEALTH SERVS. RSCH. 3549, 3550-51 (2018); Christopher S. Brunt, Joshua R. Hendrickson & John R. Bowblis, *Primary Care Competition and Quality of Care: Empirical Evidence from Medicare*, 29 HEALTH ECON. 1048, 1048-49 (2020).

122. Clayton Antitrust Act of 1914, Pub. L. No. 63-212, § 7, 38 Stat. 730, 731-32 (codified as amended at 15 U.S.C. § 18).

123. *See* U.S. DEP'T OF JUST. & FTC, 2023 MERGER GUIDELINES 39-40 (Dec. 18, 2023), https://perma.cc/PTA8-NHNN (to locate, select "View the live page," and then select "2023 Merger Guidelines").

quality or access.[124] Typically, the FTC oversees health care acquisitions (other than insurance).[125] This merger enforcement follows a series of steps, starting with pre-merger notification of the authorities, then a review period during which the transaction may not close; following review, the government may clear the deal to move ahead, request more information, or challenge the deal.[126] Most challenged transactions are resolved in a negotiated consent agreement, under which the agency allows the transaction to move ahead subject to certain conditions, such as limiting price increases, maintaining access to key services, and divesting assets to maintain or restore competition in the relevant market.[127] If the parties do not reach a settlement, the agency can seek an injunction to block the transaction in federal court.[128]

Although the market consolidation that results from PE acquisitions of health care entities could be slowed by antitrust review, there are two main barriers to effective enforcement: (1) Many acquisitions go unreported and unreviewed because no single transaction exceeds the mandatory reporting threshold under the HSR Act;[129] and (2) previous merger guidelines and legal precedent do not provide models for assessing the collective market effects of serial platform and add-on acquisitions.[130] Due to these barriers, whether driven by PE or other causes, physician markets are characterized by so-called "stealth consolidation."[131]

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124. *See id.* 6-8.

125. *Health Care Competition*, FTC, https://perma.cc/4VW3-7CDD (archived Jan. 19, 2024); Scott Hulver & Zachary Levinson, *Understanding the Role of the FTC, DOJ, and States in Challenging Anticompetitive Practices of Hospitals and Other Health Care Providers*, KFF (Aug. 7, 2023), https://perma.cc/2F3W-XJW7.

126. *Premerger Notification and the Merger Review Process*, FTC, https://perma.cc/8DQW-ZHYM (archived Jan. 19, 2024).

127. *See* DOUGLAS H. GINSBURG & JOSHUA D. WRIGHT, FTC, ANTITRUST SETTLEMENTS: THE CULTURE OF CONSENT paras. 9-11 (Feb. 28, 2013), https://perma.cc/C9Z9-3BDX; *Frequently Asked Questions About Merger Consent Order Provisions*, FTC, https://perma.cc/QLN3-PV7R (archived Jan. 19, 2024).

128. *Premerger Notification and the Merger Review Process*, *supra* note 126.

129. Hard-Scott Rodino Antitrust Improvements Act of 1976, Pub. L. No. 94-435, § 201, 90 Stat. 1383, 1390-94 (codified as amended at 15 U.S.C. § 18a). The HSR reporting thresholds are updated annually, and in 2023, the reporting threshold was set at transactions valued at $111.4 million or more. *FTC Announces 2023 Update of Size of Transaction Thresholds for Premerger Notification Filings and Interlocking Directorates*, FTC (Jan. 23, 2023), https://perma.cc/X7JW-RKPM.

130. Cory Capps, David Dranove & Christopher Ody, *Physician Practice Consolidation Driven by Small Acquisitions, So Antitrust Agencies Have Few Tools to Intervene*, 36 HEALTH AFFS. 1556, 1560-61 (2017).

131. Thomas G. Wollman, *How to Get Away with Merger: Stealth Consolidation and Its Real Effects on US Healthcare* 2-5 (Nat'l Bureau of Econ. Rsch., Working Paper No. 27274, 2020), https://perma.cc/Q32M-3Z7H; Capps et al., *supra* note 130, at 1561-62.

Moreover, the incremental add-on approach of PE investment obscures the extent of consolidation over time and across a larger geographic footprint.[132] As a result, some have called for updating federal merger guidelines to target nonhorizontal forms of consolidation beyond simple mergers between two rivals in a single geographic area.[133] In the context of PE, the updated merger guidelines indicate that antitrust enforcers will address serial add-on acquisitions that accumulate market power for a platform practice across a broader geographic area, rather than consider each transaction individually.[134]

The FTC and DOJ may be moving in this direction. In December 2023, the federal antitrust agencies released new merger guidelines to replace the existing horizontal and vertical merger guidelines, which provide guidance on how the agencies identify and analyze potentially illegal mergers.[135] The 2023 merger guidelines direct the agencies to examine the cumulative impact of smaller, serial acquisitions for anticompetitive effects under the Clayton Act.[136]

The FTC has also shown signs of more active enforcement of roll-up deals. In September 2023, the FTC filed a complaint against U.S. Anesthesia Partners (USAP) and its PE parent, Welsh Carson, alleging that they engaged in a multiyear scheme both to consolidate the market for anesthesia practices in Texas using a roll-up strategy and to drive up prices.[137] The FTC alleges (1) that USAP and Welsh Carson monopolized the market for anesthesia services in violation of Section 2 of the Sherman Act; (2) that the roll-up acquisitions of anesthesia practices violated Section 7 of the Clayton Act; (3) that they engaged in illegal agreements to set prices and allocate the market in violation of Section 1 of the Sherman Act; and (4) that their scheme to reduce competition for anesthesia services across Texas constituted an unfair method of competition under Section 5 of the Federal Trade Commission Act.[138] The case is significant for three reasons: (1) It is the first antitrust action to target the roll-up strategy

132. SCHEFFLER ET AL., *supra* note 32, at 44.

133. Aimee Cicchiello & Lovisa Gustafsson, *Federal Antitrust Tools Are Inadequate to Prevent Anticompetitive Health Care Consolidation*, COMMONWEALTH FUND (May 13, 2021), https://perma.cc/88VY-2NPG; Jaime S. King & Erin C. Fuse Brown, *The Anti-Competitive Potential of Cross-Market Mergers in Health Care*, 11 ST. LOUIS U. J. HEALTH L. & POL'Y 43, 61-67 (2017); Leemore Dafny, Kate Ho & Robin S. Lee, *The Price Effects of Cross-Market Mergers: Theory and Evidence from the Hospital Industry*, 50 RAND J. ECON. 286, 315 (2019); *see also* Keith Brand & Ted Rosenbaum, *A Review of the Economic Literature on Cross-Market Health Care Mergers*, 82 ANTITRUST L.J. 533, 533 (2019).

134. *See* SCHEFFLER ET AL., *supra* note 1, at 15-16.

135. *See generally* U.S. DEP'T OF JUST. & FTC, *supra* note 123, at 39-40.

136. *Id.* at 23.

137. Complaint for Injunctive and Other Equitable Relief at 1-5, FTC v. U.S. Anesthesia Partners, Inc., No. 23-cv-03560 (S.D. Tex. Sept. 21, 2023), ECF No. 1.

138. *Id.* at 95-105.

used by PE firms in health care; (2) it operationalizes the principle in draft merger guidelines that the agency will consider the cumulative effect of serial acquisitions; and (3) it names the PE firm as a party.[139]

In another effort to address the limitations of the HSR threshold, the FTC voted in 2021 to revive a long-abandoned remedy that requires prior notice and approval of proposed transactions by parties to a merger consent agreement (resulting from a challenged merger) for a period of ten years.[140] In 2022, the FTC applied this technique in a consent agreement with a PE-owned veterinary services provider, requiring notification and approval of future acquisitions that would otherwise not be reported under the HSR Act.[141] The FTC specifically tied the notice-and-approval remedy to the agency's concerns that "[p]rivate equity firms increasingly engage in roll up strategies that allow them to accrue market power off the Commission's radar."[142]

In June 2023, the FTC and DOJ proposed a rule to expand the HSR pre-merger notification filing form, the first major change in 45 years.[143] Among the changes, the proposed rule would expand the information reported to the agencies by merging entities on prior acquisitions in related business lines. The proposed rule would also expand the period of reportable prior transactions from five years to ten and eliminate the threshold for reportable prior

139. *See* Reed Abelson & Margot Sanger-Katz, *F.T.C. Sues Anesthesia Group Backed by Private-Equity Firm*, N.Y. TIMES (Sept. 21, 2023), https://perma.cc/35SX-WJCN; Bob Herman & Tara Bannow, *FTC Sues Private Equity Firm Welsh Carson, U.S. Anesthesia Partners for Allegedly Creating a Monopoly*, STAT NEWS (Sept. 21, 2023), https://perma.cc/M97G-PX79.

140. Press Release, FTC, FTC Rescinds 1995 Policy Statement that Limited the Agency's Ability to Deter Problematic Mergers (July 21, 2021), https://perma.cc/TNW6-S6BN; Notice and Request for Comment Regarding Statement of Policy Concerning Prior Approval and Prior Notice Provisions in Merger Cases, 60 Fed. Reg. 39745, 39745-47 (Aug. 3, 1995).

141. JAB Consumer Partners/Ethos Veterinary Health; Analysis of Agreement Containing Consent Orders to Aid Public Comment, 87 Fed. Reg. 48026, 48027 (Aug. 5, 2022) (proposed consent agreement).

142. Press Release, FTC, FTC Acts To Protect Pet Owners from Private Equity Firm's Anticompetitive Acquisition of Veterinary Services Clinics (June 13, 2022), https://perma.cc/H5TW-R2N4.

143. Premerger Notification; Reporting and Waiting Period Requirements, 88 Fed. Reg. 42178, 42178 (proposed June 29, 2023) (to be codified at 16 C.F.R. pts. 801, 803); *see also* Lina Khan, *FTC Chair Lina Khan on Proposed Amendments to Premerger Notification Form and Hart-Scott-Rodino Rules*, COLUM. L. SCH. BLUE SKY BLOG (June 30, 2023), https://perma.cc/789A-S2MG; Press Release, FTC, FTC and DOJ Propose Changes to HSR Form for More Effective, Efficient Merger Review (June 27, 2023), https://perma.cc/Q868-M7YA.

acquisitions.[144] The agency hopes to identify whether parties are engaged in serial acquisitions that collectively may pose risks to competition, even if individual transactions are too small to be reported.[145] The proposed rule does not, however, reduce the HSR's threshold for reportable transactions, so it does not fully address the problem that most of these deals go unreported. Only if a transaction is large enough to trigger notification will the agencies receive information about prior acquisitions.

The antitrust agencies have taken meaningful and promising steps to heighten antitrust scrutiny over the consolidation and competitive harms posed by PE's land grab among health care entities. But gaps remain. As discussed further below, antitrust enforcement tools can be sharpened with policy reform at the federal and state levels to better counteract PE's threats to health care competition.[146]

B. Fraud and Abuse Enforcement

PE firms' drive to increase the revenues of acquired portfolio practices can result in the adoption of illegal billing practices. These questionable practices include overutilization, inappropriate billing, medically unnecessary care, and prohibited self-referrals for ancillary services.[147] Maximizing profitability may also result in avoiding less profitable services (or patients) or inappropriately using nonphysicians.[148] The federal fraud and abuse laws generally address these threats to costs and quality, principally through the False Claims Act (FCA), Anti-Kickback Statute (AKS), and Stark Law.[149] In addition, most states have related laws, such as those that bar fee splitting and self-referral.[150] More active enforcement of these laws could counter some of the fraud and abuse risks that PE investment in physician practices poses.

Federal fraud and abuse laws hold the prospect for extensive liability. The FCA triggers up to a $27,000-per-claim penalty and "treble damages" for each improper claim for payment.[151] Thus, if PE firms direct or encourage unlawful

144. Premerger Notification; Reporting and Waiting Period Requirements, 88 Fed. Reg. at 42202-03. The proposed rule would also require reporting of prior transactions by both the acquiring and acquired entities. *Id.*

145. *Id.*

146. *See infra* Part III.A.1.

147. *See* Gondi & Song, *supra* note 52, at 1047-48; Zhu & Polsky, *supra* note 1, at 982.

148. Resneck Jr., *supra* note 97, at 13-14.

149. FUSE BROWN ET AL., *supra* note 8, at 22.

150. *See infra* Part II.C.3.

151. Any person who knowingly presents a false or fraudulent claim for payment is liable for a civil penalty plus three times the amount of damages which the government sustains. 31 U.S.C. § 3729(a)(1). FCA penalties are adjusted for inflation. Adjustments for

footnote continued on next page

conduct by portfolio practices, PE firms could face substantial financial liability or be excluded from participating in federal programs such as Medicare.[152] Nevertheless, the government typically seeks significantly less than the maximum penalties in settlements (closer to double damages than treble), which may reduce the deterrent value for PE firms.[153] An outside investor seeking to rapidly extract returns and exit may see occasional settlements as the cost of doing business and lack the reputational incentives of long-term operators of health care entities. While maximum damages may force hospitals or health systems to close and diminish access, the same may not be true of PE investors. Thus, government enforcers may want to consider the nature of the defendant when determining damages multipliers in such cases.

Each fraud and abuse statute targets different types of conduct, but they overlap in one key respect: The FCA, which imposes civil and criminal liability for false or fraudulent payment claims made to the federal government, encompasses any claims for payment that also violate the AKS or Stark Law.[154]

1. Applying the False Claims Act to private equity owners

The FCA is a potent tool to police inappropriate billing practices such as upcoding, claims for unnecessary care, or improper billing for services by mid-level practitioners.[155] In two recent cases, PE firms were sued under the FCA for the alleged fraudulent conduct of their respective portfolio companies.[156] In both cases, the plaintiffs alleged that the PE owners knew of or acquiesced to

Inflation to Civil Monetary Penalties, 88 Fed. Reg. 3, 4 (Jan. 3, 2023) (to be codified at 15 C.F.R. pt. 6). The 2023 FCA minimum penalty per claim is $13,508, and the maximum is $27,108. *Id.*

152. *See* 42 U.S.C. § 1320a-7(3).

153. Jacob T. Elberg, *A Path to a Data-Driven Health Care Enforcement*, 2020 UTAH L. REV. 1169, 1194.

154. 31 U.S.C. §§ 3729-33 (imposing liability for violations of the FCA); 42 U.S.C. § 1320a-7b(g) (establishing that claims for payment in violation of the AKS constitute false or fraudulent claims for the purposes of the FCA); *see also Fraud & Abuse Laws*, U.S. DEP'T OF HEALTH & HUM. SERVS., https://perma.cc/M4N7-7NLL (archived Jan. 19, 2024) ("The fact that a claim results from a kickback or is made in violation of the Stark law also may render it false or fraudulent, creating liability under the civil FCA as well as the AKS or Stark law.").

155. *See* Field et al., *supra* note 37, at 866 ("As private equity investment in health care continues to increase, the FCA has become the principal mechanism by which its investors can face liability for the conduct of their portfolio companies.").

