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PATIENTS VERSUS PROFITS

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Private equity (PE) has come to health care. With it comes layoffs, cuts, and new pressures for providers; higher prices for payers; and questions from patients about quality and excessive care. PE firms, driven solely by a profit motive, take over health care entities, "lean" them down, load them with debt, and hope to extract a profit for their investors when they sell the hospital, physician group, or nursing home. Their entry into health care has been stealthy but dramatic: Upwards of one-third of all for-profit hospitals in the United States and 40% of America's emergency rooms (ERs) are now run by a PE company, demonstrating the complete financialization of American health care.

Policymakers, legal scholars, medical researchers, and even senators are focused on how best to protect America's health care system from the worst excesses of PE ownership: for example, through tightening corporate practice of medicine rules, deploying antitrust solutions, engaging the fraud and abuse statutes, or trying to ban the practice altogether. For sure, PE ownership puts pressures on the provision of care. And nowhere is that pressure more acute than on the provider—the actor who

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stands in the breach between the PE owners and patients, feeling the most intense effects of a conflict between producing profits and their duties to their patients.

This Article analyzes this new burden. It highlights the challenges posed by trying to solve the PE problem by using a legal regime that is constituted to insulate clinical decision-making from profit interests. But what should be done when, like in PE ownership, those profit interests may control, own, and/or heavily pressure the decision-making of the providers?

The typical tools—the fraud and abuse statutes, and specifically, the 160-year-old federal civil False Claims Act—face daunting challenges to their efficacy in this space. Application of the doctrine of fraud needs a creative reimagining, challenged by complications related to its determination of medical necessity, whistleblowing structure, and causation. This serves as a first important step toward recalibrating the fraud and abuse regime to prevent the worst excesses of PE ownership—and to adequately protect America's providers, patients, and payers from the exploding intrusion of private profit interests into the sanctified space of health care.

INTRODUCTION 322
I. THE FINANCIALIZATION OF AMERICAN MEDICINE 326
A. Private Equity's Move Into Health Care 328
B. The Impact on Cost, Utilization, and Quality 333
C. Reduced and Shifted Staffing 338
II. BREACHING THE INNER SANCTUM: PE AND PROVIDERS 341
A. Inescapable Profit and Its Conflict with Medicine 347
B. The Reactionary Character of Regulation 351
C. Health Care as a Foundational Good 352
D. The Variability of Each Episode of Care 354
III. REANIMATING FRAUD AND ABUSE 356
A. Medical Necessity 357
B. Process Complications 360
C. Causation 361
CONCLUSION 363

INTRODUCTION

In 2021, the Gastelum family settled the lawsuit they had filed against Kool Smiles, a Yuma, Arizona, dental clinic, and its private equity-owned firm, FFL Partners.[1] The Gastelums had filed this suit upon the death of their two-year-old son Zion, whose brain was deprived of oxygen while dentists at Kool Smiles performed

1. *See* Fred Schulte, *Sick Profit: Investigating Private Equity's Stealthy Takeover of Health Care*, CBS NEWS: MONEYWATCH (Nov. 14, 2022, 10:18 AM), https://www.cbsnews.com/news/health-care-private-equity-medical-bills-stealthy-takeover/ [https://perma.cc/44WS-96G9].

root canals and capped six of his baby teeth with crowns.[2] The lawsuit alleged that Kool Smiles "overtreat[ed], underperform[ed] and overbill[ed]."[3]

It was not the first time Kool Smiles, which as of 2018 operated in seventeen states,[4] had dealt with the tragic loss of a child following dental care at one of its facilities.[5] Nor was the company a stranger to federal civil allegations of health care fraud. It settled, for $23.9 million, False Claims Act (FCA) allegations that it and its management company at the time "knowingly submitted false claims" to Medicaid programs in Texas and Connecticut for "medically unnecessary dental services performed on children" between 2009 and 2011.[6] This settlement was announced weeks after Zion Gastelum's fatal dental appointment.[7]

What happened to Zion was met with shock and outrage.[8] Its coverage brightened the spotlight on how private equity (PE) firms—firms made up of private investors that seek a return on their investment by increasingly acquiring health care entities and selling them within a few years[9]—are influencing health care and impacting patients. Unfortunately, the Gastelums are not alone.

Allegations that PE owners may lead to overtreatment are legion across the medical landscape.[10] In one lawsuit, National Spine and Pain Centers and its PE owner, Sentinel Capital Partners, were alleged to have overcharged Medicare based on unnecessary back braces and worthless drug tests.[11] National Spine and Pain Centers

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2. *Id.*

3. *Id.*

4. *See* Ryan Santistevan, *Autopsy Pending for Arizona Toddler Who Stopped Breathing in Dentist's Chair*, AZCENTRAL. (Jan. 5, 2018, 3:06 PM), https://www.azcentral.com/story/news/local/arizona/2018/01/05/zion-jay-gastelum-yuma-toddler-organs-stops-breathing-dentist-chair/1007562001/ [https://perma.cc/74JE-BV2K]; Press Release, U.S. Dep't of Just., Dental Management Company Benevis and Its Affiliated Kool Smiles Dental Clinics To Pay $23.9 Million To Settle False Claims Act Allegations Relating to Medically Unnecessary Pediatric Dental Services [hereinafter Benevis Press Release], https://www.justice.gov/opa/pr/dental-management-company-benevis-and-its-affiliated-kool-smiles-dental-clinics-pay-239 [https://perma.cc/HQ83-6YK9] (Feb 5, 2025).

5. *See* Mike Pelton, *Police Report Offers New Details in Case of 2-Year-Old Who Died After Arizona Dental Appointment*, WMAR (Feb. 8, 2018, 7:19 AM), https://www.wmar2news.com/news/national/police-report-offers-new-details-in-case-of-2-year-old-who-died-after-yuma-dental-appointment [https://perma.cc/L5YP-SKP8] (referencing the tragic death of four-year-old Lizeth Lares, who died after following a procedure in 2016).

6. Benevis Press Release, *supra* note 4.

7. *See* Alexandria Hein, *Toddler Who Died After Dental Procedure Was Hooked Up to Empty Oxygen Tank as Staff Muted Heart Alarm: Lawsuit*, FOX NEWS (Jan. 9, 2019, 2:27 PM), https://www.foxnews.com/health/toddler-who-died-after-dental-procedure-was-hooked-up-to-empty-oxygen-tank-as-staff-muted-heart-alarm-familys-lawsuit-claims [https://perma.cc/S8NK-5JKG].

8. *See* Schulte, *supra* note 1.

9. *Id*.

10. *See, e.g.*, David Heath, Mark Greenblatt & Aysha Bagchi, *Dentists Under Pressure To Drill 'Healthy Teeth' for Profit, Former Insiders Allege*, USA TODAY (Mar. 19, 2020, 12:11 PM), https://www.usatoday.com/in-depth/news/investigations/2020/03/19/dental-chain-private-equity-drills-healthy-teeth-profit/4536783002/ [https://perma.cc/2UJA-J6P2].