156. United States *ex rel.* Martino-Fleming v. S. Bay Mental Health Ctr., Inc., No. 15-13065, 2018 WL 4539684, at *1 (D. Mass. Sept. 21, 2018); United States *ex rel.* Carmen Medrano v. Diabetic Care RX, LLC, No. 15-cv-62617, 2018 WL 6978633, at *1 (S.D. Fla. Nov. 30, 2018).

billing practices that were sufficiently fraudulent to render the PE owners liable under the FCA.[157]

To prove liability under the FCA, the plaintiff must show that (1) the defendant caused a claim to be presented to the United States for payment, (2) such claim was false or fraudulent, and (3) the defendant had the requisite level of scienter or knowledge of the fraudulent conduct.[158] Therefore, it stands to reason that putative control over a medical practice may be imputed to the PE owner where the PE owner has a high level of knowledge of the acts underlying the fraud of its portfolio. Under the FCA, a third-party defendant—such as a PE investor—can be liable by proving that it possessed the requisite knowledge and control to cause the submission of false claims.[159]

Defendants are liable under the FCA where they "knowingly present[], or cause[] to be presented, to an officer, employee, or agent of the United States" "a false or fraudulent claim for payment or approval."[160] The FCA does not require specific intent to defraud; rather, the scienter requirement is established if the defendant has actual knowledge of false information, acts in deliberate ignorance of the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of the information.[161] Closely related to scienter is the causation element, as a defendant can be liable only for claims that it "causes to be presented" to the government.[162] Although scienter and causation are technically distinct elements, they often overlap, such that proving one necessarily proves the other.[163]

Scienter and causation are particularly critical to proving FCA liability of PE owners of health care entities, who argue that they are passive third-party investors who cannot be held liable for the actions of medical professionals.[164] Under the FCA, merely being a parent corporation is not sufficient to establish

157. *Martino-Fleming*, 2018 WL 4539684, at *3-6; *Medrano*, 2018 WL 6978633, at *4-5.

158. 31 U.S.C. § 3729(a)(1)(A).

159. *Id.*; *see also* Lee Turner Friedman, Jennifer S. Windom, Raph C. Mayrell & Jason A. Shaffer, *Investors Beware: Private Equity Firms Continue to Face Potential Liability Under the False Claims Act for Their Portfolio Companies' Conduct*, KRAMER LEVIN (Aug. 2, 2022), https://perma.cc/6LBW-CW9B.

160. 31 U.S.C. § 3729(a)(1)(A).

161. *Id.* § 3729(b)(1)(A)-(B).

162. *Id.* § 3729(a)(1)(A).

163. CLAIRE M. SYLVIA, THE FALSE CLAIMS ACT: FRAUD AGAINST THE GOVERNMENT § 4:3 (West 2023) ("The person or entity 'causing' the submission of the claim must have acted 'knowingly' within the meaning of the FCA.").

164. United States *ex rel.* Carmen Medrano v. Diabetic Care RX, LLC, No. 15-cv-62617, 2018 WL 6978633, at *8-11 (S.D. Fla. Nov. 30, 2018).

liability for the conduct of a subsidiary.[165] In *United States ex rel. Hockett v. Columbia/HCA Healthcare Corp.*, the court considered two possible ways to hold a parent corporation liable under the FCA.[166] First, through traditional veil-piercing frameworks, a parent may be liable on behalf of its subsidiary where a "unity of interest and ownership" essentially destroys the separate personalities of the two entities.[167] In the PE context, traditional veil piercing would likely be difficult because of the carefully crafted relationship between the medical practice and the outside management and investment entity.

Hockett also held that parent liability may be established where the parent was "directly involved in submitting false claims or causing them to be submitted to the government."[168] The parent company in *Hockett*, Columbia/HCA, was directly involved in submitting cost reports to the government that determined the amount of reimbursement the company received from government payers.[169] Due to the administrative control exerted by PE over acquired medical practices, this direct-involvement theory of parent liability seems more viable than veil piercing. PE firms are known for their high degree of involvement in the billing practices and procedures of the medical practice.[170] Unlike other forms of capital investment, PE firms acquire a controlling share of their portfolio companies and direct management to take steps to quickly increase revenues.[171] The aggressive focus on revenue by the PE fund's general partner and active involvement with the revenue-generation strategies of portfolio companies could form a basis for establishing the requisite level of knowledge and control for FCA liability to attach.[172]

Private and government enforcers have begun to sketch out a counter-playbook to bring FCA claims against PE owners of health care firms. Two recent cases illustrate how scienter and causation can be established to hold PE parent companies liable for FCA violations of their portfolio companies. The PE firm in *United States ex rel. Carmen Medrano v. Diabetic Care RX, LLC* used a common organizational structure: acquisition of portfolio companies through a wholly owned management company, which owns and/or manages the

165. United States *ex rel.* Hockett v. Columbia/HCA Healthcare Corp., 498 F. Supp. 2d 25, 59-60 (D.D.C. July 17, 2007) (citing United States *ex rel.* Tillson v. Lockheed Martin Energy Sys., Inc., No. 00-cv-00039, 2004 WL 2403114, at *33 (W.D. Ky. Sept. 30, 2004)).

166. *Id.* at 60-63.

167. *Id.* at 60 (quoting Labadie Coal Co. v. Black, 672 F.2d 92, 96 (D.C. Cir. 1982)).

168. *Id.* at 62.

169. *Id.*

170. *See* Appelbaum & Batt, *supra* note 1, at 65.

171. *Id.* at 6-7.

172. Field et al., *supra* note 37, at 884 ("A private equity firm . . . can be shown to have sufficient knowledge and control over the operating organization to implicate FCA liability.").

acquired companies.[173] In *Medrano*, the PE firm acquired a controlling stake in a portfolio pharmacy via a management contract with the firm's wholly owned management company.[174] The government alleged that the portfolio pharmacy violated the Anti-Kickback Statute by engaging marketing companies to refer beneficiaries to the pharmacy to purchase an expensive topical cream.[175] The management company argued that it could not be held liable under the FCA because it had no knowledge of the pharmacy's scheme and did not cause the claims to be submitted to the government.[176] The court disagreed.[177] First, the court held that the PE owner had knowledge of the scheme because it approved the pharmacy's decision to use the marketers to generate referrals.[178] Second, the PE owner caused the violation when it provided $2 million in commissions to the marketers for generating referrals.[179]

The PE firm in *United States ex rel. Martino-Fleming v. South Bay Mental Health Center, Inc.* acquired its ownership stake in a mental health center through a holding company.[180] The plaintiff, a private whistleblower, alleged that the defendant mental health facility employed unlicensed staff and provided inadequate supervision to employees providing care.[181] Submission of claims for payment in violation of these requirements constitutes a false claim.[182] The plaintiff alleged that the board of directors, many of whom were partners in the PE firm, rejected her recommendation to bring the facility into compliance.[183] The court found that the plaintiff adequately alleged causation because "knowingly ratif[ying] the prior policy of submitting false claims by rejecting recommendations to bring [the facility] into regulatory compliance constitutes sufficient participation in the claims process to trigger FCA

173. United States *ex rel.* Carmen Medrano v. Diabetic Care RX, LLC, No. 15-cv-62617, 2018 WL 6978633, at *1 n.3 (S.D. Fla. Nov. 30, 2018).

174. *Id.*

175. *Id.* at *3.

176. *Id.* at *10-11.

177. *Id.* at *12.

178. *Id.* at *10.

179. *Id.* at *12.

180. Amended Consolidated Complaint at 8-9, United States *ex. rel.* Martino-Fleming v. S. Bay Mental Health Ctr., Inc., No. 15-cv-13065, 2018 WL 4539684 (D. Mass. Sept. 21, 2018), 2019 WL 13167541. It appears that the subject transaction was not subject to the corporate practice prohibition because the portfolio company was a Massachusetts licensed for-profit corporation rather than a professional corporation. *Id.* at 5. Before acquisition, it was wholly owned by a licensed mental health care provider. *Id.* at 2.

181. *Martino-Fleming*, 2018 WL 4539684, at *3-4, *6.

182. *Id.* at *4.

183. *Id.* at *4-5.

liability."[184] In doing so, the court expressly relied on the *Hockett* case in holding that the PE firm may be liable because it was "directly involved in the operations" of the medical practice.[185]

United States ex rel. Anderson v. Curo Health Services, Inc. further supports the proposition that PE owners can be liable for the actions of their acquired companies under the FCA.[186] *Anderson* centered around a group of PE-owned Tennessee hospice providers that were alleged to have falsely certified to Medicare and Medicaid that patients' illnesses had reached a terminal stage, resulting in the submission of false claims.[187] Curo Health Services Holdings, Inc. is a private equity-backed operator of hospice chains which purchased smaller providers, including Avalon Hospice, which operated twenty-seven hospice agencies in Tennessee.[188] The crux of the case involved the government's claim that Curo was liable for Avalon's submission of false claims for ineligible hospice patients.[189] The government argued Curo was liable due to its active involvement in assessing patient eligibility, as well as its history of pressuring Avalon to admit patients into hospice through management practices and financial incentives.[190] The Court ruled in favor of the government, finding that it had established the elements necessary to establish liability on behalf of Avalon's corporate parents—including PE-backed Curo.[191]

Medrano, Martino-Fleming, and *Anderson* demonstrate that the substantial level of control PE owners exert over their acquired medical practices can expose them to FCA liability for the actions of those practices.[192] Even where sophisticated contracting obscures formal control enough to evade the state corporate practice of medicine doctrine,[193] various forms of influence and

184. *Id.* at *5.

185. *Id.*

186. United States *ex rel.* Anderson v. Curo Health Servs., Inc., No. 13-cv-00672, 2022 WL 842937, at *4, *7 (D. Tenn. Mar. 21, 2022).

187. *Id.* at *1.

188. *Id.* at *4.

189. *Id.*

190. *Id.* at *4-6.

191. *Id.* at *15.

192. *Id.* at *1; United States *ex rel.* Carmen Medrano v. Diabetic Care RX, LLC, No. 15-cv-62617, 2018 WL 6978633, at *1 n.3, *11-13 (S.D. Fla. Nov. 30, 2018); United States *ex rel.* Martino-Fleming v. S. Bay Mental Health Ctr., Inc., No. 15-cv-13065, 2018 WL 4539684, at *5 (D. Mass. Sept. 21, 2018); *see also* Field et al., *supra* note 37, at 877-78 (reviewing *Medrano, Martino-Fleming*, and *Anderson* and concluding that taken together, the three cases establish that private equity investors can be liable under the FCA).

193. *See infra* Part II.C.

oversight can establish that private equity owners act with the requisite level of scienter and causation to be liable under the FCA.[194]

2. Applying the Stark Law to private equity owners

Enforcement of the Stark Law can target another revenue strategy of PE-acquired physician practices: self-referrals for ancillary, wrap-around services within the PE's portfolio practices. This strategy seems to motivate PE's recent acquisition of office-based specialties like dermatology, ophthalmology, and gastroenterology that provide outpatient procedures and lucrative ancillary services such as physician-administered drugs or pathology laboratory services.[195]

The Stark Law bars Medicare payment for services generated by prohibited referrals for "designated health services."[196] This referral prohibition attaches to physicians who have a financial relationship with entities that render the service, unless the arrangement satisfies one of a series of specific exceptions.[197] Stark is a strict liability statute, so—unlike the FCA or AKS—the government does not have to prove the defendant's intent to violate the law.[198] This feature of Stark may make it easier to establish a violation by PE investors or the PE-controlled managed company.

A portfolio practice, management company, and a group's physicians may enter into financial arrangements, including a physician's ownership interest in a PE-backed practice, revenue-sharing among the parties, the practice's management services agreement, and the basic employment compensation for physicians.[199] Under the Stark Law, these financial arrangements must satisfy a Stark exception.[200] Otherwise, the group's physicians cannot lawfully make

194. *See Medrano*, 2018 WL 6978633, at *11-13; *Martino-Fleming*, 2018 WL 4539684, at *5.

195. FUSE BROWN ET AL., *supra* note 8, at 13.

196. 42 U.S.C. § 1395nn(a); 42 U.S.C. § 1395nn(h)(6) (defining "designated health services" to be any of the following items or services: "(A) Clinical laboratory services. (B) Physical therapy services. (C) Occupational therapy services. (D) Radiology services, including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services. (E) Radiation therapy services and supplies. (F) Durable medical equipment and supplies. (G) Parenteral and enteral nutrients, equipment, and supplies. (H) Prosthetics, orthotics, and prosthetic devices and supplies. (I) Home health services. (J) Outpatient prescription drugs. (K) Inpatient and outpatient hospital services. (L) Outpatient speech-language pathology services.").

197. 42 U.S.C. § 1395nn(a).

198. FUSE BROWN ET AL., *supra* note 8, at 23.

199. *Id.*

200. 42 U.S.C. § 1395nn(a)-(b).

within-group referrals for ancillary services, which form a key revenue stream targeted by PE investors.[201]

The Stark Law exception for "in-office ancillary services" is critical to many PE investors' strategies for revenue generation.[202] This exception is intended to facilitate rapid diagnostic or therapeutic services during a patient's office visit so that patients do not need to go elsewhere for services such as imaging, laboratory, or physical therapy.[203] If satisfied, the in-office ancillary services exception allows members of a group practice to share revenues earned from referrals within the practice, which would otherwise be unlawful.[204]

To use the in-office ancillary services exception, the practice must meet the Stark Law's requirements for designation as a "group practice."[205] First, the practice must be a single legal entity.[206] Additionally, physician members must render substantially all of their patient services through the group practice; the business must be unified through centralized administration, billing, and financial reporting; and at least 75% of physician services must be provided by physician members rather than contractors.[207] In addition, the exemption applies intricate requirements on physician compensation and profit-sharing.[208]

PE-backed portfolio practices may struggle to meet some of these requirements. For instance, the "single legal entity" provision does not include "separate group practices under common ownership or control through a physician practice management company . . . or other entity or organization."[209] Each add-on practice in a portfolio would be considered its own entity and so could not be considered a single group practice.[210] In addition, it may be difficult to meet the unified business and centralized decisionmaking requirements, where a representative body has effective control over the practice's billing and finances; the PE-owned management company often takes over administration

201. *Id.* § 1395nn(b)(2); FUSE BROWN ET AL., *supra* note 8, at 23.

202. 42 C.F.R. § 411.355(b) (2022); 42 U.S.C. § 1395nn(b)(2); Madeline E. DeWane, Eliot Mostow & Jane M. Grant-Kels, *The Corporatization of Care in Academic Dermatology*, 38 CLINICS IN DERMATOLOGY 289, 290 (2020).

203. FUSE BROWN ET AL., *supra* note 8, at 24.

204. 42 U.S.C. § 1395nn(b)(2); 42 C.F.R. § 411.355(b).

205. 42 C.F.R. § 411.352 (2022); s*ee also* Am. Med. Ass'n, Key Considerations in Providing Ancillary Services in Your Physician Practice (2021), https://perma.cc/3YKT-CB4S (providing a checklist for physician groups to comply with Stark Law requirements when considering offering ancillary services to patients).

206. 42 C.F.R. § 411.352(a).

207. *Id.* § 411.352(d)(1).

208. *Id.* § 411.352.

209. *Id.* § 411.352(a).

210. *See id.* § 411.352(a).

and management for all the portfolio practices.[211] Thus, the portfolio practices may not qualify as a single group practice necessary to share revenues and to permit referrals across the practices.

Qualifying as a group practice is only one of the requirements of the in-office ancillary services exception.[212] Other requirements include restrictions on who may perform the services (only by the referring physician, another physician in the group practice, or someone supervised by them), the location where the services may be provided, and who may bill for the services.[213]

Because Stark's group practice definition and its requirements for the in-office ancillary services exception are so complex, many PE investments are likely noncompliant. Particularly for PE investments in procedural specialties such as dermatology, gastroenterology, and ophthalmology that rely on in-office procedures and ancillary services as a revenue strategy, deeper investigations into the structure and revenue sharing of these practices may uncover violations.[214] Although the Stark Law is a strict liability statute, for a Stark violation to constitute a false claim under the FCA, the government or *qui tam* relator would still need to prove the PE firm acted with the requisite intent (i.e., that it knowingly violated the Stark Law)—which may prove difficult, given the complicated requirements of the Stark Law.[215] Nevertheless, PE's hands-on management and revenue strategies for increasing billing and referrals may create opportunities for further enforcement scrutiny.

Existing fraud and abuse laws provide ample authority to address some of PE investors' egregious practices. Thus, government enforcers and private whistleblowers have begun to hold PE companies liable for upcoding, billing for medically unnecessary care or unapproved treatments, kickback schemes, and improper use of midlevel practitioners.[216] Expanding these targeted

211. *Id.* § 411.352(f); *see* BALLOU, *supra* note 50, at 109-10; OLSON, *supra* note 35, at 82.

212. 42 C.F.R. § 411.355(b).

213. *Id.* § 411.355(b)(1)-(3); s*ee also* Victoria Vaskov Sheridan, Gary W. Herschman & Joseph E. Lynch, *Recent Settlements May Indicate Increased Government Focus on the Stark Law's "Group Practice" Requirements and Exception for "In-Office Ancillary Services,"* EPSTEIN BECKER GREEN (Feb. 26, 2018), https://perma.cc/CXR5-AQML (explaining how recent settlements illustrate how the government is enforcing the Stark Law requirements for group practices and in-office ancillary services).

214. FUSE BROWN ET AL., *supra* note 8, at 24.

215. *See* United States *ex rel.* Bartlett v. Ashcroft, 39 F. Supp. 3d 656, 674-75 (W.D. Pa. 2014) (denying the *qui tam* relators' motion for partial summary judgment related to their FCA claim where the relators failed to provide sufficient evidence of the physician's and hospital defendants' subjective knowledge); *see also* United States *ex rel.* Drakeford v. Tuomey, 792 F.3d 364, 393 (4th Cir. 2015) (Wynn, J., concurring) (noting that health care lawyers and their clients find the Stark Law complicated and counterintuitive).

216. *See* Press Release, U.S. Dep't of Just., EEG Testing and Private Investment Companies Pay $15.3 Million to Resolve Kickback and False Billing Allegations (July 21, 2001), https://perma.cc/UAJ8-227J (explaining that PE firm Ancor Holdings LP agreed to

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investigations of PE portfolio company practices could further uncover and deter bad behavior and recoup improper payments from government health programs.

Existing fraud and abuse laws may be further supplemented to curtail overutilization. One approach, recommended by the Government Accountability Office, is to add a self-referral "flag" to claims for certain in-office referrals that are more likely to entail unnecessary services.[217] The Medicare Payment Advisory Commission (MedPAC) has also endorsed additional steps to limit the in-office ancillary exception or to counter the exemption's financial incentives for group physicians to increase the volume of inappropriate care.[218] Recent amendments to the Stark and AKS rules, however, have loosened rather than tightened the rules (or in the case of Medicare accountable care organizations, waived the rules altogether), in an effort to promote value-based payment arrangements that reduce compliance burdens.[219] One way to address the risk of overutilization created by fee-for-service payments would be to adopt alternative payment models, such as capitation or bundled payments, for physician practices that self-refer

pay $1.8 million for false claims resulting from an ongoing kickback scheme engineered by the portfolio company); Press Release, U.S. Att'y's Off., E. Dist. of Pa., Former Owners of Therakos, Inc. Pay $11.5 Million to Resolve False Claims Act Allegations of Promotion of Drug-Device System for Unapproved Uses to Pediatric Patients (Nov. 19, 2020), https://perma.cc/V3AW-5TYY (explaining that the Gores Group agreed to pay $1.5 million to settle a FCA lawsuit filed after their portfolio company allegedly marketed an unapproved cancer treatment for pediatric patients, resulting in the submission of false claims to federal programs); United States *ex rel.* Carmen Medrano v. Diabetic Care RX, LLC, No. 15-cv-62617, 2018 WL 6978633, at *1 (S.D. Fla. Nov. 30, 2018) (involving an action by relators against a pharmacy for allegedly violating the FCA); *see also* United States *ex rel.* Martino-Fleming v. S. Bay Mental Health Ctr., Inc., No. 15-13065, 2018 WL 4539684, at *1 (D. Mass. Sept. 21, 2018) (involving an action by a relator against a mental health center); United States *ex rel.* Cho v. H.I.G. Cap., LLC, No. 17-cv-00983, 2020 WL 5076712, at *1 (M.D. Fla. Aug. 26, 2020) (involving an action by relators against a surgery center).

217. U.S. GOV'T ACCOUNTABILITY OFF., GAO-13-445, MEDICARE: ACTION NEEDED TO ADDRESS HIGHER USE OF ANATOMIC PATHOLOGY SERVICES BY PROVIDERS WHO SELF-REFER 24-25 (2013), https://perma.cc/BGQ7-KGPC.

218. MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: ALIGNING INCENTIVES IN MEDICARE 219-21 (2010), https://perma.cc/W9MF-BG57 (discussing the evidence that volume of ancillary services under the exception has increased and questioning the appropriateness of such services); *id.* at 224-32 (recommending policies to curb the overutilization of in-office ancillary services, including narrowing the scope of the Stark exception and changing payment methodologies to blunt incentives for overutilization of ancillary services).

219. Medicare Program; Modernizing and Clarifying the Physician Self-Referral Regulations, 85 Fed. Reg. 77492, 77503 (Dec. 2, 2020) (codified at 42 C.F.R. pt. 411); Medicare Program; Final Waivers in Connection with the Shared Savings Program, 76 Fed. Reg. 67992, 67994 (Nov. 2, 2011) (codified at 42 C.F.R. chs. IV, V).

ancillary services.[220] However, value-based and capitated payments can drive their own fraud, upcoding, and gaming, so they are no panacea to overutilization and waste.[221]

A further limitation of federal fraud and abuse laws is that some of the specialties targeted by PE firms are attractive because of their extensive cash-pay services that are not reimbursed by federal health care programs (e.g., cosmetic dermatology or refractive vision services).[222] Federal fraud and abuse laws do not apply if the services are not paid for by a federal health care program. Preventing overutilization of these services paid for by commercial insurance or by cash would fall more naturally under state fraud enforcement or evade regulation altogether.

C. Corporate Practice of Medicine and State Fee-Splitting Laws

The "corporate practice of medicine" prohibition has traditionally been used to address many of the commercialization and profit-seeking concerns that PE investment raises. This doctrine, which is a product of state professional licensure laws, common law, and statutes, generally prohibits nonprofessionals from owning or controlling medical practices.[223] Similarly, state anti-fee-splitting laws sought to prevent corporations from profiting from physicians' medical care.[224] These two historical doctrines prove useful to address the contemporary issues raised by PE investment in physician practices.

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220. Capitation is a payment method where the payer pays the provider (or group of providers) a fixed monthly fee for each insured patient. *See Capitation and Pre-payment*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://perma.cc/3UH5-LFVR (archived Feb. 26, 2024). Bundled payments pay a team of providers a fixed fee for all the services involved in an episode of care—for example, a lump sum for the hospital, physician, and post-acute care for a hip replacement. *See Bundled Payments for Care Improvement (BPCI) Initiative: General Information*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://perma.cc/8FVL-LKWT (archived Jan. 19, 2024). These alternative payment arrangements counter the physicians' incentives under fee-for-service payments to increase the volume and intensity of services by putting the providers at financial risk for managing all the patient's services under a fixed fee. If they provide efficient care, they make money, and if they provide inefficient care, they lose money. *See* Michael E. Porter & Robert S. Kaplan, *How to Pay for Health Care*, HARV. BUS. REV. (July-Aug. 2016), https://perma.cc/Z3EC-PK38.

221. Paul A. Branstad & Claude R. Maechling, *Explaining Corporate America's Aggressive Investment in Primary Care*, HEALTH AFFS. (Apr. 5, 2023), https://perma.cc/H5Q7-ENRH; Shah et al., *supra* note 10, at 99-100; Reed Abelson & Margot Sanger-Katz, *'The Cash Monster Was Insatiable': How Insurers Exploited Medicare for Billions*, N.Y. TIMES (Oct. 8, 2022), https://perma.cc/2NFZ-H9LM.

222. FUSE BROWN ET AL., *supra* note 8, at 13.

223. André Hampton, *Resurrection of the Prohibition on the Corporate Practice of Medicine: Teaching Old Dogma New Tricks*, 66 U. CIN. L. REV. 489, 497 (1998).

224. FUSE BROWN ET AL., *supra* note 8, at 22.

1. The history and current application of the corporate practice of medicine doctrine

The prohibition against the corporate practice of medicine has its roots in ethical standards promulgated by the American Medical Association (AMA) during the 1800s.[225] The guidelines, which prohibit corporations or lay entities from employing physicians, set out to distinguish professionally trained doctors from "quacks" who offered substandard or fraudulent medical care.[226]

The AMA's ban on the corporate practice of medicine reflected public policy concerns about the safety and legitimacy of the medical practice in the hands of for-profit or other nonprofessional entities.[227] The public policy concern was that lay control over the medical profession would create perverse profit motives at the expense of patients.[228] Additionally, corporate control over medicine would remove the physician's autonomy in decisionmaking critical to the patient's care.[229] Broadly, the corporate practice prohibition responded to a concern about the commercialization of the medical profession and the fear of conflicting interests between profit and patient care.[230]

Eventually, the AMA successfully turned these ethical guidelines into state laws by lobbying state legislatures to adopt strict medical practice acts incorporating much of the AMA's framework.[231] Organized medicine[232] maintained that prohibition of corporate control over physicians is implicit in that only natural persons, not corporations, could be licensed to practice medicine.[233] Many newly adopted laws also prohibited fee splitting between

225. Nicole Huberfeld, *Be Not Afraid of Change: Time to Eliminate the Corporate Practice of Medicine Doctrine*, 14 HEALTH MATRIX 243, 245-47 (2004).

226. *Id.*

227. Mark Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431, 514 (1988); AM. MED. ASS'N, PRINCIPLES OF MEDICAL ETHICS, ch. 3, art. 6, § 5, *in* AM. MED. ASS'N, AMERICAN MEDICAL DIRECTORY 15 (15th ed. 1938).

228. Hall, *supra* note 227, at 514; Hampton, *supra* note 223, at 497.

229. Hall, *supra* note 227, at 514; Hampton, *supra* note 223, at 497.

230. Hall, *supra* note 227, at 514.

231. Kathrine Marous, Comment, *The Corporate Practice of Medicine Doctrine: An Anchor Holding America Back in the Modern and Evolving Healthcare Marketplace*, 70 DEPAUL L. REV. 157, 161 (2020).

232. The term "organized medicine" refers to the collection of professional associations, including the AMA, representing the political interests of medical profession. It was a major political and economic force, particularly in the twentieth century. PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 26-28 (1982); R. Scott Jones, *Organized Medicine in the United States*, 217 ANNALS SURGERY 423, 423-25 (1993).

233. Hall, *supra* note 227, at 509-10; Huberfeld, *supra* note 225, at 249-50.

medical professionals and lay entities.[234] Finally, courts affirmed that state medical practice acts barring the unlicensed practice of medicine implicitly prohibit corporate ownership or employment of physicians, cementing public policy against corporate control of the medical profession.[235]

From its inception, the corporate practice of medicine doctrine did not escape criticism.[236] Some critics argued that the AMA's guidelines were profit-seeking attempts at stifling competition.[237] A century after the ethical code was first passed, the FTC challenged the doctrine as anticompetitive.[238] During the 1970s and 1980s, the FTC successfully argued that the AMA's ethical guidelines prevented physicians from adopting "more economically efficient business formats."[239]

An additional impetus to scale back the corporate practice prohibition came from public policy embrace of health maintenance organizations, as manifested in the Health Maintenance Organization (HMO) Act of 1973.[240] The Act incentivized the creation of managed care entities where physicians could contract directly with corporate entities.[241] Most medical practice acts, however, were interpreted to prohibit physicians from associating with HMOs.[242] The corporate practice of medicine doctrine therefore stood in the way of innovation and reforms intended to control the skyrocketing price of health care in the 1970s and 1980s.[243]

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234. Huberfeld, *supra* note 225, at 249; *see infra* Part II.C.3.

235. *See, e.g.*, Neill v. Gimbel Bros., Inc., 199 A. 178, 182 (Pa. 1938) (holding that a department store could not employ an optometrist); Bartron v. Codington County, 2 N.W.2d 337, 346 (S.D. 1942) (concluding that corporations' engagement in the practice of medicine is against public policy because it reduces the quality of care); *see also* Huberfeld, *supra* note 225, at 251.

236. *See* Hall, *supra* note 227, at 510 ("The doctrine has a long history of suppressing needed innovation in times of industry upheaval.").

237. *See id.* at 515 ("When courts enforce the corporate practice doctrine, they mistakenly suppose they are enforcing the legislature's *public* protection polices when in fact they are enforcing the profession's *economic* protection policies."); *see also* Marous, *supra* note 231, at 161 (explaining that the AMA sought to "control the health care market" by limiting the practice of medicine to people with formal medical training).

238. Hall, *supra* note 227, at 515; Huberfeld, *supra* note 225, at 255.

239. *In re* Am. Med. Ass'n, 94 F.T.C. 701, 1017-18 (1979); *see* Hall, *supra* note 227, at 515; *see also* Huberfeld, *supra* note 225, at 255. The FTC based its conclusion in part on concerns over the AMA's statements that "[i]t is unprofessional for a physician to dispose of his services under conditions . . . which interfere with reasonable competition among the physicians of a community." *Id.* at 246 n.5 (quoting AM. MED. ASS'N, *supra* note 227, at 15).

240. Huberfeld, *supra* note 225, at 255; Hampton, *supra* note 223, at 501.

241. Huberfeld, *supra* note 225, at 255; *see* Hampton, *supra* note 223, at 501.

242. Huberfeld, *supra* note 225, at 255-56.

243. Hall, *supra* note 227, at 510-11; *see* Huberfeld, *supra* note 225, at 255.

Following the HMO Act and the managed care revolution, the corporate practice of medicine doctrine fell into legal disfavor.[244] Just as legislators carved out exceptions for managed care entities, courts increasingly recognized exceptions for other officially endorsed forms of corporate practice such as hospitals and nonprofit clinics, which were allowed to employ medical professionals.[245]

Despite its apparent diminution, the doctrine still persists in many states, leading some observers to challenge the doctrine's role in the modern health care economy.[246] These critiques broadly contend that the doctrine's originating concerns are out of step with current realities in three ways.

First, managed care is now an industry norm and has grown even more important since the passage of the Affordable Care Act and the shift away from fee-for-service reimbursement.[247] Payment reforms involving risk sharing and value-based payment necessitate care coordination and management efforts that entail more corporate involvement.[248]

Second, physicians are motivated in part by financial concerns.[249] Therefore, managed care deploys payment methods that encourage physicians to consider what treatment costs, which is in tension with the purity of motivation that the corporate practice prohibition seeks.[250]

Third, the rise of consumer-directed health insurance—which pairs high deductible health plans with health savings accounts to encourage the consumer to price shop for health services—has furthered the notion that health care is an ordinary consumer product.[251] In these various ways, modern health plans have created a reality in which insurance-like entities exercise control over the delivery of care.[252]

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244. Marous, *supra* note 231, at 168-69.

245. Hall, *supra* note 227, at 517; Marous, *supra* note 231, at 168.

246. Hall, *supra* note 227, at 509-11, 516; *see* Marous, *supra* note 231, at 158 (arguing that "[t]he justification behind barring corporate influence from medical practice overlooks the realities of the current healthcare marketplace").