11. *See* Schulte, *supra* note 1 (discussing the details of the lawsuit's allegations); Press Release, U.S. Att'y's Off., E. Dist. of Va., Pain Management Clinics Settle Medicare Civil Fraud Claims (Apr. 25, 2019), https://www.justice.gov/usao-edva/pr/pain-management-clinics-settle-medicare-civil-fraud-claims [https://perma.cc/25CX-46XP] (discussing the resolution of the lawsuit).

settled the allegations without any admission of wrongdoing,[12] and Sentinel Capital Partners "had sold the pain management chain to another private equity firm" at the time of National Spine and Pain Centers' settlement.[13]

In another case, a PE-owned pharmacy settled allegations that its providers unnecessarily prescribed pain creams to Tricare beneficiaries.[14] Allegations included a physician who "admitted prescribing the creams to scores of patients he had never seen, examined, or even spoken to."[15] There were also allegations of the payment of kickbacks to telemarketers as part of the case.[16]

Finally, in yet another case, a doctor whose practice was acquired by a PE firm noted that the acquisition led to increased utilization and excessive patient scheduling.[17] Part of Pinnacle Dermatology, which at the time was a PE-owned group of nearly one hundred dermatology practices, encouraged providers to schedule more patients in order to qualify for a bonus incentive.[18] This dermatologist-turned-whistleblower alleged she was pressured to overbook patients, and that patients had to endure multiple visits when only one would have sufficed[19] in an effort to make the practice more profitable.[20] Recent studies have shown that PE-backed dermatology practices have become increasingly financially precarious.[21]

The invasion of the health care space by PE firms has attracted attention from leading health law scholars,[22] a number of medical and health care researchers,[23] and now, even the attention of the U.S. Senate.[24] The senators' nascent investigation has

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12. *See* Schulte, *supra* note 1; Press Release, U.S. Att'y's Off., E. Dist. of Va., *supra* note 11.

13. Schulte, *supra* note 1. Tricare is the current military health insurance plan. *Id.*

14. *See id.*

15. *Id.*

16. *Id.*

17. *See* Gretchen Morgenson, *'Get that Money!' Dermatologist Says Patient Care Suffered After Private Equity-Backed Firm Bought Her Practice*, NBC NEWS (Dec. 20, 2021, 8:55 AM) [hereinafter Morgenson, *'Get that Money!*,*'* https://www.nbcnews.com/health/health-care/get-money-dermatologist-says-patient-care-suffered-private-equity-back-rcna9152 [https://perma.cc/H6ZJ-GXSW].

18. *Id.*

19. *Id.*

20. Pinnacle was acquired by BayPine LP, a private investment firm, in 2021. *See BayPine To Acquire Pinnacle Dermatology in Partnership with Management*, BUS. WIRE (Oct. 29, 2021, 7:30 AM), https://www.businesswire.com/news/home/20211029005118/en/BayPine-to-Acquire-Pinnacle-Dermatology-in-Partnership-With-Management [https://perma.cc/VWB3-PWF9].

21. *See, e.g.*, Rohail Memon, Abdullah Memon, Joseph Francis & Sailesh Konda, *Trends in Debt Valuations of Private Equity-Backed Dermatology Groups Before and During the COVID-19 Pandemic*, 158 JAMA DERMATOLOGY 395 (2022).

22. *See* Erin C. Fuse Brown & Mark A. Hall, *Private Equity and the Corporatization of Health Care*, 76 STAN. L. REV. 527 (2024); 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).

23. *See infra* notes 123–39 and accompanying text.

24. *See* Gretchen Morgenson, *Senators Launch Bipartisan Probe of Private Equity's Growing Role in U.S. Health Care*, NBC NEWS (Dec. 6, 2023, 10:30 AM), https://www.nbcnews.com/politics/congress/senators-grassley-whitehouse-probe-private-equity-us-health-care-rcna128070 [https://perma.cc/S9P8-JRK6] (noting that Senator Charles "Chuck" Grassley (R-IA) and Senator Sheldon Whitehouse (D-RI) have "launched a bipartisan investigation into secretive and powerful private-equity firms' involvement in health care in the nation, demanding documents and information from executives associated with two hospital

focused on patient care issues brought about by PE ownership.[25] Senator Charles "Chuck" Grassley has specifically focused on Apollo Global Management, the nation's second largest PE firm,[26] which was the owner of a regional health center in Iowa with "shocking" and "horrific" patient safety and quality lapses that were detailed in news reporting.[27]

Even in an era of increased value-based purchasing models,[28] the advancing ownership of the health care marketplace by PE firms requires multifaceted and extensive scholarly and policy-based attention. Holistic and incisive legal scholarly work on the PE challenge has been done.[29] This instant project focuses on the structural limitations within the fraud and abuse regime—and particularly, limitations posed by the FCA[30]—to respond to the challenge posed by PE.

It is not hard to imagine that every time a PE firm pressures a provider to administer care or intervenes *at all* in the clinical decision-making could constitute a violation of the FCA. It may not even be controversial to assert that, where PE uses its influence to impact the quality of care that patients receive and the types of procedures payers pay for based on what is best for the PE firm's bottom line, the fraud statutes *should* apply. This fundamental breakdown of clinical decision-making should constitute activity that is easily subject to the fraud and abuse laws, and, specifically, the FCA, because of a clear conflict of interest. This is, after all, the whole reason we have a health care fraud and abuse regime.

But required elements within the FCA make it difficult to rely on to prevent a PE firm from pressuring providers to provide excessive care. These challenges, exacerbated by the PE threat, include the conception and role of medical necessity,[31] the procedural enforcement of how allegations are investigated, and the complicated arguments around causation within the FCA. As a result, the FCA needs a creative reimaging and more aggressive usage to address a major threat to American health care; the first step is identifying those cross-pressures.

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systems to assess how much profit they have generated through their complex financial arrangements and whether the deals harmed patients and clinicians").

25. *Id.*

26. *See* Rebecca Baldridge, *Top 10 U.S. Private Equity Firms of 2025*, FORBES, https://www.forbes.com/advisor/investing/best-private-equity-firms/ [https://perma.cc/235U-AAAP] (Nov. 1, 2024, 4:32 PM).

27. *See* Letter from Sen. Sheldon Whitehouse and Sen. Charles E. Grassley to Marc Rowan, Chief Exec. Officer, Apollo Glob. Mgmt., Inc. (Dec. 6, 2023), https://www.grassley.senate.gov/imo/media/doc/whitehouse_grassley_to_apollo_global_-_private_equity_hospital_investigation.pdf [https://perma.cc/9AYQ-UBK8].

28. *See* Corinne Lewis, Celli Horstman, David Blumenthal & Melinda K. Abrams, *Value-Based Care: What It Is, and Why It's Needed*, COMMONWEALTH FUND (Feb. 7, 2023), https://www.commonwealthfund.org/publications/explainer/2023/feb/value-based-care-what-it-is-why-its-needed [https://perma.cc/3DQZ-G3AZ].