247. Marous, *supra* note 231, at 174.

248. Huberfeld, *supra* note 225, at 257-58; Marous, *supra* note 231, at 173-74. In the context of health care payments, risk-sharing refers to the agreements to share financial risk between the payer and providers for the cost and quality of care provided to the health plan's enrollees. Value-based payments are a form of reimbursement where the payer ties payment to the quality and efficiency of health care provided, rather than paying based on volume. *See* Jacqueline LaPointe, *Understanding the Value-Based Reimbursement Model Landscape*, RECYCLE INTEL. (Sept. 9, 2016), https://perma.cc/YDH5-YTPW.

249. Hall, *supra* note 227, at 515; Huberfeld, *supra* note 225, at 258-59.

250. Huberfeld, *supra* note 225, at 258-59.

251. TIMOTHY STOLTZFUS JOST, HEALTH CARE AT RISK: A CRITIQUE OF THE CONSUMER-DRIVEN MOVEMENT 17-19 (2007).

252. Marous, *supra* note 231, at 174-75.

Accordingly, although a few states still vigorously enforce the doctrine, others have made it easier for corporations to employ medical professionals.[253] In addition to maintaining the carved-out exceptions previously noted, such states allow some form of corporate control over medicine as long as the physician retains ultimate control over the delivery of care.[254]

2. Applying the corporate practice prohibition to private equity

Despite its near demise and unpopularity, the prohibition against the corporate practice of medicine persists in most states in some form.[255] States vary in the extent of their enforcement, ranging from a nearly *per se* ban to practical nonenforcement.[256] Even in states that strongly enforce the corporate practice of medicine doctrine, PE firms have successfully circumvented the prohibition by using investment models that grant them significant control over medical practices, even without outright ownership.[257] Nevertheless, because the corporate practice prohibition remains on the books in most states, the doctrine can be revived and redeployed to address the commercialization concerns over PE's increasing investment in and influence over physician practices. The following Subparts explore several ways this might occur or is in fact occurring.

a. The MSO model

The most common attempt to outmaneuver the corporate practice prohibition involves a management services organization (MSO) owned and controlled by a PE firm contracting with a physician-owned professional corporation to provide administrative and other services for a fee.[258] This model is popular with both parties because it alleviates the physicians' burdens of running the business while granting financial and operational control over the medical practice to the investor.[259] The MSO's administrative services may

253. Stuart I. Silverman, *In an Era of Healthcare Delivery Reforms, the Corporate Practice of Medicine Is a Matter that Requires Vigilance*, 9 AM. U. HEALTH L. & POL'Y BRIEF 1, 2 (2015).

254. *Id.* at 8.

255. *See* Jane M. Zhu, Hayden Rooke-Ley & Erin Fuse Brown, *A Doctrine in Name Only—Strengthening Prohibitions Against the Corporate Practice of Medicine*, 389 NEW ENG. J. MED. 965, 966 (2023); Matt Wilmot, Wes Scott & Ethan Rosenfeld, *Corporate Practice of Medicine Doctrine: Increased Enforcement on the Horizon?*, NELSON MULLINS (Jan. 17, 2023), https://perma.cc/46E2-2CCQ.

256. Marous, *supra* note 231, at 163-67.

257. *Id.* at 170-71.

258. *Id.*

259. Carol Lucas, *Corporate Practice of Medicine on Steroids*, JD SUPRA (May 11, 2021), https://perma.cc/M48A-VYDA.

include purchasing office space and equipment, billing and collections, and hiring nonphysician staff.[260] While the MSO may provide administrative services, the corporate practice prohibition requires that clinical decisions be made by the physicians.[261]

Even though the MSO does not technically employ the physicians, the MSO can use various mechanisms to maintain effective control over the medical practice.[262] For example, as part of the deal, some physician-owners of the medical practice are required to sign stock restriction agreements preventing them from selling their interests or exercising certain rights in the practice without the approval of the MSO.[263] Physician-owners are also obligated to sign tight restrictive covenants and nondisclosure agreements.[264]

In California, a state with a historically strong corporate practice prohibition, the legislature recently considered a bill that took aim at the MSO investment model by requiring the physician-owners of the practice to exercise ultimate control over the business aspects of the medical practice:

> (a) The shareholders, directors, and officers of a medical corporation . . . shall manage and have ultimate control over the assets and business operations of the medical corporation and shall not be replaced, removed, or otherwise controlled by any lay entity or individual, including, without limitation, through stock transfer restriction agreements or other contractual agreements and arrangements.
>
> (b) For purposes of this section, "ultimate control" shall mean and be consistent with the definition provided by generally accepted accounting principles.[265]

The California bill did not advance to a vote, but other states, including Oregon, have pursued similar measures to strengthen the corporate practice of medicine doctrine.[266] Such legislation would severely curtail the ability of PE and other lay investors to use the MSO model to avoid the corporate practice of medicine prohibition. More than just requiring that physicians control the

260. *Id.*

261. Adam M. Freiman, *The Abandonment of the Antiquated Corporate Practice of Medicine Doctrine: Injecting a Dose of Efficiency into the Modern Health Care Environment*, 47 EMORY L.J. 697, 739-40 (1998) (describing MSO arrangements and requirements that the MSO not interfere with physicians' medical decisions).

262. Marous, *supra* note 231, at 171.

263. *Id.*

264. FUSE BROWN ET AL., *supra* note 8, at 21-22.

265. S.B. 642, Cal. Leg., 2021-2022 Reg. Sess. (Cal. 2021).

266. *See* H.B. 4130, 82d Legis. Assemb., 2024 Reg. Sess. (Or. 2024) (proposing legislation to strengthen the corporate practice of medicine prohibition in Oregon); *see also* Amelia Templeton, *Oregon Lawmakers Could Limit Corporate Ownership of Medical Practices*, OR. PUB. BROAD. (Feb. 22, 2024, 6:00 AM), https://perma.cc/BV7J-SBMS.

clinical decisionmaking, this proposal requires medical professionals to have control over the business aspects of the practice.[267]

b. Litigation over PE investment models

The "friendly PC" model is similar to the MSO model and allows PE firms to control physician practices without running afoul of the corporate practice prohibition.[268] A standard way physicians satisfy the corporate practice prohibition is to incorporate their practice as a medical professional corporation (PC), which must be owned only by one or more licensed physicians.[269] In the friendly PC adaptation, PE firms appoint which licensed physician will be the PC's owner.[270] This "friendly" physician owner then hires other physicians and enters into contracts for the delivery of care.[271]

The friendly PC model is at issue in the California case, *AAEMPG v. Envision*, involving one of the largest PE firms in the health care marketplace, Kohlberg Kravis Roberts (KKR).[272] In 2017, KKR bought Envision Physician Services, one of the largest multispecialty physician groups in the country.[273] The plaintiff is a physician management company that lost a contract with another emergency medical group after a hospital granted an exclusive contract with an Envision-owned emergency group.[274] The plaintiff alleges that Envision, through a friendly PC, exercises an impermissible level of control over the delivery of care by its affiliate in violation of California's corporate practice prohibition.[275]

Specifically, the plaintiff alleges that the affiliate is owned by a California-licensed physician who is either directly employed by Envision or is under its substantial control.[276] The physician-owner must sign a stock transfer agreement that prevents them from having actual control over the company, including restrictions on the ability to issue dividends, create additional stock,

267. Cal. S.B. 642.

268. Marous, *supra* note 231, at 170-71.

269. Am. Med. Ass'n, Issue Brief: Corporate Practice of Medicine 1 (2015), https://perma.cc/X92W-CSBU.

270. Marous, *supra* note 231, at 171.

271. Michael Gawley, *A Friendly Reminder: Friendly PC Arrangements Are Subject to Scrutiny*, JD SUPRA (June 20, 2022), https://perma.cc/TV6J-TPQV; *Don't Forget the "PC" in the "Friendly PC" Model*, NOSSAMAN LLP (Feb. 15, 2022), https://perma.cc/6F9G-GZ5W.

272. Complaint at 5, Am. Acad. of Emergency Med. Physician Grp., Inc. v. Envision Healthcare Corp., No. 22-cv-00421 (N.D. Cal. Jan. 21, 2022), ECF No. 1-1.

273. *Id.*

274. *Id.* at 7-8.

275. *Id.* at 6-7, 16.

276. *Id.* at 8.

or sell the medical group.[277] Moreover, KKR-backed Envision retained control over several key aspects of the practice: physician employment, compensation, work schedules, and staffing levels; negotiating contracts with payers; and setting quality and performance metrics.[278]

Although the case is still pending, the federal district court rejected Envision's motion to send the case first to the state medical board.[279] Though unresolved at this time, the case may affect the ability of PE firms to exercise control over their health care investments in California.[280]

Texas is another state with a strong prohibition against the corporate practice of medicine.[281] Addressing what constitutes "control" over the medical practice, Texas courts indicate that control over a medical practice is a fact-intensive inquiry, requiring close review of the individual MSO agreements at issue. In *Flynn Brothers, Inc. v. First Medical Associates*, two business partners contracted with an emergency physician in Texas through various corporate entities and management agreements.[282] Because the investors were not licensed physicians, the emergency physician formed a professional corporation that could contract with a hospital to provide emergency services.[283] The management agreement between the two parties gave lay investors the following rights: to prevent the physician from selling his interest in the practice, to receive two-thirds of the practice's net profit, to encumber the practice's assets to raise capital and other financing, to trade on the physician's medical license, and to decide which of the PC's medical staff would work at the hospital.[284]

The court invalidated the agreement under the Texas Medical Practice Act because it found that the physician was essentially under the employment of the unlicensed investors.[285] The court reasoned that the "contractual scheme

277. *Id.*

278. *Id.* at 9-10.

279. Am. Acad. of Emergency Med. Physician Grp., Inc. v. Envision Healthcare Corp., No. 22-cv-00421, 2022 WL 2037950, at *6, *11 (N.D. Cal. May 27, 2022).

280. *See, e.g.*, Gawley, *supra* note 271 (describing the implications of *AAEMPG v. Envision* for the corporate practice of medicine); Dan Weissmann, *Private Equity Might Run Your Local Emergency Room. Meet the Doctors Suing to Kick Them Out*, AN ARM & A LEG (June 16, 2022), https://perma.cc/4YH9-BUNP (discussing the plaintiff's legal strategy using state corporate practice of medicine laws to challenge private equity investment in physician practices).

281. Flynn Bros. v. First Med. Assocs., 715 S.W.2d 782, 785 (Tex. App. 1986); Xenon Health, L.L.C. v. Baig, 662 F. App'x 270, 274 (5th Cir. 2016).

282. *Flynn Bros.*, 715 S.W.2d at 783.

283. *Id.*

284. *Id.* at 783-85.

285. *Id.* at 785.

was developed to do indirectly that which they freely concede they could not do directly under the Medical Practices Act."[286] Relevant to the PE context, the court disallowed using a physician's emergency practice as an investment vehicle for those who could not practice medicine independently.[287] Additionally, there are comparisons between the pledging of the PC's assets noted in this case and the LBO model utilized by most PE acquisitions.

The Fifth Circuit likewise weighed in on what contractual terms would constitute the unlicensed practice of medicine in violation of the Texas Medical Practice Act in *Xenon Health, L.L.C. v. Baig*.[288] Although the entity that violated the law was a California professional corporation and not a lay corporation, the reasoning of the case could apply as well to a PE-backed MSO not licensed to practice medicine in Texas. In *Xenon*, a joint venture agreement between the California PC and the Texas PC gave the California PC (owned by a physician not licensed in Texas) the exclusive authority over many aspects of the practice in Texas, including: hiring, credentialing, and scheduling physicians in the Texas clinic; ordering supplies and equipment; billing and collection; monitoring regulatory compliance; financial reporting and management; and implementing quality assurance programs.[289] Additionally, the joint venture agreement prevented the Texas PC from "paying any dividends or distributions, incurring any debt, or selling company assets" without the consent of the California PC.[290] The court concluded that, as a whole, the agreement violated the Texas Medical Practice Act because it took "total control of" of the Texas PC.[291]

Although *Flynn Brothers* and *Xenon* provide examples of impermissible control by unlicensed entities over medical practices through the use of management agreements, other case law in Texas finds no violation where the management agreements stop short of converting physician owners into virtual agents or employees.[292] Thus, whether or not a corporate investor or management firm exerts impermissible levels of control over a medical practice is highly fact specific—even in a state like Texas with a vigorous corporate practice prohibition.[293] The nature of the PE investment model,

286. *Id.*

287. *Id.*

288. Xenon Health, L.L.C. v. Baig, 662 F. App'x 270, 271 (5th Cir. 2016).

289. *Id.* at 271, 273.

290. *Id.* at 273.

291. *Id.* at 272-73.

292. Gupta v. E. Idaho Tumor Inst., Inc., 140 S.W.3d 747, 754 (Tex. App. 2004); McCoy v. FemPartners, Inc., 484 S.W.3d 201, 210 (Tex. App. 2015).

293. *See Gupta*, 140 S.W.3d at 754 (distinguishing the instant case from *Flynn Bros.* because the physician retained authority over personnel and billing decisions); *McCoy*, 484

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with active management by the PE general partner, inherently pushes the limits of allowable nonprofessional control. Because investors want maximum control of the business, management agreements between private equity firms and medical practices might edge toward those found to be impermissible in the *Flynn Bros.* and *Xenon* cases.

3. State fee-splitting laws

As a corollary to the corporate practice of medicine doctrine, many states have adopted laws prohibiting the splitting of professional fees between medical professionals and lay entities.[294] These fee-splitting laws aim to prevent unlicensed corporations from profiting from a physician's professional income and grew out of the same AMA lobbying efforts that convinced state legislatures to limit the practice of medicine to physicians.[295] The policy concern was that fee-splitting arrangements could divide physicians' loyalty to their patients and would place nonprofessionals in a position to influence medical practice for financial gain.[296]

As with the corporate practice prohibition, states vary in the degree to which they enforce fee-splitting laws.[297] Where enforced, fee-splitting laws are used to invalidate agreements to share a percentage of professional revenue with outside entities, such as management companies.[298] In New York, the state fee-splitting law has been applied to invalidate management service arrangements between medical practices and lay entities, where the lay entity shares a percentage of the revenues generated by medical services.[299]

In other states, state legislatures have watered down judicial enforcement of fee-splitting laws.[300] For example, the Illinois Supreme Court had previously applied the state fee-splitting law[301] to invalidate percentage-of-

S.W.3d at 212 (holding that lay persons only controlled "nonmedical functions and services," leaving recruitment and oversight of physicians in the hands of physicians).

294. Huberfeld, *supra* note 225, at 261-62.

295. *Id.* at 249.

296. *See* Ari J. Markenson & Angela Humphreys, *What Is . . . the Corporate Practice of Medicine and Fee-Splitting?: Fee-Splitting Prohbitions*, AM. BAR ASS'N. (Feb. 2021), https://perma.cc/VU63-PJML.

297. Silverman, *supra* note 253, at 20-23.

298. *Id.* at 22.

299. Necula v. Conroy, No. 96-cv-08990, 2000 WL 877009, at *1-3, *11 (S.D.N.Y. June 30, 2000) (striking down the agreement between a radiologist and an MSO because the physician agreed to pay the MSO a fixed percentage of the receipts for billing services), *aff'd*, 13 F. App'x 24 (2d Cir. 2001).