29. *See* Fuse Brown & Hall, *supra* note 22.

30. *See* 31 U.S.C. §§ 3729–3733 (2022).

31. This Article does not focus on the admirable work done by other legal scholars that adroitly examine medical necessity's history, definitional complexity, or even modern development, but on its limitations in America's fraud and abuse regime. *See, e.g.*, Janet L. Dolgin, *Unhealthy Determinations: Controlling "Medical Necessity,"* 22 VA. J. SOC. POL'Y & L. 435 (2015); Amy Monahan & Daniel Schwarcz, *Rules of Medical Necessity*, 107 IOWA L. REV. 423 (2022) (investigating the migration and shift of medical necessity within the insurance context from standards to rules).

This argument unfolds in three Sections. Section I documents the general problem of the phenomenon of financialization of American medicine and PE's influence on that development. Section II summarizes how fraud and abuse could be implicated in PE's advancement into the patient-physician relationship and the cross-pressures that exist within health law. Finally, Section III introduces the overlay with fraud, and, specifically, the FCA, and identifies the open questions within the regime that limit its application within the PE space.

I. THE FINANCIALIZATION OF AMERICAN MEDICINE[32]

A health care system awash with money has adopted revenue generation as its North Star.[33] This focus is nothing new, but it is a culmination of decades of activity that has increasingly centered medicine's focus on generating profits.[34] For sure, it is not noteworthy to say that American health care has primarily become a for-profit, revenue-driven enterprise[35]—with dramatic effects.[36] This truism implicates actors from all corners of the industry—from corporate hospital chains, to large insurance companies, to massive pharmaceutical firms, and beyond.

The trends are unmistakable. In 2023, 36.1% of all Medicare-enrolled hospitals were for-profit,[37] up from 21.3% in 2017.[38] In addition to becoming increasingly

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32. *See* Joseph Dov Bruch, Victor Roy & Colleen M. Grogan, *The Financialization of Health in the United States*, 390 NEW ENG. J. MED. 178, 178 (2024).

> As defined by social scientists and historians, financialization refers to the growing influence of financial markets, motives, institutions, and elites in our economy and society. This dynamic encompasses the expanding influence of financial actors—including commercial and investment banks, [PE] firms, venture capital firms, and other types of investors—and a shift in the business of non-finance-related entities away from trade and commodity production toward new financial channels and maneuvers.

Id. (footnote omitted).

33. *See* Richard Gunderman, *Making Profits and Differences at Hospitals*, ATLANTIC (Mar. 27, 2014), https://www.theatlantic.com/health/archive/2014/03/making-profits-and-differences-at-hospitals/359626/ [https://perma.cc/Q954-JBQQ] ("Daily conversations in healthcare are increasingly dominated by money. Healthcare reform is relentlessly focused on cost cutting. Hospitals are frantically developing strategies to keep themselves profitable in a newly-capitated system of financing. Health professionals are struggling to maintain their incomes in the face of declining payments.").

34. *See* Louis Jamtgaard & Lawrence M. Lewis, *The Monetization of Emergency Medicine*, 120 MO. MED. 172, 172–75 (2023).

35. *See* L. Allen Dobson, *Beware the Trend of For-Profit Medicine*, MED. ECON. (Nov. 1, 2021), https://www.medicaleconomics.com/view/beware-the-trend-of-for-profit-medicine [https://perma.cc/5UCQ-6LBF] (noting that, in 2000, only one of the top twenty-five Fortune 500 companies was a health care company, but by 2020, "9 of the top 25 were primarily health care businesses with several others in the top 25 entering the health care space").

36. *See, e.g.*, Deborah Becker, *Steward's Financial Woes Raise Questions About For-Profit Health Care*, WBUR (Feb. 1, 2024), https://www.wbur.org/news/2024/02/01/steward-health-care-for-profit [https://perma.cc/LYQ7-89QA] (describing the plight of Steward Health Care and the possibility of hospital closures in Massachusetts).

37. *See* W. PETE WELCH, LANLAN XU, NANCY DE LEW & BENJAMIN D. SOMMERS, ASSISTANT SEC'Y FOR PLAN. & EVALUATION, OFF. OF HEALTH POL'Y, HP-2023-14, OWNERSHIP OF HOSPITALS: AN ANALYSIS OF NEWLY-RELEASED FEDERAL DATA & A METHOD FOR ASSESSING COMMON OWNERS (2023), https://aspe.hhs.gov/sites/default/files/documents/582de65f285646af741e14f82b6df1f6/hospital-ownership-data-brief.pdf [https://perma.cc/YM5W-UYWN].

for-profit, hospitals have also become increasingly owned by large chains: from 12% in the 1980s to 50% in the late 2000s to about two-thirds today.[39] In 2022, the top for-profit hospital chain, HCA Healthcare, reported a profit of more than $5.6 billion.[40]

But it is not just hospitals. Private insurance companies have experienced record profits, with UnitedHealth Group's profits topping $20 billion in both 2022 and 2023.[41] And Pfizer, the highest-grossing pharmaceutical company, continues to rapidly increase its sales, amassing more than $100 billion in 2022.[42] The trends are accelerating.[43]

What makes recent developments, particularly the entry of PE firms into the sanctified social good of American health care, categorically different in kind from these general trends is the identities of the players who are now profiting off the industry, and the acute pressures they pose to it. As the health care industry has moved from traditionally nonprofit actors, to for-profit behemoths,[44] to PE dominance, external threats brought by corporatization and financialization have moved ever closer

38. *See* Brooke Murphy, *50 Things To Know About the Hospital Industry | 2017*, BECKER'S HOSP. REV. (Jan. 25, 2017), https://www.beckershospitalreview.com/hospital-management-administration/50-things-to-know-about-the-hospital-industry-2017.html [https://perma.cc/H8CP-TZMU].

39. *See* Jamtgaard & Lewis, *supra* note 34, at 172.

40. *See* Nick Thomas & Alan Condon, *Ten Health Systems Reporting Net Profits in 2022*, BECKER'S HOSP. CFO REP. (Mar. 22, 2023), https://www.beckershospitalreview.com/finance/10-health-systems-reporting-profits-in-2022.html [https://perma.cc/V2MK-5MTR].

41. *See* Jakob Emerson, *"The House Always Wins": Insurers' Record Profits Clash with Hospitals' Hardship*, BECKER'S PAYER ISSUES (Jan. 3, 2023), https://www.beckerspayer.com/payer/the-house-always-wins-health-systems-face-worst-finances-in-decades-as-payers-rake-in-record-profits.html [https://perma.cc/ZU76-FUYL] (noting that UnitedHealth Group profit was up more than 28% from 2021 to 2022, for a record $5.3 billion in Q3 profits). In 2022, UnitedHealth Group made more than $20 billion in profits. *See* Will Humble, *Americans Suffer When Health Insurers Place Profits Over People*, PA. CAPITAL-STAR (Aug. 10, 2023, 5:00 AM), https://www.penncapital-star.com/uncategorized/americans-suffer-when-health-insurers-place-profits-over-people/ [https://perma.cc/Z2N8-66J8]. Cigna's profits neared $7 billion in 2022. *Id.* And in 2023, UnitedHealth Group profits were $22 billion. *See* Bruce Japsen, *UnitedHealth Group Profits Hit $22 Billion in 2023*, FORBES (Jan. 12, 2024, 7:14 AM), https://www.forbes.com/sites/brucejapsen/2024/01/12/unitedhealth-group-profits-hit-23-billion-in-2023/?sh=6ea1890f67ad [https://perma.cc/Z7JB-UB3Y].

42. *See* Spencer Kimball, *The Covid Pandemic Drives Pfizer's 2022 Revenue to a Record $100 Billion*, CNBC (Feb. 2, 2023, 4:35 AM), https://www.cnbc.com/2023/01/31/the-covid-pandemic-drives-pfizers-2022-revenue-to-a-record-100-billion.html [https://perma.cc/5VSS-L77Q].

43. *See* Eyal Press, *The Moral Crisis of America's Doctors*, N.Y. TIMES (July 14, 2023), https://www.nytimes.com/2023/06/15/magazine/doctors-moral-crises.html ("Throughout the medical system, the insistence on revenue and profits has accelerated.").

44. *See* Scott Hulver, Zachary Levinson & Jamie Godwin, *Operating Margins Among the Largest For-Profit Health Systems Have Exceeded 2019 Levels for the Majority of the COVID-19 Pandemic*, KAISER FAM. FOUND. (Dec. 5, 2022), https://www.kff.org/health-costs/issue-brief/the-largest-for-profit-health-systems-have-exceeded-their-2019-financial-performance-for-the-majority-of-the-covid-19-pandemic/ [https://perma.cc/D6NW-SYK9] (noting that the operating margins of the largest for-profit health systems in the country—HCA Healthcare, Tenet Healthcare Corporation, and Community Health Systems—"met or exceeded pre-pandemic levels" in 2022).

to the patient-physician relationship,[45] leading legal scholars to question whether PE firms are "barbarians at the gate."[46]

To understand the general impacts of this kind of financialization, (1) a summary of the migration of PE firms into American health care; (2) an examination of the cost, utilization, and quality impacts of that migration; and (3) employment changes that follow PE ownership of hospitals, are presented below.

A. Private Equity's Move Into Health Care

Leading health law scholars and professors, Erin Fuse Brown and Mark Hall, have argued that the entrance of PE in the health care industry continues the corporatization and financialization of medicine.[47] Indeed, movement of PE firms into the health care space[48]—in which the firm, made up of large, pooled investments[49] and constrained by primary duties to its private and large institutional investors,[50] takes over ownership and management of a health care entity—signals yet another level of entangling financial involvement within American health care.[51] With doctors groups owned by PE firms, the for-profit pressures that had existed are supercharged.[52] This spread of PE has been referred to as a "disaster,"[53] a "metastasizing disease,"[54] and "[a m]arriage [m]ade in [h]ell."[55]

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45. *See* Reed Abelson, *Corporate Giants Buy Up Primary Care Practices at Rapid Pace*, N.Y. TIMES (May 12, 2023), https://www.nytimes.com/2023/05/08/health/primary-care-doctors-consolidation.html ("[T]hese major acquisitions threaten the personal nature of the doctor-patient relationship . . . .").

46. Field et al., *supra* note 22.

47. *See* Fuse Brown & Hall, *supra* note 22, at 527.

48. *See* Yashaswini Singh & Christopher Whaley, Opinion, *Private Equity Is Buying Up Health Care, but the Real Problem Is Why Doctors Are Selling*, THE HILL (Dec. 21, 2023, 8:00 AM), https://thehill.com/opinion/healthcare/4365741-private-equity-is-buying-up-health-care-but-the-real-problem-is-why-doctors-are-selling/ [https://perma.cc/3RRM-GY5A].

49. *See* Schulte, *supra* note 1 ("Private equity firms pool money from investors, ranging from wealthy people to college endowments and pension funds.").

50. *See* U.S. Sec. & Exchange Comm'n, *Private Equity Funds*, INVESTOR.GOV, https://www.investor.gov/introduction-investing/investing-basics/investment-products/private-investment-funds/private-equity [https://perma.cc/9QWT-6EME] (last visited Mar. 15, 2025) ("A private equity fund is typically open only to accredited investors and qualified clients. Accredited investors and qualified clients include institutional investors, such as insurance companies, university endowments and pension funds, and high income and net worth individuals. The initial investment amount for a private equity investment is often very high.").

51. *See* Erin Fuse Brown et al., *Private Equity Investment as a Diving Rod for Market Failure: Policy Responses to Harmful Physician Practice Acquisitions*, USC-BROOKINGS SCHAEFFER INITIATIVE FOR HEALTH POL'Y 1 (Oct. 5, 2021), https://www.brookings.edu/wp-content/uploads/2021/10/Private-Equity-Investment-As-A-Divining-Rod-For-Market-Failure-15.pdf [https://perma.cc/V8TZ-HJ2J] (describing the "influx of profit-driven entities into the sector").

52. *See* Reed Abelson & Margot Sanger-Katz, *Who Employs Your Doctor? Increasingly, a Private Equity Firm*., N.Y. TIMES (July 10, 2023) [hereinafter Abelson & Sanger-Katz, *Who Employs Your Doctor?*], https://www.nytimes.com/2023/07/10/upshot/private-equity-doctors-offices.html; Ashish K. Jha, Opinion, *Private Equity Firms Are Gnawing Away at U.S. Health Care*, WASH. POST (Jan. 10, 2024), https://www.washingtonpost.com/opinions/2024/01/10/private-equity-health-care-costs-acquisitions/.

53. Brendan Ballou, *Private Equity Is Gutting America—and Getting Away with It*, N.Y. TIMES (Apr. 28, 2023), https://www.nytimes.com/2023/04/28/opinion/private-equity.html.

For sure, to the individual physician, one may argue that these profit motives are not different *in kind* from the typical pressures that were operating on millions of providers nationwide in our *already* profit-driven health care system.[56] The profit motive is lodged deep within the DNA of American health care, and PE intervention simply juices those preexisting pressures.[57] Indeed, perhaps the centrality of the profit motive in American health care has provided cover to PE firms as they have quietly acquired a substantial share of this country's health care delivery.[58] But the pressures they bring to the industry[59] lead to an "aggressive focus on revenue generation" that can create "unique risks to quality of care and place[] strain on standards of medical ethics,"[60] as PE ownership creates an environment where profits become the sole focus.[61]

In practical terms, the life cycle of PE involvement in the health care space is straightforward. First, the PE firm seeks to either acquire companies or invest in buyouts comprised of consortia.[62] Then, the PE firm manages this portfolio company in an effort to make it more valuable to its investors. Within this phase, the firm increases efficiency by cutting costs and increasing revenues.[63] Finally, the PE firm seeks to sell the portfolio company within a few years,[64] turning a large profit.[65]

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54. *See* Emily Stewart & Jim Baker, *Private Equity: The Metastasizing Disease Threatening Health Care*, HEALTH AFFS. (Dec. 18, 2023), https://www.healthaffairs.org/content/forefront/private-equity-metastasizing-disease-threatening-health-care [https://perma.cc/6B9J-QH5Q] ("This trend has produced troubling impacts for patients and health care workers across the country.").