300. Silverman, *supra* note 253, at 21.

301. 225 ILL. COMP. STAT. ANN. 60/22.2 (West 2023) (providing that "[a] licensee under this Act may not directly or indirectly divide, share or split any professional fee or other

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revenue agreements in *Vine Street Clinic v. HealthLink, Inc.*[302] At issue were two financial arrangements between the defendant corporation and physician groups: (1) an administrative fee equal to 5% of the physician groups' revenue; and (2) a flat fee based on the volume of claims submitted by the physician groups in the preceding calendar year.[303] The court invalidated the percentage of revenue arrangement as against the public policy expressed by the fee-splitting prohibition but upheld the flat fee arrangement because it was not "based or linked to [the physician's] revenue."[304]

Following the *Vine Street* decision, however, the Illinois legislature amended the fee-splitting law to allow certain types of arrangements—even those where an unlicensed entity receives a percentage of professional fees—if certain requirements are met.[305] The new exception permits medical providers to pay fair market value to an unlicensed entity to perform "billing, administrative preparation, or collection services based upon a percentage of professional fees billed or collected," provided that: (1) the medical practice controls the amount of fees charged or collected; and (2) all charges collected are deposited into an account controlled by the medical practice or are held in trust by a licensed collection agency.[306] This exception, although it requires medical practices to retain control over professional fees, creates room for the "friendly PC" and MSO arrangements that PE investors use.

California's fee-splitting law contains a similar fee-splitting exception, which also gives significant leeway for private investment.[307] That law provides that:

> The payment or receipt of consideration for services other than the referral of patients that is based on a percentage of gross revenue or similar type of contractual arrangement shall not be unlawful if the consideration is commensurate with the value of the services furnished or with the fair rental value of any premises or equipment leased or provided by the recipient to the payer.[308]

California courts have applied this exception to uphold at least one financial arrangement between a physician and MSO where the court concluded the

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form of compensation for professional services with anyone in exchange for a referral *or otherwise* . . . ." (emphasis added)).

302. Vine St. Clinic v. HealthLink, Inc., 856 N.E.2d 422, 434 (Ill. 2006).

303. *Id.* at 426-27; *see also* Silverman, *supra* note 253, at 21.

304. *Vine St. Clinic*, 856 N.E.2d at 434-35.

305. 225 ILL. COMP. STAT. ANN. 60/22.2 (West 2023); *see* Silverman, *supra* note 253, at 21.

306. 225 ILL. COMP. STAT. ANN. 60/22.2 (West 2023).

307. CAL. BUS. & PROF. CODE § 650(b) (West 2023).

308. *Id.*

management services fee was commensurate with fair market value.[309] Although not explicitly pled under the California fee-splitting statute, the plaintiff in the pending *AAEMPG v. Envision* case alleges an illegal fee-splitting scheme because Envision "earns amounts from the physician's billings that exceed the reasonable value of . . . administrative services Envision provides."[310]

Not all states have adopted exceptions to their fee-splitting laws.[311] New York's law remains relatively strong; it explicitly prohibits the type of arrangement that California and Illinois amended their laws to allow.[312] In many states, however, lay corporations wishing to invest in or operate physician practices can avoid state fee-splitting laws with a carefully structured agreement. In states with stronger fee-splitting laws, the aggressive nature of the PE model might make such agreements legally vulnerable. By exerting aggressive control over investments in the medical practice, PE firms might be more prone to impermissible behavior, such as setting the fees billed by physicians, controlling the practice's revenue, or providing services to the medical practice at nonmarket rates. If the practice was set up to avoid sharing revenues from federally reimbursed services and entanglements under the Stark Law,[313] the practice may still violate state fee-splitting laws, which do not discriminate based on the source of the revenue by payer or type of service. If indications of PE control over acquired practices are evident, state fee-splitting laws might remain a viable oversight mechanism.

D. Physician Employment Laws

State and federal laws regulating the use of noncompete, antidisparagement, and nondisclosure clauses in employment agreements could offer stronger protection for physicians' clinical and professional autonomy from control by PE investors. After acquisition by a PE firm, physicians typically must sign employment agreements with the PE-backed practice.[314] These agreements generally include restrictive covenants, under which the physician is not permitted to work within a defined geographic

309. Epic Med. Mgmt., LLC v. Paquette, 244 Cal. App. 4th 504, 516-17 (2015).

310. Complaint at 9, Am. Acad. of Emergency Med. Physician Grp., Inc. v. Envision Healthcare Corp., No. 22-cv-00421 (N.D. Cal. Jan. 21, 2022), ECF No. 1-1.

311. *See* Zhu et al., *supra* note 255, at 961.

312. N.Y. EDUC. LAW § 6530 (McKinney 2023) (prohibiting "any arrangement or agreement whereby the amount received in payment for furnishing space, facilities, equipment or personnel services used by a licensee constitutes a percentage of, or is otherwise dependent upon, the income or receipts of the licensee from such practice").

313. *See supra* notes 196-201.

314. *See* Bonnie Darves, *Physician Employment Contracts: Strategies for Avoiding Pitfalls*, NEJM CAREERCENTER (Nov. 20, 2019), https://perma.cc/97Z7-XYJ7; Abelson & Sanger-Katz, *supra* note 1.

radius of the employer for a certain period of time, sometimes years, after employment.[315] Further, physician noncompetes can be anticompetitive. In its antitrust suit against U.S. Anesthesia Partners and Welsh Carson, the FTC alleged that USAP used noncompetes to prevent physicians from "splitting off and forming their own groups or joining other groups looking to challenge USAP's market position."[316] The use of noncompetes are common in physician employment agreements to protect the value of the investment by retaining the physician's expertise, labor, and patient base.[317] Some physician contracts with PE, however, go further to include nondisclosure and antidisparagement clauses which may prevent physicians from expressing concerns about the practice's operation, including concerns over billing practices, patient safety, or staffing.[318]

Although noncompete agreements have become relatively common for physicians, they remain controversial.[319] Regulation of noncompetes is traditionally the realm of state law, but the FTC has recently stepped in with a proposed rule to bar noncompete clauses in employment contracts across all sectors, including for physicians.[320] The proposed rule would classify the use of employee noncompete agreements as an unfair method of competition.[321] While some question the applicability of the rule to nonprofit hospitals over which the FTC has limited jurisdiction,[322] analysts predict that the FTC's ban on noncompetes could cause a dramatic collapse of investment in physician practices if investors could not prevent the core value of the investment (the physicians) from walking away.[323]

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315. Derek W. Loeser, *The Legal, Ethical, and Practical Implications of Noncompetition Clauses: What Physicians Should Know Before They Sign*, 31 J.L. MED. & ETHICS 283, 283 (2003).

316. Complaint for Injunctive and Other Equitable Relief at 83, FTC v. U.S. Anesthesia Partners, No. 23-cv-03560 (S.D. Tex. Sept. 21, 2023), ECF No. 1.

317. FUSE BROWN ET AL., *supra* note 8, at 21.

318. Heather Perlberg, *How Private Equity Is Ruining American Healthcare*, BLOOMBERG (updated May 20, 2020, 2:09 PM PDT), https://perma.cc/8CG8-Y9BX.

319. FUSE BROWN ET AL., *supra* note 8, at 21; Erik B. Smith, *Ending Physician Noncompete Agreements—Time for a National Solution*, 2 JAMA HEALTH F. e214018, at 1 (2021), https://perma.cc/6CVN-XEJW.

320. Non-Compete Clause Rule, 88 Fed. Reg. 3482 (proposed Jan. 19, 2023) (to be codified at 16 C.F.R. pt. 910).

321. *Id.*

322. *See, e.g.*, Frank Diamond, *How FTC's Noncompete Agreements Rule Could Impact Healthcare*, FIERCE HEALTHCARE (Jan. 6, 2023, 5:00 PM), https://perma.cc/NB66-Z9GU; Samantha Liss, *Nonprofit Hospitals May Evade Noncompete Ban Enforcement, Experts Say*, HEALTHCARE DIVE (Jan. 20, 2023), https://perma.cc/A25R-7ERY.

323. *See, e.g.*, Samantha Liss, *Doctors No Longer Bound by Noncompetes Under FTC's Proposed Ban*, HEALTHCARE DIVE (Jan. 11, 2023), https://perma.cc/7LCX-F7AT; Blake Madden, *What to Know About the CVS-Carbon Health Deal and What It Means for Healthcare*,

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States that limit physician noncompete clauses via state statute or case law do so based on policy concerns about the physician-patient relationship and the availability of medical services.[324] With increased market consolidation, geographic restrictions may be so broad as to force a physician to either relocate to another region upon termination or to cease practice for a period of years.[325] Such onerous restrictions may chill physicians' willingness to voice concerns about an employer's practices or exit an employment situation they consider ethically questionable.

Most states limit, rather than ban, physician noncompete agreements through judicial application of general public policy considerations and a reasonableness standard.[326] Some states extend more explicit statutory protection to physicians.[327] Covenants not to compete are unenforceable in New Hampshire if they restrict the right of the physician to practice in any geographic region within the state.[328] In Connecticut, noncompetes may not restrict a physician's ability to practice more than fifteen miles from the primary site where the physician practices.[329] Additionally, restrictive covenants in Connecticut are unenforceable if the physician's agreement is terminated by the employer without cause.[330] In 2023, Indiana passed a law that makes noncompetes for physicians unenforceable in most circumstances starting July 1, 2023, and establishes a buyout process for physicians who entered into noncompete agreements prior to July 1, 2023.[331]

Other states concerned about preserving physician autonomy under PE investment could adopt similar laws or declare physician noncompetes presumptively unenforceable. Strengthening statutory or regulatory limits on physician noncompete clauses would provide quicker and clearer policy

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WORKWEEK (Jan. 10, 2023) (predicting that if the FTC's ban on noncompetes is finalized, "[p]hysician practice M&A would fall apart"), https://perma.cc/2MHV-EV24.

324. Loeser, *supra* note 315, at 287-88.

325. *Id.* at 284.

326. *Id.* at 287.

327. *Id.*

328. N.H. REV. STAT. ANN. § 329:31-a (2023).

329. CONN. GEN. STAT. § 20-14p(b)(2)(A)(ii) (West 2023).

330. *Id.* § 20-14p(b)(2)(B)(ii).

331. *See* S. Enrolled Act 7, 123rd Gen. Assemb., 1st Reg. Sess. (Ind. 2023). A noncompete for employed physicians is unenforceable if any of the following circumstances occur: "(1) The employer terminates the physician's employment without cause. (2) The physician terminates the physician's employment for cause. (3) the physician's employment contract has expired, and both the physician and employer have fulfilled their obligations under the contract." IND. CODE ANN. § 25-22.5-5.5-2(b) (West 2023). Noncompetes for primary care physicians are barred in all circumstances. *Id.* § 25-22.5-5.5-2.5(b).

change, rather than relying on courts to scrutinize the reasonableness of noncompete restrictions case by case.

Imposing nondisclosure or antidisparagement clauses—also known as gag clauses—is another restrictive employment practice that inhibits physicians from confronting troubling aspects of the PE investment.[332] These gag clauses might, for instance, prevent physicians from speaking out publicly or to patients about utilization practices, upcoding, reductions in staffing levels or supervision, or other concerns about quality of patient care.[333] In a *New York Times Magazine* article on the moral crisis facing U.S. physicians due to health care corporatization, the reporter noted:

> [T]he physicians I contacted were afraid to talk openly . . . . Some sources I tried to reach had signed nondisclosure agreements that prohibited them from speaking to the media without permission. Others worried they could be disciplined or fired if they angered their employers, a concern that seems particularly well founded in the growing swath of the health care system that has been taken over by private-equity firms.[334]

Similar concerns about the use of gag clauses in physician contracts arose in the managed care era in the 1990s. During this period, managed care plans contractually barred physicians from discussing with patients the availability of medically necessary treatment options not covered by the health plan.[335] Other gag provisions prevented physicians from making remarks that would undermine confidence in the health plan.[336] While the plans contended the gag clauses protected proprietary information and enhanced market competition, critics worried they undermined patient safety, the ability of patients to provide informed consent, and physicians' clinical judgment.[337]

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332. Perlberg, *supra* note 318; Morgenson, *supra* note 16.

333. *See* Perlberg, *supra* note 318.

334. Press, *supra* note 16. Press illustrated this concern with a story of an emergency room physician, Ming Lin, who was employed by private-equity-owned TeamHealth. *Id.* Dr. Lin lost his post after publicly voicing concerns over his hospital's Covid-19 safety protocols. *Id.*

335. *See generally* Julia A. Martin & Lisa K. Bjerknes, Comment, *The Legal and Ethical Implications of Gag Clauses in Physician Contracts*, 22 AM. J.L. & MED. 433, 434 (1996) (discussing the scope, prevalence, and legality of gag clauses imposed on physicians by managed care organizations (MCOs)); Joan H. Krause, *The Brief Life of the Gag Clause: Why Anti-Gag Clause Legislation Isn't Enough*, 67 TENN. L. REV. 1, 2-6, 10-13 (1999) (examining the incentives that MCOs have to withhold information and the limitations of current anti-gag-clause legislation); Bethany J. Spielman, *After the Gag Episode: Physician Communication in Managed Care Organizations*, 22 SETON HALL LEGIS. J. 437, 441 (1998) (identifying subject matters commonly covered within gag clauses, as well as how the law has responded to such matters, and addressing lingering uncertainties about what physicians and MCOs are and are not required to disclose).

336. Martin & Bjerknes, *supra* note 335, at 444.

337. Spielman, *supra* note 335, at 445, 448; Martin & Bjerknes, *supra* note 335, at 449.

Under pressure from the AMA and the public, several states passed laws regulating or restricting the use of gag clauses in physician-managed care plan contracts.[338] Most prohibit clauses that prevent physicians from discussing treatment options, although some statutes more broadly protect physicians who publicly express concerns about the plan—akin to an antidisparagement ban.[339]

Despite the popularity of anti-gag clause laws during the managed care era, retrospective assessments cast doubt on their effectiveness.[340] One problem was the lack of precision about what constitutes a gag clause, leaving it unclear whether antidisparagement or confidentiality agreements were covered by the gag clause bans.[341] Another problem is that gag clause prohibitions were a "paper tiger" because they did not change managed care plans' ability to terminate physicians without cause, the ultimate weapon to elicit physician compliance.[342]

Thus, if states today want to protect physicians' clinical autonomy from control by investors, it is not enough to prohibit gag clauses. Such protections should be paired with legal protections for whistleblowers as an exception to the at-will employment doctrine.[343] In a state with such an exception, an employee may not be terminated for exposing employer conduct that is against the public policy of the state.[344] This exception may enable some to voice their concerns.[345] Policymakers could also explicitly define the types of noncompete, nondisclosure, and antidisparagement clauses that are against public policy when applied to physicians by corporate employers.[346]

Restricting the use of these various provisions in physician employment agreements can help preserve physicians' autonomy to leave or speak out about practices that may pose dangers to patient care.[347] Additionally, courts'

338. Krause, *supra* note 335, at 3-4.

339. *Id.* at 20-24; Spielman, *supra* note 335, at 456-57. The state of Washington, for a brief time, expressly protected physicians who criticized health plans. *Id.* at 457. But the provision was repealed in 2000. Act Relating to Health Care Patient Protection, ch. 5, § 29(1), 2000 Wash. Sess. Laws 37.

340. Krause, *supra* note 335, at 2.

341. *Id.* at 10; *see also* U.S. GOV'T ACCOUNTABILITY OFF., GAO/HEHS-97-175, MANAGED CARE: EXPLICIT GAG CLAUSES NOT FOUND IN HMO CONTRACTS, BUT PHYSICIAN CONCERN REMAINS 5 (1997) (finding that there was "little consensus" about what provisions constituted gag clauses), https://perma.cc/8SJB-66ZU.

342. Krause, *supra* note 335, at 12-15.

343. Jennifer L. D'Isidori, Note, *Stop Gagging Physicians!*, 7 HEALTH MATRIX 187, 210-11 (1997).

344. *Id.* at 212-13.