55. Edward P. Hoffer, Commentary, *Private Equity and Medicine: A Marriage Made in Hell*, 137 AM. J. MED. 5, 5 (2024).

56. *See* Sarah Kliff, *Hospitals Knew How to Make Money. Then Coronavirus Happened.*, N.Y. TIMES (May 20, 2020), https://www.nytimes.com/2020/05/15/us/hospitals-revenue-coronavirus.html ("The American health care system for years has provided many hospitals with a clear playbook for turning a profit: Provide surgeries, scans and other well-reimbursed services to privately insured patients, whose plans pay higher prices than public programs like Medicare and Medicaid.").

57. *See* Fuse Brown et al., *supra* note 51, at 16 (describing the "myriad perverse incentives and market failures off which private equity (and others) profit").

58. *See* Joseph Bruch, Dan Zeltzer & Zirui Song, *Characteristics of Private Equity-Owned Hospitals in 2018*, 174 ANNALS INTERNAL MED. 277, 277–79 (2020) (finding that about 1,300 of 5,200 community hospitals nationwide are investor-owned for-profit hospitals that are owned by corporations, groups of physicians, or other private entities); Zawn Villines, *What Is Private Equity in Healthcare?*, MED. NEWS TODAY (Nov. 11, 2021), https://www.medicalnewstoday.com/articles/private-equity-in-healthcare [https://perma.cc/U9R6-3QLL].

59. Erik Robinson, *Private Equity Changes Workforce Stability in Physician-Owned Medical Practices*, OHSU (Jan. 9, 2023), https://news.ohsu.edu/2023/01/09/private-equity-changes-workforce-stability-in-physician-owned-medical-practices [https://perma.cc/8JUQ-EXHP] (noting a "line of research" that points to the fact that "private equity firms are increasing pressure to maximize profits").

60. 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*, AM. ANTITRUST INST. & PETRIS CTR. SCH. OF PUB. HEALTH, UNIV. OF CAL., BERKELEY 28 (May 18, 2021) [hereinafter Scheffler et al., *Soaring Private Equity*], https://publichealth.berkeley.edu/wp-content/uploads/2021/05/Private-Equity-I-Healthcare-Report-FINAL.pdf [https://perma.cc/YG44-SW9W].

61. *See* Morgenson, *'Get that Money!,' supra* note 17.

62. *See* James Chen, *Private Equity Explained with Examples and Ways To Invest*, INVESTOPEDIA https://www.investopedia.com/terms/p/privateequity.asp [https://perma.cc/EY99-BAPJ] (Apr. 10, 2024).

63. *See* Emily Pisacreta & Emmarie Huetteman, *Betting on 'Golden Age' of Colonoscopies, Private Equity Invests in Gastro Docs*, KFF HEALTH NEWS (May 27, 2022), https://kffhealthnews.org/news/article

At base, PE firms seek to quickly make money for their investors and are motivated to rapidly increase profitability of the portfolio company.[66] Indeed, "[t]heir model is to pay as little as possible of their own money for businesses they acquire, cutting expenses and reducing overhead, investing as little as possible and then selling the now more profitable business for as much as possible."[67] PE has targeted a number of health care entities, including physician practices, while extolling all the potential benefits its management and intervention can provide.[68] As physician practices "face a lot of administrative work, deciding to sell to a PE firm to reduce this workload and focus on patient care (not to mention, getting a hefty payout) is a tempting proposal."[69]

But because the PE firm often owns a controlling stake in the portfolio company, what makes its involvement different from any other individual investor is the depth of its ability to influence and control important decisions of the recently acquired portfolio company.[70] The PE firm can pressure, demand, restructure, and radically change the portfolio company, seeking its lifeblood of revenue. This, of course, creates the potential for conflict with the financial health of the portfolio company, and finally, with patients.[71]

/private-equity-gastroenterologist-colonoscopy/ [https://perma.cc/27XJ-LRBM] ("It may switch to cheaper suppliers, shorten appointment windows, bill aggressively, or lay off staff, to name a few strategies—the kind of changes that save money at the expense of patient care.").

64. These firms typically seek to "flip" their investment within three to seven years. *See* Schulte, *supra* note 1.

65. *See* Chen, *supra* note 62.

66. *See* Felix Barber & Michael Gold, *The Strategic Secret of Private Equity*, HARV. BUS. REV. (Sept. 2007), https://hbr.org/2007/09/the-strategic-secret-of-private-equity [https://perma.cc/54AC-KHYR].

> [PE's] ability to achieve high returns is typically attributed to a number of factors: high-powered incentives both for private equity portfolio managers and for the operating managers of businesses in the portfolio; the aggressive use of debt, which provides financing and tax advantages; a determined focus on cash flow and margin improvement; and freedom from restrictive public company regulations.

Id.

67. Hoffer, *supra* note 55, at 5.

68. *See id.* at 5–6 ("PE appears to offer a chance to unload the financial and administrative responsibilities while making a profitable sale taxed at favorable capital gains rates. In addition, the promise of infusion of capital, upgrade in technology, cost-cutting strategies, enhanced revenue cycle management, and continued partial ownership of the practice appeal to many physicians."); Ryan Crowley, Omar Atiq & David Hilden, *Financial Profit in Medicine: A Position Paper from the American College of Physicians*, 174 ANNALS INTERNAL MED. 1447 app. at 4 (2021) ("Physicians may be encouraged to sell to private equity firms because of large upfront payments and better competitive position with insurers, in addition to the promise of reduced billing and technology-related financial stress.").

69. Judith Garber, *The Rising Danger of Private Equity in Healthcare*, LOWN INST. (Jan. 23, 2024), https://lowninstitute.org/the-rising-danger-of-private-equity-in-healthcare/ [https://perma.cc/2HX2-ZXSZ].

70. *See* Chris Morran & Daniel Petty, *What Private Equity Firms Are and How They Operate*, PROPUBLICA (Aug. 3, 2022, 5:00 AM), https://www.propublica.org/article/what-is-private-equity [https://perma.cc/D3XA-Q4G4] ("Once private equity firms acquire a company, they encourage executives to make the company operate more efficiently before selling—or 'exiting'—several years later, either through a sale to another investor or through an initial public offering.").

71. *See* Garber, *supra* note 69 (noting that one PE firm engages in concerning social responsibility practices, "including putting high levels of debt that lowers hospitals' credit ratings and increases their interest rates, cutting staff and essential healthcare services, and selling off real estate for a quick buck").