345. *Id.* Some state whistleblower laws, however, cover only criminal acts or apply only to state employees. *Id.* at 217-18.

346. *See id.* at 213.

347. *See, e.g.*, SCHEFFLER ET AL., *supra* note 32, at 34-35; Morgenson, *supra* note 16; Perlberg, *supra* note 318.

willingness to award punitive damages when whistleblowers are wrongfully terminated for raising these concerns may embolden physicians who would otherwise be chilled by the threat of termination.[348] As in eras past, professional associations have published ethical guidelines to reiterate the primacy of the patient's best interests over financial profit.[349] Though responding to contemporary commercialization in medicine, these professional and ethical guidelines reference state laws, such as the corporate practice of medicine doctrine, that are nearly a century old.[350] Thus, these ethical guidelines are an additional reminder that the legal tools to regulate the contemporary surge of PE investment in health care have been around for decades.

III. Toward Better Regulation of Private Equity in Health Care

The profit-seeking genie is out of the bottle. Rosy tales of health care's historically charitable and mission-driven nature have always been exaggerated.[351] As long as there has been money to be made in health care, there have been incentives for profit maximization.[352] So while we may lament the corporate financialization of health care, there is no going back.

PE investment in health care is just the latest manifestation of the long trend of increasing commercialization of medicine.[353] And so long as the

348. Brovont v. KS-I Med. Servs., 622 S.W.3d 671, 694, 703 (Mo. Ct. App. 2020) (affirming lower court's decision to submit the plaintiff's wrongful-discharge claim to a jury and reinstating the jury's punitive damages award of $10 million against a defendant).

349. *See* Ryan Crowley, Omar Atiq & David Hilden, *Financial Profit in Medicine: A Position Paper from the American College of Physicians*, 174 ANNALS INTERNAL MED. 1447, 1460 (2021); Matthew DeCamp & Lois Synder Sulmansy, *Ethical and Professionalism Implications of Physician Employment and Health Care Business Practices: A Policy Paper from the American College of Physicians*, 174 ANNALS INTERNAL MED. 844, 845 (2021); Am. Med. Ass'n, Corporate Investors 1-2 (2019), https://perma.cc/CF7B-H4H4.

350. *See* STARR, *supra* note 232, at 215-20 (describing the development of the corporate practice of medicine doctrine between 1900 and 1930).

351. *See id.* at 21-29 (describing the U.S. health system as one historically dominated by the professional sovereignty of physicians, how that authority translated into economic power, and how it clashed with hospital and corporate interests in the latter half of the twentieth century).

352. *See, e.g.*, Arnold S. Relman, *The New Medical-Industrial Complex*, 303 NEW ENG. J. MED. 963, 963 (1980) (lamenting the rise of the "'medical-industrial complex,' . . . a large and growing network of private corporations engaged in the business of supplying healthcare services to patients for a profit—services heretofore provided by nonprofit institutions or individual practitioners"); Bruce Steinwald & Duncan Neuhauser, *The Role of the Proprietary Hospital*, 35 L. & CONTEMP. PROBS. 817, 818-20 (1970) (describing the history of "proprietary" for-profit hospitals in the United States, dating back to the late nineteenth century).

353. *See* STARR, *supra* note 232, at 428; *see also* McDonough, *supra* note 1 (writing in 2022 that private equity has "achieved growing prominence as a force in the American economy

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United States treats health care as a market commodity, profit-seeking will persist. One response would be to fundamentally rebuild the health care system around the principle that health care is a human right rather than a market commodity.[354] Nevertheless, reasonable minds differ about whether and what role private ordering, and thus private profit, should play in delivering health care within a universal care system.[355] Moreover, fundamentally restructuring health care finance and delivery is, at best, a long-term goal.

Meanwhile, the incursion of PE threatens the health care system *now*, and policymakers and enforcers need tools readily at hand. Thus, setting aside as currently unattainable those reforms that would turn health care from a commodity to a social good, the policy goal we propose—to address the problems of PE in health care—is more instrumental, incremental, and immediate. Rather than uprooting or barring PE investment in health care providers altogether, we seek legal interventions aimed at curbing the aspects of that investment that pose the most significant risks to patients, the profession, and health care spending: the assertion of control by corporate profit-maximizing interests over clinical decisionmaking.

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and in the United States health care system" and continues the forty-five-year trend toward the financialization of the American economy).

354. Although a full survey of this debate is beyond the scope of this Article, one of the authors has written elsewhere about what such foundational reforms might look like. *See* Erin C. Fuse Brown, Matthew B. Lawrence, Elizabeth Y. McCuskey & Lindsay F. Wiley, *Social Solidarity in Health Care: American-Style*, 48 J.L. MED. & ETHICS 411, 423 (2020) ("For next-step health reforms to move us toward greater social solidarity in health care, reformers must contend with four legal fixtures—federalism, pluralism, privatization, and individualism—that have stymied the ACA and previous reform efforts."); Wiley et al., *supra* note 23, at 661 ("We must reconstruct health reform, and ultimately the health system, using new principles and a new method. Incremental reforms . . . must be designed to be *intentionally confrontational*, with an eye toward their place in the broader project of upending or transcending the legal structures that undermine public health and propagate subordination and inequity.").

355. *See* MARTHA MINOW, PARTNERS, NOT RIVALS: PRIVATIZATION AND THE PUBLIC GOOD 140 (2002); Lindsay F. Wiley, *Privatized Public Health Insurance and the Goals of Progressive Health Reform*, 54 U.C. DAVIS L. REV. 2149, 2208 (2021) (concluding that private administration can be compatible with solidarity principles of public health care programs); Jon D. Michaels, *Privatization's Pretenses*, 77 U. CHI. L. REV. 717, 717-18 (2010); David J. Meyers, Andrew M. Ryan & Amal N. Trivedi, *How Much of an "Advantage" Is Medicare Advantage?*, 328 JAMA 2112, 2112 (2022) (concluding that research on Medicare Advantage (MA)—the private insurance plans for Medicare beneficiaries—suggests mixed benefits, with studies finding modest quality-of-care advantages but significant overpayments to MA plans compared with traditional Medicare); *see also* Megan Brenan, *Majority in U.S. Still Say Gov't Should Ensure Healthcare*, GALLUP (Jan. 23, 2023), https://perma.cc/AG7U-RX2H (finding in public opinion poll that 57% of American adults say that the government should ensure universal coverage, but 53% say the health system should be based on private insurance).

The specific harms can take the form of increased prices, diminished patient access from consolidation, overutilization and overbilling, diminished quality from inadequately supervised care or understaffed care, and constraints on physicians' autonomy and clinical decisionmaking from corporate controls and restrictive employment agreements.[356] Policy tools to curb the harms of corporate control of health care are as old as the health care system itself, offering a small glimmer of hope. For the most part, we already have in some form the legal tools needed to address some of the most worrisome risks of PE in health care—they just need to be sharpened to apply to this particular problem.

These policy levers exist at the federal and state levels, including antitrust laws, federal fraud and abuse laws, state prohibitions of the corporate practice of medicine, state fee-splitting laws, and state employment laws.[357] As this Part explains, legislative or regulatory tweaks may be needed to better target these existing laws.[358] In other instances, however, new policies may be needed to force PE investors to make their operations more transparent and to close the payment loopholes that PE investors have exploited for profit. Policymakers are not writing on a blank slate: They can build upon a foundation of federal and state laws that have been addressing different forms of the same problem for decades—the distortions created by a profit motive in the delivery of health care.

A. Improving and Better Using Existing Laws

1. Sharpening antitrust enforcement tools

Enforcement of federal antitrust laws can target harmful effects of PE-driven consolidation, and federal fraud and abuse enforcement can recoup ill-gotten revenues from PE-backed health care entities that engage in upcoding, overbilling, or providing inadequate supervision as a revenue strategy.

At the federal level, the HSR Act's reporting threshold for pre-merger review could be revised to address the cumulative effect of the serial acquisition of physician practices.[359] Various antitrust experts and enforcement officials advocate such reforms as part of broader legislation to strengthen antitrust enforcement.[360]

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356. *See supra* Part I.C.

357. *See supra* Part II.

358. FUSE BROWN ET AL., *supra* note 8, at 18-25.

359. MARTIN GAYNOR, BROOKINGS INST., WHAT TO DO ABOUT HEALTH-CARE MARKETS? POLICIES TO MAKE HEALTH-CARE MARKETS WORK 23 (2020), https://perma.cc/QA2F-S2WJ.

360. JONATHAN B. BAKER & FIONA SCOTT MORTON, ECON. FOR INCLUSIVE PROSPERITY, CONFRONTING RISING MARKET POWER 4 (2019), https://perma.cc/7QHY-HWB3; Gaynor, *supra* note 359, at 22-24; FTC, Remarks of Commissioner Rebecca Kelly

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This reduction of the HSR threshold for health care transactions would allow more visibility, review, and oversight of all smaller health care transactions (including facilities like hospices or behavioral health treatment centers), not just those pursued by PE firms.[361] The 2023 merger guidelines indicate that the FTC and DOJ will assess the market impact of accretive, add-on acquisitions cumulatively, instead of individually.[362] Even more powerful would be court precedent establishing that PE's serial acquisitions strategy can violate the antitrust laws, as alleged in the FTC's case against U.S. Anesthesia Partners and Welsh Carson.[363] Further, the FTC should use its subpoena authority to shed light on health care transactions such as PE investments that fall below the current reporting threshold.[364]

Even if federal antitrust authorities were to take these steps, their resources are too limited to oversee all health care transactions.[365] Thus, federal antitrust enforcement should be augmented by state enforcement and oversight. Parallel antitrust authority by state attorneys general allows them to also review and challenge smaller acquisitions of physician practices.[366] States could require notification of proposed transactions even if their dollar values fall below the federal threshold.[367] Connecticut, Massachusetts, Oregon, and Washington have already taken this step.[368] A 2022 California law requires prior notice of all

Slaughter as Prepared for Delivery: Antitrust and Health Care Providers Policies to Promote Competition and Protect Patients 5 (2019), https://perma.cc/6LA6-TM7X.

361. Gaynor, *supra* note 359, at 23.

362. *See generally* U.S. DEP'T OF JUST. & FTC, *supra* note 123

363. *See supra* notes 137-38 and accompanying text.

364. FTC, Statement of Commissioner Rohit Chopra: Regarding Private Equity Roll-ups and the Hart-Scott Rodino Annual Report to Congress (2020), https://perma.cc/5ZRV-YB89; FTC, Statement of Commissioner Christine S. Wilson, Joined by Commissioner Rohit Chopra: Concerning Non-Reportable Hart-Scott Rodino Act Filing 6(b) Orders (2020), https://perma.cc/74NW-BJ4N.

365. *See, e.g.*, FTC, Remarks of Chair Lina M. Khan: Regarding the Proposed Rescission of the 1995 Policy Statement Concerning Prior Approval and Prior Notice Provisions (2021), https://perma.cc/YL8Z-Y58T (noting the scarcity of agency resources for merger review as justification for reviving prior approval and notice requirements for future transactions by parties to consent agreements).

366. FUSE BROWN ET AL., *supra* note 8, at 20.

367. JAIME S. KING ET AL., SOURCE ON HEALTHCARE PRICE & COMPETITION, PREVENTING ANTICOMPETITIVE HEALTHCARE CONSOLIDATION: LESSONS FROM FIVE STATES 9 (2020), https://perma.cc/JC4L-DZ74.

368. WASH. REV. CODE ANN. § 19.390.030(3) (West 2023); CONN. GEN. STAT. ANN. § 19a-486i(c) (West 2023); MASS. GEN. LAWS ANN. ch. 6D, § 13(a) (West 2023); OR. REV. STAT. ANN. §§ 415.500-415.501 (West 2023) (requiring pretransaction notice, review, and approval by the Oregon Health Authority for all transactions involving health care entities including physicians, where one party had average revenue of $25 million or more and the other party had average revenue of $10 million or more in the preceding three fiscal years).

material transactions involving health care entities—including physician practices with twenty-five or more physicians—to the state's Office of Health Care Affordability (OHCA), which is authorized to conduct a market-impact review.[369] Although the OHCA does not have the authority to stop a transaction or attach conditions of approval, it may refer any worrisome transaction to the state attorney general for further action.[370] Going beyond the federal government, several states have created authorities to review a broader array of health care transactions, including physician practice acquisitions by PE investors, which may prompt more states to follow suit.[371]

2. Sharpening the corporate practice of medicine prohibition

The corporate practice of medicine doctrine, although seemingly antiquated, remains a viable tool to regulate the recent incursion of PE into the health care marketplace. Many states maintain a medical practice act that controls, to varying degrees, the ability of corporate lay-entities to own or employ physicians and thereby control the practice of medicine.[372] Some states have amended their laws in an attempt to modernize the delivery of care, while others remain vigilant in protecting the medical profession from corporate interests.[373] The task for legislatures, regulators, and private litigants is to protect the health care profession from dangerous levels of corporate control without squelching desirable innovations or entrenching obstructive turf guarding.

By amending their medical practice acts, legislatures can narrow or close the loopholes currently exploited by PE firms to circumvent the corporate practice prohibition.[374] Through S.B. 642, for example, the California legislature attempted to prevent the continued abuse of the MSO model currently used by many PE health care ventures.[375] Requiring the medical

369. CAL. HEALTH & SAFETY CODE § 127507 (West 2023) (requiring prior notice of transactions by health care entities that sell, transfer, dispose of, or transfer control of a "material amount of its assets" on or after April 1, 2024); *id.* § 127500.2 (defining "health care entity" to include physician organizations and medical groups with twenty-five or more physicians); *see* Act of June 30, 2022, sec. 19, 2022 Cal. Legis. Serv. ch. 47 (West) (enacting these sections of the California Health and Safety Code).

370. CAL. HEALTH & SAFETY CODE § 127507 (West 2023).

371. ALEXANDRA D. MONTAGUE, KATHERINE L. GUDIKSEN & JAMIE S. KING, MILBANK MEM'L FUND, STATE ACTION TO OVERSEE CONSOLIDATION OF HEALTH CARE PROVIDERS 10 (2021), https://perma.cc/PZ6A-RXLN.

372. Zhu et al., *supra* note 255, at 965.

373. *See* Marous, *supra* note 231, at 160, 165 (noting that, although Illinois provides no express exemption from the prohibition on the corporate practice of medicine, Virginia is "more permissive").

374. Zhu et al., *supra* note 255, at 967.

375. *See* S.B. 642, Cal. Leg., 2021-2022 Reg. Sess. (Cal. 2021).

practice to maintain the reality—rather than just the appearance of—control over its business operations makes the MSO model a less attractive private equity investment.[376]

However, legislatures must strike a delicate balance between protecting the integrity of the health care industry and embracing innovation. Legislation enacted in California permits health care providers to share a portion of their professional fees with management organizations, presumably to promote economic efficiencies and scale.[377] The legislation strikes this balance because licensed physicians would continue to control key business decisions that could affect patient care while still being permitted to contract with lay entities to increase operational efficiencies.[378] Furthermore, the bill achieves this balance while making the medical practice less attractive for PE, which would like the maximal amount of control in order to quickly sell the practice for a profit.

For many health care regulators, necessary measures may be as straightforward as enforcing the laws on the books. New York, for example, maintains a strong prohibition against professional fee splitting.[379] Other states, such as California and Illinois, prohibit fee splitting but have carved out statutory exceptions that allow PE firms room to maneuver.[380] Nevertheless, the nature of the PE investment and ownership possibly renders the corporate structure unlawful. Illinois' fee-splitting law, for instance, allows health care providers to share their professional fees so long as the medical practice controls the amount of fees charged or collected.[381] Due to the control PE exerts over a practice's business operations, it would not be surprising or uncommon for the firm to have control over the fees charged by the physicians. In many states, therefore, health care regulators need to look no further than the business arrangement between the medical practice and the PE investor to provide effective oversight.

Finally, private litigants can use existing laws in ways that creatively challenge corporate control over the medical practice. In *AAEMPG v. Envision*, a management services organization is suing PE-backed physician-staffing firm, Envision, under California's existing medical practice laws.[382] Although the plaintiff is promoting its pecuniary interest, other organizations see this type

376. *See id.*

377. CAL. BUS. & PROF. CODE § 650(b) (West 2023).

378. *See* Cal. S.B. 642.

379. N.Y. EDUC. LAW § 6530 (McKinney 2023).

380. *See supra* text accompanying notes 300-09.

381. 225 ILL. COMP. STAT. ANN. 60/22.2(d) (West 2023).

382. Complaint at 4-5, Am. Acad. of Emergency Med. Physician Grp., Inc. v. Envision Healthcare Corp., No. 22-cv-00421 (N.D. Cal. Jan. 21, 2022), ECF No. 1-1.

of litigation as a way to combat PE directly in the courts.[383] Take Medicine Back, a nonprofit organization seeking to "reclaim the professional integrity of the field of emergency medicine," has stated that "[e]nforcing, strengthening, and litigating existing state prohibitions on the corporate practice of medicine should become a priority."[384] In July 2022, Take Medicine Back sent a letter to Joshua Stein, Attorney General of North Carolina and president-elect of the National Association of Attorneys General, urging him to use his leadership position to help "launch a multistate investigation into the widespread lack of enforcement of [corporate practice of medicine] laws in the United States."[385]

During the course of litigation in the *Envision* case, parties will inevitably face complex corporate agreements that seek to disguise the level of control private equity exerts over medical practice. Where sophisticated contracting obscures de facto control on paper, litigants may turn to other sources of law, such as federal fraud and abuse laws, to demonstrate PE's level of knowledge and influence over the medical practice.[386]

B. Where We Need New Laws

Beyond simply sharpening the legal tools we have, in some cases, we need new laws, administrative rules, or significant statutory amendments to address the harms of PE investment in health care. These new laws fall into three categories: (1) closing Medicare payment loopholes being exploited by PE and others; (2) increasing transparency of PE ownership; and (3) altering the tax treatment of PE investors. The first category is specific to health care but not PE, while the latter two are the opposite—specific to PE but not to health care.

1. Closing payment loopholes

PE has targeted physician practices to take advantage of two revenue opportunities in Medicare payment policy: Medicare Part B payment for physician-administered drugs and Medicare Advantage risk-based payment policy.[387]

383. MITCHELL LOUIS JUDGE LI, ROBERT MCNAMARA, NATALIE NEWMAN, MEGHAN GALER & AAYLA SECURA [PSEUDONYM], THE RECLAMATION OF EMERGENCY MEDICINE: "TAKE EM BACK" WHITE PAPER 5, 7 (2021), https://perma.cc/8GVZ-NKDE.

384. *Id.* at 5.

385. Letter from Mitchell Li, Founder, Take Med. Back, to Joshua Stein, Att'y Gen., N.C. Dep't of Just. (July 15, 2022), https://perma.cc/58FK-UAWQ.

386. *See supra* Part II.B.

387. FUSE BROWN ET AL., *supra* note 8, at 2, 18.

The Medicare Part B drug payment loophole is part of the investment strategy targeting procedural specialties, such as dermatology, ophthalmology, and gastroenterology, offering ancillary services that generate additional revenue beyond the office visit.[388] One such ancillary service is physician-administered drugs that are delivered in the office, which Medicare reimburses under Medicare Part B (for physician services) rather than Medicare Part D (the prescription drug benefit).[389] Physicians purchase Part B drugs and biologics and then bill the payer under a "buy and bill" system, which pays physicians more to administer more expensive drugs.[390] Medicare Part B's drug payment rules pay physicians an add-on payment calculated as 6% of the drug's average sales price, creating a perverse incentive to prescribe more expensive drugs, even if cheaper alternatives are available.[391] For example, Medicare Part B's payment incentives influence ophthalmologists' selection of drugs to treat wet macular degeneration: Physicians continue to administer a drug (Lucentis) that is at least forty times more expensive, despite the availability of an equally effective, cheaper alternative (Avastin).[392] Investors target certain physician specialties like oncology that profit from the Part B payment incentive.[393]

One way to narrow the Medicare Part B drug payment loophole would be to alter the calculation for the add-on payment for Part B drugs, switching from 6% of the average sales price to a flat payment, grouped by therapeutic class and diagnosis.[394] A flat add-on payment change would flip the incentives

388. *Id.* at 13-14.

389. Kavita K. Patel & Caitlin Brandt, *A Controversial New Demonstration in Medicare: Potential Implications for Physician-Administered Drugs*, HEALTH AFFS. (May 3, 2016), https://perma.cc/36ZD-PY5W.

390. Paul B. Ginsburg & Steven M. Lieberman, *Medicare Payment for Physician-Administered (Part B) Drugs: The Interim Final Rule and a Better Way Forward*, BROOKINGS (Feb. 10, 2021), https://perma.cc/DSV6-5344.

391. *See* Patel & Brandt, *supra* note 389; Ginsburg & Lieberman, *supra* note 390 (describing how Medicare statutes pay physician practices 106% of the average sales price).

392. NIH, Avastin and Lucentis Are Equivalent in Treating Age-Related Macular Degeneration (Apr. 30, 2012), https://perma.cc/MSJ8-L77D; U.S. DEP'T OF HEALTH & HUM. SERVS., OEI-03-10-00360, MEDICARE PAYMENTS FOR DRUGS USED TO TREAT WET AGE-RELATED MACULAR DEGENERATION 5, 12 (2012), https://perma.cc/F6YE-ETXS; Peter Whoriskey & Dan Keating, *An Effective Eye Drug is Available for $50, but Many Doctors Choose a $2,000 Alternative*, WASH. POST (Dec. 7, 2013, 8:25 PM EST), https://perma.cc/C66B-UPVG.

393. *See* Jeah Jung, Roger Feldman & Yamini Kalidindi, *The Impact of Integration on Outpatient Chemotherapy Use and Spending in Medicare*, 28 HEALTH ECON. 517, 517-19 (2019).

394. BIPARTISAN POL'Y CTR., TRANSITIONING FROM VOLUME TO VALUE: ACCELERATING THE SHIFT TO ALTERNATIVE PAYMENT MODELS 19-21 (2015), https://perma.cc/Z7TZ-DKHC (recommending flat add-on payments and better methods of calculating average sales prices for Medicare Part B drugs).

for physicians to prescribe the cheaper alternative, but it would require a change in the Medicare statute.[395] Commentators and MedPAC recommend this and other adjustments to Medicare Part B payment policy to address lack of competition and price discipline for biosimilars and new, high-cost specialty drugs.[396] Such reforms would narrow the opportunities PE firms have to exploit payment loopholes and market power under existing law.

One such payment loophole stems from the way Medicare pays the private Medicare managed care plans known as Medicare Advantage (MA) plans. Medicare's "risk-adjusted" payment method creates incentives to inflate beneficiaries' risk scores through aggressive coding of diagnoses, in order to draw higher payments.[397] Aggressive coding (or risk-score gaming) can exaggerate how sick enrollees appear to be, which triggers higher payments from Medicare.[398] This payment loophole draws PE and other corporate investors to purchase primary care practices that serve MA enrollees and push providers to aggressively code diagnoses.[399] Some investors even vertically integrate the primary care practices with MA plans to bolster physicians' incentives to generate higher payments.[400] MedPAC estimated that in 2021, MA plans' coding practices resulted in risk scores that were 4.9% higher than if the beneficiary had been in traditional fee-for-service Medicare, causing $17 billion in overpayments to MA plans.[401] In the six years from 2007 to 2023, MedPAC estimates that excess risk coding in MA led to $124 billion in overpayments to MA plans.[402]

395. *See* Ginsburg & Lieberman, *supra* note 390.

396. *Id.*; MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: MEDICARE AND THE HEALTH CARE DELIVERY SYSTEM 83-84 (2022), https://perma.cc/3JVV-TUEQ.

397. FUSE BROWN ET AL., *supra* note 8, at 15.

398. JP Sharp, Leslie McKinney, Scott Heiser & Rahul Rajkumar, *Realizing the Vision of Advanced Primary Care: Confronting Financial Barriers to Expanding the Model Nationwide*, HEALTH AFFS. (Mar. 30, 2020), https://perma.cc/7P6X-GKBV; Abelson & Sanger-Katz, *supra* note 221.

399. *See* Shah et al., *supra* note 10, at 100; Abelson, *supra* note 10.

400. Geruso & Layton, *supra* note 9, at 1009-10, 1022.

401. MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 324-25, 354 (2023), https://perma.cc/2NED-8S27.

402. *Id.* at 355.

Risk-code gaming is a massively lucrative (or costly) phenomenon.[403] MA accounts for nearly half of total Medicare spending.[404] Some estimate that the current payment policy and coding intensity will cause Medicare to overpay MA plans by $600 billion over the 2023-2031 period.[405]

The Centers for Medicare & Medicaid Services (CMS) could take certain actions under its existing regulatory and enforcement authority to curb risk-score gaming. First, CMS could increase the statutorily authorized coding intensity adjuster to account for the extent of risk-score gaming by MA plans that are driving historic profits for MA plans.[406] Under its existing regulatory authority, CMS could modify the risk-adjustment formula to reduce the impact of risk upcoding.[407] Currently, CMS applies the statutory-minimum adjustment of 5.9%, but it has authority to go further, and some analysts estimate that using a higher—but empirically justified coding-intensity adjustment—would save taxpayers $600 billion in overpayments between 2023 and 2030.[408] Second, CMS could increase efforts to recoup overpayments from unsupported coding practices through increased audit and enforcement of the Overpayment Rule, which, among other provisions, requires MA plans to return excess payments based on unsupported risk codes.[409] To do so, CMS could expand the scope of its Risk Adjustment Data Validation audits of MA plan coding practices and allocate more resources to investigation and enforcement of Overpayment Rule.[410] Further, CMS could reweight the risk-

403. Richard Kronick & F. Michael Chua, Industry-Wide and Sponsor-Specific Estimates of Medicare Advantage Coding Intensity 2-3 (Nov. 11, 2021) (unpublished manuscript), https://perma.cc/EFP8-BTKJ (estimating that due to risk-coding intensity, Medicare Advantage Plans will receive $600 billion in excess payments between 2023-2031); Paul D. Jacobs & Richard Kronick, *The Effects of Coding Intensity in Medicare Advantage on Plan Benefits and Finances*, 56 HEALTH SERVS. RSCH. 178, 178 (2021) (finding that excess coding intensity increased MA plan revenue by 1-4% in 2018); Abelson & Sanger-Katz, *supra* note 221 (reporting on multiple fraud cases against MA plans for unjustified risk coding used to inflate MA plan profits by billions of dollars).

404. Jeannie Fuglesten Biniek & Tricia Neuman, *The Growth in Share of Medicare Advantage Spending*, KFF (Apr. 7, 2022), https://perma.cc/HPX6-8FV8.

405. Kronick & Chua, *supra* note 403.

406. 42 U.S.C. § 1395w-23(a)(1)(C)(ii)(III).

407. *See* Erin C. Fuse Brown, Travis C. Williams, Roslyn C. Murray, David J. Meyers & Andrew M. Ryan, *Legislative and Regulatory Options to Improve Medicare Advantage*, 48 J. HEALTH POLS. POL'Y & LAW 919, 935 (2023).

408. Kronick & Chua, *supra* note 403, at 2-3.

409. The 2014 Overpayment Rule requires MA plans to return any overpayments identified by the plan within sixty days or else they become false claims under the False Claims Act. 42 U.S.C. § 1320a-7k(d); 42 C.F.R. § 422.326 (2014); 42 C.F.R. § 422.330 (2015); 42 C.F.R. § 422.504(l) (2022).

410. Fuse Brown et al., *supra* note 407, at 935-37 (2023); Travis C. Williams, Erin C. Fuse Brown, David J. Meyers, Roslyn Murray & Andrew M. Ryan, *Medicare Advantage Audit*

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coding formula and restrict the use of chart reviews and health-risk assessments to target factors and practices that MA plans exploit most heavily to inflate risk scores.[411] Notably, none of these steps would require an act of Congress; CMS could take each of these measures under existing regulatory authority.[412]

Just as recent legislation addressed surprise billing, PE's appetite to acquire physician practices could be diminished by closing the payment loopholes that entice investment yet provide no value to patients.

2. Transparency in ownership

In a forthcoming article, political scientists Colleen Grogan and Miriam Laugesen make the case that the lack of transparency in ownership and financial structures hampers the ability of policymakers, regulators, and payers to gauge the effects of PE investment.[413] Unlike publicly traded firms, PE funds are not required to register with or make disclosures to the SEC.[414] Publicly available sources of ownership information for health care providers often fail to disclose the identity of the parent organization and obscure ownership hierarchies of interrelated entities.[415] Accordingly, short of directly regulating PE investment in physician practices, enhanced ownership transparency could enable better monitoring of any effects on quality, price, utilization, and patient experience. Two existing online databases that CMS administers—Open Payments (for pharmaceutical and device manufacturers payments to physicians) and Medicare Care Compare (which reports provider performance on certain quality metrics)—could be adapted to include practice-ownership status.[416] In 2023, Representative Pramila Jayapal (D-WA) introduced the

Changes Let Plans Keep Billions in Overpayments, HEALTH AFFS. (Feb. 27, 2023), https://perma.cc/LE6Y-LMR7.

411. Fuse Brown et al., *supra* note 407, at 938-39.

412. Letter from Erin C. Fuse Brown, Andrew Ryan, Roslyn Murray & Travis Williams, to Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health & Hum. Servs. (Aug. 30, 2022), https://perma.cc/87V7-Y4H7; Fuse Brown et al., *supra* note 407, at 930, 934-939.

413. Grogan & Laugesen, *supra* note 6 (manuscript at 7); *see also* COLLEEN M. GROGAN, GROW & HIDE: THE HISTORY OF AMERICA'S HEALTH CARE STATE 356-57 (2023) (making a similar point about the lack of transparency in private equity's growing role and effects in the health care industry).

414. *Private Fund*, SEC, https://perma.cc/D92R-T6S9 (last updated Aug. 23, 2023).

415. Yashaswini Singh & Erin C. Fuse Brown, *The Missing Piece in Health Care Transparency: Ownership Transparency*, HEALTH AFFS. (Sept. 22, 2023), https://perma.cc/Q3EB-XLRY; MEDICARE PAYMENT ADVISORY COMM'N, *supra* note 396, at 72, 81-82.

416. *See Open Payments*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://perma.cc/5UEX-TP4J (last updated Feb. 1, 2024, 12:30 PM); *Care Compare: Doctors and Clinicians Initiative.*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://perma.cc/A3KM-6QMD (last updated Jan. 18, 2024, 12:16 PM); *see also* FUSE BROWN ET AL., *supra* note 8, at 25 (developing this recommendation).