Ultimately, the PE firm is able to extract wealth from the portfolio company through the acquisition and sale process.[72] This wealth is then often sent outside of the health care industry.[73] In contrast to traditional health care nonprofits that are required to reinvest any remaining capital to serve charitable goals[74] and for-profits who can handsomely reward investors,[75] PE firms eventually extract wealth from the industry when they sell their ownership interest in the company,[76] often leaving it financially precarious.[77]

According to ProPublica, the number of PE deals in health care tripled from 2009 to 2016, with PE's intervention focused mainly on hospital groups and staffing companies.[78] More recently, PE deals in health care grew from $42 billion to $120 billion from 2010 to 2019.[79] Specifically, physician group PE deals increased from 75 in 2012 to 484 in 2021.[80] In total, in the COVID-19-influenced boom year of 2021, PE deals in the health care industry amounted to more than $206 billion.[81]

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72. *See* Morran & Petty, *supra* note 70.

73. *See, e.g.*, Eileen Appelbaum, *Private Equity in Healthcare: Profits Before Patients and Workers*, CTR. FOR ECON. & POL'Y RSCH. (Feb. 1, 2022), https://cepr.net/private-equity-in-healthcare-profits-before-patients-and-workers/ [https://perma.cc/3APF-CNEZ] (noting that PE firms act in a way that allows "them to extract wealth from providers in the short run and to exit the company before disaster hits"); Ballou, *supra* note 53 (referencing the story of the purchase of ManorCare by the PE firm, the Carlyle Group, and noting "that ManorCare was forced to pay nearly half a billion dollars a year in rent to occupy buildings it once owned," and that "Carlyle also extracted over $80 million in transaction and advisory fees from the company it had just bought, draining ManorCare of money").

74. *See* Hossein Zare, Matthew Eisenberg & Gerard Anderson, *Charity Care and Community Benefit in Non-Profit Hospitals: Definition and Requirements*, J. HEALTH CARE ORG., PROVISION, & FIN., June 24, 2021, at 1, 2 ("The legal authority governing non-profit organizations requires them to retain or reinvest or distribute any operating surplus to [the] community . . . .").

75. *See* Ramish Cheema, *5 Best Healthcare Stocks for the Long-Term*, INSIDER MONKEY (Dec. 8, 2023, 10:11 AM), https://www.insidermonkey.com/blog/5-best-healthcare-stocks-for-the-long-term-2-1233417/?singlepage=1 [https://perma.cc/J4KR-TMS2] (recommending Centene Corporation and Cigna Group, among others, as great health care investments); Laura Dyrda, *12 Top Healthcare Companies by Revenue*, BECKER'S HOSP. REV. (May 5, 2023), https://www.beckershospitalreview.com/rankings-and-ratings/12-top-healthcare-companies-by-revenue-may-5.html [https://perma.cc/H29F-8RTZ] (including a list of UnitedHealth Group, CVS Health, McKesson, AmerisourceBergen, Cardinal Health, Elevance Health, Centene, HCA Healthcare, Fresenius, and Molina Healthcare as the top ten health care companies by revenue, as of May 2023).

76. *See* Appelbaum, *supra* note 73 ("Some PE firms combine all of these financial tactics to extract wealth from healthcare providers . . . .").

77. *See, e.g.*, Alan Condon & Nick Thomas, *From Private Equity to Bankruptcy: Envision's Last 5 Years*, BECKER'S HOSP. REV. (May 18, 2023), https://www.beckershospitalreview.com/finance/from-private-equity-to-bankruptcy-envisions-last-5-years.html [https://perma.cc/4S8K-U6JA]; Muhammad Hammad Asif & Annie Sabater, *Bankruptcies Among Private Equity Portfolio Companies on Track for 13-Year High*, S&P GLOB. (Aug. 4, 2023), https://www.spglobal.com/marketintelligence/en/news-insights/latest-news-headlines/bankruptcies-among-private-equity-portfolio-companies-on-track-for-13-year-high-76865450 [https://perma.cc/359N-ZLDE] ("Since Jan. 1, private equity portfolio company bankruptcies have been largely concentrated in healthcare and consumer discretionary . . . ."); Ballou, *supra* note 53 ("Companies bought by private equity firms are far more likely to go bankrupt than companies that aren't.").

78. Morran & Petty, *supra* note 70.

79. Jeanne A. Markey & Raymond M. Sarola, *Private Equity, Health Care, and Profits: It's Time To Protect Patients*, STAT (Mar. 24, 2022), https://www.statnews.com/2022/03/24/private-equity-health-care-profits-time-to-protect-patients/ [https://perma.cc/E8MV-UNG4].

80. Richard M. Scheffler et al., *Monetizing Medicine: Private Equity and Competition in Physician Practice Markets*, AM. ANTITRUST INST., NICHOLAS C. PETRIS CTR. ON HEALTH CARE MARKETS AND

Although 2022 was a slower year than 2021, there were still more than 860 PE deals closed in that year.[82] A high inflation rate threatens to cool the health care marketplace for PE further—especially for deals involving provider groups.[83] Still, as of the beginning of 2024, PE has quickly infiltrated America's nursing homes,[84] emergency rooms (ERs),[85] specialty practices,[86] and physician practices.[87]

Over the last decade, the total amount of PE investment has approached $1 trillion, numbering eight thousand health care transactions.[88] As many as 40% of hospital emergency departments in the United States are now run by staffing and management companies that are PE-funded.[89] Additionally, about 30% of all for-profit hospitals are now PE-owned.[90] And, incredibly, in more than 25% of local markets, "a single [PE] firm owned more than 30[%] of practices in a given specialty in 2021."[91]

CONSUMER WELFARE, UNIV. OF CA., BERKELEY & WASH. CTR. FOR EQUITABLE GROWTH 4 (July 10, 2023) [hereinafter Scheffler et al., *Monetizing Medicine*], https://www.antitrustinstitute.org/wp-content/uploads/2024/02/AAI-UCB-EG-Private-Equity-Physician-Practice-Report-Addenda_FINAL.pdf [https://perma.cc/KTE9-PSQT]; David Blumenthal, *Private Equity's Role in Health Care*, COMMONWEALTH FUND (Nov. 17, 2023), https://www.commonwealthfund.org/publications/explainer/2023/nov/private-equity-role-health-care [https://perma.cc/JU7G-AQDK].

81. *See* Schulte, *supra* note 1.

82. *See* Rebecca Pifer, *Private Equity Notched Second-Highest Year of Healthcare Dealmaking in 2022, Pitchbook Finds*, HEALTHCARE DIVE (Feb. 6, 2023), https://www.healthcaredive.com/news/private-equity-deals-healthcare-2022-pitchbook/642029/ [https://perma.cc/FR2Z-YQC9].