Healthcare Ownership Transparency Act, which would require Medicare-enrolled providers to disclose the identities of their owners, private equity investors, debts, fees, portfolio performance, and political spending.[417] Although such legislation would provide significant visibility into PE ownership of health care entities, key health care transparency bills advancing though Congress in 2023 did not include ownership transparency.[418]

Also, federal or state lawmakers could look to other aspects of corporate and business law that require advance disclosure of anticipated transactions in order to provide opportunity to vet their fairness or social impacts.[419] The FTC's 2023 proposed rule on the HSR pre-merger notification form would require merging parties to provide the agencies with information about the identities of the parent entity and minority shareholders, and officers and board members.[420] In addition, the rule would require information about the organizational structure of both the acquiring and acquired entities.[421]

Finally, going beyond the anti-gag clause legislation that gives physicians freedom to discuss their concerns, lawmakers could consider requiring active disclosure to patients of key aspects of practice ownership or management. Such a move could follow the pattern that arose in response to controversy over managed-care incentives. In that era, the prohibition of gag clauses was soon followed by state enactments that required providers or insurers to inform patients about physician incentives and payment arrangements.[422] These measures were meant to help patients understand possible motivations behind treatment (or nontreatment) recommendations so that patients could make more informed decisions.[423] Equivalent transparency requirements regarding PE ownership or management could offer similar advantages.

417. Healthcare Ownership Transparency Act, H.R.1754 § 2, 118th Cong. (2023).

418. Singh & Fuse Brown, *supra* note 415.

419. Possible analogues include advance notice of plant closings, 29 U.S.C. § 2101, or disclosures in advance of takeover bids, 15 U.S.C. § 78n(d). *Cf.* Lucian A. Bebchuk & Roberto Tallarita, *The Illusory Promise of Stakeholder Governance*, 106 CORNELL L. REV. 91, 133-37 (2020) (expressing skepticism that corporate leaders will, even if prompted, seriously consider factors other than shareholder value).

420. Premerger Notification; Reporting and Waiting Period Requirements, 88 Fed. Reg. 42178, 42187-88 (proposed June 29, 2023) (to be codified at 16 C.F.R. pts. 801, 803).

421. *Id.* at 42187.

422. Krause, *supra* note 335, at 34-38.

423. *Id.* at 37.

3. Tax treatment of private equity

The profitability of PE investment is enhanced by tax advantages. As compensation for its management services, PE fund managers typically receive a management fee calculated as 2% of assets under management plus 20% of the profits generated by a fund.[424] The 2% fee is subject to ordinary-income and self-employment taxes, while the 20% return on the investment profits (known as "carried interest") is taxed at preferential capital-gains rates and is not subject to self-employment taxes for Social Security and Medicare.[425]

Though the PE managers' 20% share of the fund's profits can be viewed as compensation for the management of the investment, the tax code does not tax these returns as ordinary income. Many argue this loophole gives an unfair tax advantage to wealthy private equity fund managers compared to other capital investors or regular employees and other service providers that pay higher ordinary-income tax rates on their compensation.[426]

Several bills and tax proposals have aimed to close or narrow the carried interest loophole.[427] An earlier version of the 2022 Inflation Reduction Act would have required PE fund managers to hold their assets for five years (instead of three) to qualify for the preferred long-term capital-gains rate (of 20% rather than 37%).[428] Nevertheless, Senator Kyrsten Sinema (I-AZ) insisted

424. *Briefing Book: What Is Carried Interest, and How Is It Taxed?*, TAX POL'Y CTR., https://perma.cc/YZ5Z-5QDP (last updated May 2020); Victor Fleisher, *Two and Twenty: Taxing Partnership Profits in Private Equity Funds*, 83 N.Y.U. L. REV. 1, 3-4 (2008).

425. The PE fund managers' 20% share of profits is subject to the 20% long-term capital-gains rate, rather than the ordinary-income tax rate of 37% for top earners. *See* Greg Iacurci, *What Carried Interest Is, and How It Benefits High-Income Taxpayers*, CNBC (Aug. 8, 2022, 3:09 PM EDT), https://perma.cc/SK23-B5ZU (describing how carried interest for private equity managing partners is taxed); IRS, *Self-Employment Tax (Social Security and Medicare Taxes)*, https://perma.cc/NF6L-XKLF (last updated Aug. 3, 2022) (describing self-employment tax rates); *Tax Carried Interest as Ordinary Income*, CONG. BUDGET OFF. (Dec. 13, 2018), https://perma.cc/Z9S9-JDGC (describing how carried interest is currently taxed, estimating that taxing it as ordinary income would generate $14 billion in additional revenues from 2019 to 2028, and stating that "carried interest is not subject to the self-employment tax.").

426. *See Briefing Book: What Is Carried Interest, and How Is It Taxed?*, *supra* note 424; Ams. for Fin. Reform, Close the Carried Interest Loophole that Is a Tax Dodge for Super-Rich Private Equity Executives 1 (2021), https://perma.cc/AB9X-5UA5.

427. *See, e.g.*, Press Release, White House, FACT SHEET: The American Families Plan (Apr. 28, 2021), https://perma.cc/WR4W-W3W7 (proposing "to close the carried interest loophole so that hedge fund partners will pay ordinary-income rates on their income just like every other worker."); Carried Interest Fairness Act of 2021, H.R. 1068, 117th Cong. (2021) (proposing to tax carried interest compensation to private equity or hedge fund partners as ordinary-income tax rates, not capital gains).

428. Inflation Reduction Act of 2022, H.R. 5376, 117th Cong. (2022) (enacted); *see* Alan Rappeport & Emily Flitter, *Carried Interest Is Back in the Headlines. Why It's Not Going Away.*, N.Y. TIMES (Aug. 5, 2022), https://perma.cc/XYM6-NYH4; Erik Wasson,

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on removing the tax reform for PE as a condition of her support for the Inflation Reduction Act, so this tax advantage for PE continues.[429] These tax reform proposals would apply to PE broadly, not just their health care investments, and they seek to put the tax treatment of PE's earnings on the same level with other investors, managers, or service providers.

Though it faces much stronger political headwinds than closing the carried interest loophole, an alternative tax reform to achieve similar ends would entail having equal tax rates for capital gains and ordinary income.[430] Physician-owners currently reap tax advantages when they sell their practice to a buyer for a high acquisition price in exchange for employment contracts for lower salaries for a period of years.[431] This deal structure permits physicians selling the practice to convert some of their employment income (which is taxed as ordinary income) into long-term capital gains (which is taxed at lower rates).[432] Having equal rates for ordinary income and capital gains would eliminate this form of tax arbitrage, whether pursued by PE or other sources of capital.

Tax reforms such as closing the carried interest loophole or equalizing ordinary-income and capital-gains rates would dampen the tax distortions favoring capital over labor and corporate profit over professional independence. These tax reforms might cool PE investors' voracious appetite for health care targets, but they would not eliminate it.

C. The Past, Present, and Future of Corporatization and Financialization of Health Care

In years past, one of us has questioned the continuing need for certain laws as the health care delivery system has changed—particularly with the rise of managed care in the 1980s and 1990s.[433] Public enforcers seem to agree. The corporate practice of medicine doctrine has fallen dormant, state fee-splitting

Democrats Drop Carried Interest as Sinema Paves Way for Tax Vote, BLOOMBERG (updated Aug. 5, 2022, 4:26 AM PDT), https://perma.cc/3BKV-9QCD.

429. Andrew Ross Sorkin et al., *A Tax Loophole's Powerful Defender*, N.Y. TIMES (Aug. 5, 2022), https://perma.cc/HLH5-BKQ5.

430. *See, e.g.*, Press Release, White House, *supra* note 427 (proposing to equalize ordinary-income and capital-gains tax rates). Note that if the carried interest loophole persisted, the returns on investment would still be exempt from self-employment taxes.

431. FUSE BROWN ET AL., *supra* note 8, at 26.

432. Barry F. Rosen, *Sale to Private Equity—Part 2*, GORDON FEINBLATT LLC (Dec. 14, 2020), https://perma.cc/Z9XA-HM58.

433. *See* Hall, *supra* note 227, at 510 (noting, with respect to the corporate practice of medicine doctrine, "[t]his puzzling doctrine is clouded with confused reasoning and is founded on an astounding series of logical fallacies"); *see also* Marous, *supra* note 231, at 168-69 (discussing the rise of managed care).

and physician-employment laws have largely gathered dust, and even federal fraud and abuse laws have been critiqued for their inflexibility and burden on the industry's shift to value-based payment.[434]

However, faced with the contemporary problem of PE's rapid entry into health care, we find ourselves revisiting past policy tools in search of ones well suited to address the perennial concerns over the corporatization and financialization of health care. Doing so brings new appreciation for what may seem like outmoded measures, which may prove useful against the enormous risks PE investment poses to the health care system. Moreover, existing legal tools can be adapted much more quickly than new policies can be designed. In some instances, broad new laws—like the No Surprises Act—are the only way to close gaping loopholes. But such sweeping reforms are hard to pass, so we should not focus solely on creating new policies when existing ones can be sharpened and redeployed.[435]

A second realization underscores state law's importance in addressing the risks of PE investment in health care.[436] Despite states' traditional roles as the regulators of medical practice,[437] the centrality of states may still be surprising in this era of increased federal oversight over a sprawling health care industry.[438] Sometimes, a state's role is that of co-enforcer of federal laws or their state equivalents (such as antitrust or fraud and abuse laws).[439] In other

434. *See, e.g.*, Huberfeld, *supra* note 225, at 244 ("The corporate practice of medicine doctrine is a relic; a physician-centric guild doctrine that is at best misplaced, and at worst obstructive, in the present incarnation of the American health care system."); *Modernizing Stark Law to Ensure the Success Transition from Volume to Value in the Medicare Program: Hearing Before the Subcomm. on Health of the H. Comm. on Ways and Means*, 115th Cong. (2018) (statement of the American Hospital Association); Marilyn L. Uzdavines, *The Great American Health Care System and the Dire Need for Change: Stark Law Reform as a Path to a Vital Future of Value-Based Care*, 7 TEX. A&M L. REV. 573, 575 (2020) ("Health care fraud and abuse laws are one of the main barriers . . . limiting new payment options to support a value-based payment model."); Anne B. Claiborne, Julia R. Hesse & Daniel T. Roble, *Legal Impediments to Implementing Value-Based Purchasing in Healthcare*, 35 AM. J.L. & MED. 442, 455-57 (2009); Zhu et al., *supra* note 255, at 967 (observing that "states' enforcement has been dormant" because "[w]ith the rise of managed care and integrated delivery systems, the CPOM doctrine became perceived as unnecessary and outmoded in the face of health care market innovations").

435. *See supra* Part III.A.

436. *See supra* Part II.C-.D.

437. *See, e.g.*, Patricia J. Zettler, *Toward Coherent Federal Oversight of Medicine*, 52 SAN DIEGO L. REV. 427, 446 (2015); Nathan Cortez, *The Law of Licensure and Quality Regulation*, 387 NEW ENG. J. MED. 1053, 1053-54 (2022).

438. *Cf.* Gluck & Huberfeld, *supra* note 23, at 1704-05 (describing and critiquing widely held narratives of health care federalism as a trend toward national takeover of areas of traditional state regulation and arguing instead for a more nuanced joint state-federal framework for understanding modern health care federalism).

439. *See supra* Part III.A.1.

cases, the laws themselves are state created with no existing federal counterpart. Corporate practice of medicine prohibitions and physician-employment laws are obvious examples.[440] In short, relevant policy levers exist within every branch and at multiple levels of government: state, federal, judicial, regulatory, and legislative.

Nor are the laws limited to government enforcement.[441] Rather, there are a variety of private actions that aggrieved parties can bring, whether physicians, patients, would-be competitors, or *qui tam* whistleblowers.[442] The good news is that we have a variety of existing tools to address the commercialization of health care by PE.[443] But the bad news is that our twentieth-century tools may not be up to this twenty-first-century problem. PE is vastly resourced, shrouded in secrecy, and extremely nimble.[444] Against the march toward corporatization and financialization in health care, we have plenty of tools, but they may not be enough.

Conclusion

Six decades ago, Nobel Prize-winning economist Kenneth Arrow articulated the core reasons for shielding physician practice from conventional market dynamics of crass commodification and commercialization.[445] As medical-cost inflation raged out of control, however, this position came under attack for supporting physicians' attempts to fend off any form of economizing influence.[446] It was rightly felt that Arrow's strong defense of professional values needed to yield, at least to some extent, to market-driven efforts to restrain and rationalize medical spending.[447] It now appears that the market-professionalism pendulum has swung too far in the direction of unconstrained profiteering. Some balance must be maintained between core professional values in medical practice and the market economy in which medical care is

440. *See supra* Part II.C.2 (describing state corporate practice of medicine and physician-employment laws).

441. *See supra* Part II.B.1-.2.

442. *See supra* Part II.B.1-.2.

443. *See supra* Part III.A.

444. Olson, *supra* note 35, at 8.

445. Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 948-54 (1963).

446. *See generally* UNCERTAIN TIMES: KENNETH ARROW AND THE CHANGING ECONOMICS OF HEALTH CARE (Peter. J. Hammer, Deborah Haas-Wilson, Mark A. Peterson & William M. Sage eds., 2003) (reexamining Arrow's observations on how traditional market forces are often inapplicable to the market for health care).

447. *See id.*

practiced. Rampant PE investment in physician practices threatens to disrupt that balance.

Through past cycles of this never-ending tug-of-war, various bodies of law and regulation have been marshalled to guard the professional ground.[448] At times, these defenses have been excessive, but now they appear unable to withstand the assault.

The influx of PE in health care, the ongoing consolidation of the health care market, and rising costs show that the corporatization of health care has not delivered affordable, equitable, or accessible health care—quite the opposite. The legal tools we have are ultimately unable to solve the bigger issue: We still have not found the right balance between treating health care as a social good or as a market commodity.

PE investment in health care is just the latest manifestation of the commercialization of medicine, and it will not be the last. By taking commercialization to new extremes, however, the influx of PE marks a critical juncture for reassessment of the role of professionalism in health care delivery. Without returning to a bygone era or complete capitulation to professional hegemony, a more robust set of public policy mechanisms is needed to prevent powerful providers and suppliers from dictating prices, gaming reimbursement, and treating health care as an extractive exercise rather than a social good—one that must be regulated, accessible, and affordable to all.

448. *See* Hall, *supra* note 227, at 446-48 (reviewing the history of legal attempts to balance professionalism and profiteering in medicine).

Appendix: Policies to Address Private Equity Investment in Health Care

Policy	Risk Addressed	State, Federal, or Both	Policy Change
Antitrust review	Consolidation, higher prices	Both (parallel federal and state antitrust enforcement authority)	Reduce or eliminate Hart-Scott-Rodino Act reporting threshold for smaller health care transactions; state legislation to expand merger review below HSR reporting threshold, including serial add-on acquisitions
Fraud and abuse enforcement	Overbilling, upcoding, risk-score gaming, overutilization, self-referrals	Both (federal and private enforcement of federal laws, state enforcement of state equivalents)	None; increase enforcement under existing laws
Corporate practice of medicine, fee-splitting laws	Financial conflicts of interest, loss of physician autonomy	State	Clarify laws to restrict inappropriate uses of MSO model
Employment laws	Anticompetitive restrictions on physicians, patient access to providers, quality concerns	Both	FTC proposed rule to ban noncompetes; state legislative changes to restrict noncompetes, nondisclosure/gag, and nondisparagement clauses

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Policy	Risk Addressed	State, Federal, or Both	Policy Change
Closing Medicare payment loopholes	Overbilling, risk-score gaming, overutilization	Federal	Federal statutory or regulatory action to change Medicare Part B prescription drug payment incentives, adjust for Medicare Advantage risk-score gaming
Transparency	Opacity of private equity ownership obscures accountability, research	Both	Federal or state statutory or regulatory action to require transparency of health care provider ownership or advance disclosure of anticipated transactions
Tax treatment of PE	Unequal tax incentives for private equity investors	Federal	Eliminate carried interest loophole