83. *See* Justin Doshi et al., *Healthcare Private Equity in a Downturn*, BAIN & CO. (Apr. 2023), https://www.bain.com/insights/downturn-healthcare-private-equity-and-ma-report-2023/ [https://perma.cc/94KU-9FA7] ("While we have not seen a disproportionate decline in provider activity on an annual basis, provider deals dropped nearly 50% from Q3 to Q4, and may continue to impact []PE deal volumes in 2023.").

84. *See* Yasmin Rafiei, *When Private Equity Takes Over a Nursing Home*, NEW YORKER (Aug. 25, 2022), https://www.newyorker.com/news/dispatch/when-private-equity-takes-over-a-nursing-home [https://perma.cc/L6GL-YVKL].

85. *See* Gretchen Morgenson, *Doctor Fired From ER Warns About Effect of For-Profit Firms on U.S. Health Care*, NBC NEWS (Mar. 28, 2022, 2:54 PM), https://www.nbcnews.com/health/health-care/doctor-fired-er-warns-effect-profit-firms-us-health-care-rcna19975 [https://perma.cc/F373-L9LW].

86. *See* Harris Meyer, *Specialty Physician Groups Attracting Private Equity Investment*, MODERN HEALTHCARE (Aug. 31, 2019, 12:00 AM), https://www.modernhealthcare.com/physicians/specialty-physician-groups-attracting-private-equity-investment [https://perma.cc/4MYQ-N2LD].

87. *See* Abelson & Sanger-Katz, *Who Employs Your Doctor?*, *supra* note 52 (noting that a recent survey found that in more than one-fourth of local markets, "a single private equity firm owned more than 30[%] of [physician] practices in a given specialty in 2021"). Unsurprisingly, when a practice is acquired by private equity, researchers found that the prices paid by private insurers "increased sharply." *Id.*

88. Schulte, *supra* note 1.

89. Gretchen Morgenson, *Patients at Private-Equity-Owned Hospitals Get More Infections and Fall More Often, Says a New Study by Harvard Researchers*, NBC NEWS (Dec. 26, 2023, 11:00 AM) [hereinafter Morgenson, *Patients at Private-Equity-Owned Hospitals*], https://www.nbcnews.com/health/health-care/patients-private-equity-hospitals-more-infections-falls-jama-study-rcna130956 [https://perma.cc/9CF3-5EJM]; *see also* Bernard J. Wolfson, *ER Doctors Call Private Equity Staffing Practices Illegal and Seek To Ban Them*, KFF HEALTH NEWS (Dec. 22, 2022), https://kffhealthnews.org/news/article/er-doctors-call-private-equity-staffing-practices-illegal-and-seek-to-ban-them/ [https://perma.cc/7NGT-TGCA] (estimating between 25 and 40%).

90. Garber, *supra* note 69.

91. Abelson & Sanger-Katz, *Who Employs Your Doctor?*, *supra* note 52.

PE now "dominates" many specialties, including anesthesiology, dermatology, and gastroenterology, among others.[92]

B. The Impact on Cost, Utilization, and Quality

For their part, PE firms may contend that they are providing a social benefit. Many would argue that their participation in the health care delivery marketplace pushes providers and entities to be more efficient, which has to be a win-win.[93] Purporting to bear this out, research has shown that some targets of PE have become more efficient.[94]

Indeed, a recent review that examined hospitals that had been acquired by PE owners found a decrease in the cost per discharge for the hospital studied and an increase in that hospital's operating margin.[95] It also found an increase in patient throughput, which is defined as the "movement of patients from arrival to discharge."[96]

It follows that efficiency gains can turn into increased profitability for hospitals after PE acquisition.[97] This tracks the argument that PE increases firm value due to increasing operational efficiency.[98] Voices from within the industry echo these positives, praising efficiency gains and incentives for developing new technologies, which eventually, they argue, lead to greater access[99] and expertise.[100]

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92. Schulte, *supra* note 1; *see also* Scheffler et al., *Monetizing Medicine*, *supra* note 80.

93. *See* Sheelah Kolhatkar, *How Private-Equity Firms Squeeze Hospital Patients for Profits*, NEW YORKER (Apr. 9, 2020), https://www.newyorker.com/business/currency/how-private-equity-firms-squeeze-hospital-patients-for-profits [https://perma.cc/XZR7-99DL] ("Their task, then, is to make their portfolio companies more attractive to other buyers in a relatively short time; ideally, this is accomplished by making improvements to the business, such as by bringing in talented managers and making the company more innovative and efficient.").

94. *See* Marcelo Cerullo et al., *Financial Impacts and Operational Implications of Private Equity Acquisition of US Hospitals*, 41 HEALTH AFFS. 523, 529 (2022).

95. *Id.*

96. Victoria Bailey, *Private Equity Acquisitions Improved Hospital Financial Performance*, TECHTARGET (Apr. 5, 2022), https://www.techtarget.com/revcyclemanagement/news/366600924/Private-Equity-Acquisitions-Improved-Hospital-Financial-Performance [https://perma.cc/AWS2-ER49] ("Hospitals saw higher operating margins, decreases in costs per adjusted discharges, and increased inpatient utilization following private equity acquisitions, according to a *Health Affairs* study sent to journalists."); *see also* Cerullo et al., *supra* note 94, at 523.

97. *See* Cerullo et al., *supra* note 94, at 523 ("[F]inancial performance improved after acquisition . . . ."); Bailey, *supra* note 96; Blumenthal, *supra* note 80 (noting that PE could "adopt reforms that make care more efficient and reduce costs"); Steven Ross Johnson, *Study: Private Equity Hospital Takeovers Tied to Increases in Patient Falls, Infections*, U.S. NEWS & WORLD REP. (Dec. 26, 2023, 11:09 AM), https://www.usnews.com/news/health-news/articles/2023-12-26/study-private-equity-hospital-takeovers-tied-to-increases-in-patient-falls-infections [https://perma.cc/MWP2-R8UV].

98. *See* Janet Gao, Merih Sevilir & Yongseok Kim, *Private Equity in the Hospital Industry* 35 (Eur. Corp. Governance Inst., Working Paper No. 787/2021, 2023) ("PE acquirers improve the operating efficiency of target hospitals without a compromise in healthcare quality.").

99. *See* Michael Kroin & Ezra Simons, *Industry Voices—Private Equity Investment in Healthcare Is Making a Positive Impact … Especially for Doctors*, FIERCE HEALTHCARE (Apr. 28, 2023, 1:00 PM), https://www.fiercehealthcare.com/finance/industry-voices-private-equity-investment-healthcare-making-positive-impact-especially [https://perma.cc/KM2V-KSML].

But there is a wide concern about negative impacts on access to services. For sure, PE-owned companies could leverage "market position to drive smaller independent practices out of business," which shrinks the number of providers in a given area.[101] Further, the fact that some PE-backed entities declare bankruptcy due to their often-high debt load following PE-acquisition "often leave[s] underserved populations with limited access to care" once those facilities close.[102]

Studies have demonstrated other types of mixed impacts. While a 2015 study that examined patenting showed that PE involvement can lead to innovative behavior,[103] generally, "private equity tends to increase health care prices and utilization."[104] This has been borne out by a cohort of studies examining nursing homes.[105] For sure, PE-owned entities commonly attempt to both increase physician productivity and "seek a more lucrative mix of procedures" for patients.[106] And, as seen below, these activities have triggered allegations of overtreatment.[107]

To that point, a 2022 study concluded that PE acquisition led to "increases in allowed amount and charges per claim, volume of encounters, and new patients seen."[108] Importantly, PE acquisition was associated with an increase of $71 in charges per claim, and $23 in the allowed amount per claim.[109] The study also found greater "intensity of care"—"an increase in patient utilization from both established patients coming in more often and from the addition of new patients."[110] This could be due to changes in operations, or it could be "explained by overutilization of profitable services

100. Wolfson, *supra* note 89 ("Jamal Hagler, vice president of research at the American Investment Council, said private equity brings expertise to hospital systems, 'whether it's to hire new staff, grow and open up to new markets, integrate new technologies, or develop new technologies.'").

101. Suhas Gondi & Zirui Song, *Potential Implications of Private Equity Investments in Health Care Delivery*, 321 JAMA 1047, 1048 (2019).

102. HMS Commc'ns, *Care Riskier for Patients at Private Equity Hospitals*, HARV. GAZETTE (Jan. 2, 2024), https://news.harvard.edu/gazette/story/2024/01/healthcare-riskier-for-patients-at-private-equity-hospitals/ [https://perma.cc/R56R-XSX8].

103. Kevin Amess, Joel Stiebale & Mike Wright, *The Impact of Private Equity on Firms' Innovation Activity* (Düsseldorf Inst. for Competition Econ., Discussion Paper No. 184, 2015), https://www.dice.hhu.de/fileadmin/redaktion/Fakultaeten/Wirtschaftswissenschaftliche_Fakultaet/DICE/Discussion_Paper/184_Amess_Stiebale_Wright.pdf [https://perma.cc/T2UH-2ZT2].

104. Blumenthal, *supra* note 80.

105. Robert Tyler Braun et al., *Association of Private Equity Investment in US Nursing Homes With the Quality and Cost of Care for Long-Stay Residents*, JAMA HEALTH F., Nov. 19, 2021, at 1; Atul Gupta, Sabrina T. Howell, Constantine Yannelis & Abhinav Gupta, *Owner Incentives and Performance in Healthcare: Private Equity Investment in Nursing Homes*, 26 (Nat'l Bureau of Econ. Rsch., Working Paper No. 28474, 2023), https://www.nber.org/system/files/working_papers/w28474/w28474.pdf [https://perma.cc/QQ7Q-WB3D].

106. Hoffer, *supra* note 55, at 6.

107. *See infra* notes 108–12 and accompanying text.

108. Yashaswini Singh et al., *Association of Private Equity Acquisition of Physician Practices with Changes in Health Care Spending and Utilization*, JAMA HEALTH FORUM, Sept. 2, 2022, at 1, 1.

109. Anastassia Gliadkovskaya, *Private Equity Deals Drive Up Healthcare Use, Costs Among Physician Practices, JAMA Study Finds*, FIERCE HEALTHCARE (Sept. 13, 2022, 10:00 AM), https://www.fiercehealthcare.com/finance/private-equity-associated-greater-spending-utilization-jama-study-finds [https://perma.cc/B5FS-QZMR].

110. *Id.*

or low-value care."[111] According to the researchers, "[g]iven that [the] study design held constant the physicians at each practice before and after acquisition, increased patient utilization per practice was unlikely to be the result of new physician hires,"[112] suggesting some other cause of the increased utilization.

Further, researchers have noted that "more new patients [were] seen and more fee-generating procedures [were] performed immediately after [PE] takeovers."[113] It is understood that PE investment in provider practices is associated with increased health care utilization.[114] This research suggests that PE investment leads to an increase in the number of health care services provided, as well as increases in the costs of those services.

To that end, an additional systematic review found that "PE ownership was most consistently associated with increases in costs to patients or payers."[115] This analysis, which focused on eight countries (with most of the entities reviewed located in the United States), examined studies done on nursing homes, hospitals, dermatology settings, multiple specialties, general physician groups, urology, gastroenterology, orthopedics, surgical centers, fertility centers, obstetrics and gynecology, anesthesia, hospice, oral or maxillofacial surgery, otolaryngology, and plastics specialty groups.[116] Further, "costs to patients or payers showed the most consistent pattern across a total of 12 studies."[117] No studies showed a decrease in costs, "nine showed increased costs to patients or payers[,] . . . and three found no differences."[118]

Finally, and perhaps most importantly, when hospitals, providers, and other entities consolidate, prices rise due to increased market power.[119] Indeed, "accelerated acquisitions have anticompetitive effects making the survival of independent practices more difficult."[120] With higher prices and market dominance, it is fair to assume that PE involvement does not constitute a positive development for the payers of American health care.

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111. *Id.* (noting the study argued that "understanding the strategies of private equity that drive greater profits is 'critically important' to devising policies to monitor them"); *see also* Singh et al., *supra* note 108, at 8.

112. Singh et al., *supra* note 108, at 8.

113. Hoffer, *supra* note 55, at 6; *see also* Scheffler et al., *Monetizing Medicine*, *supra* note 80, at 7.

114. *See* Scheffler et al., *Monetizing Medicine*, *supra* note 80, at 15 ("Other studies have also measured impact on utilization and expenditures, and found increases in each.").

115. 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*, BMJ, July 19, 2023, at 1, 1, https://www.bmj.com/content/bmj/382/bmj-2023-075244.full.pdf [https://perma.cc/N2DN-2JDY].

116. *See id.*

117. *Id.* at 10.

118. *Id.*

119. *See generally* Zack Cooper, Stuart V. Craig, Martin Gaynor & John Van Reenen, *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*, 134 Q.J. ECON. 51 (2019).

120. Sajith Matthews & Rento Roxas, *Private Equity and Its Effect on Patients: A Window into the Future*, 23 INT. J. HEALTH ECON. MGMT. 673, 675 (2022).

But what about patients? After all, safety is expensive.[121] In an environment where cost cutting and reductions in staff are common, one may be concerned about the quality of care for patients who visit doctors and hospitals whose practices and facilities are backed by a PE firm.

On the question of quality, although somewhat mixed,[122] most data suggest that PE acquisition harms the quality of care for patients. Overall, there is "no evidence that private equity ownership leads to systematic improvements in care."[123] To that point, a recent Journal of the American Medical Association (JAMA) study found that "PE acquisition had no substantial association with the patient-level outcomes examined."[124] However, that same study found that PE acquisition "was associated with a moderate improvement in mortality among Medicare beneficiaries hospitalized with AMI [(acute myocardial infarction)]."[125]

A systematic review found that "PE ownership was associated with mixed to harmful impacts on quality" and "was associated with reduced nurse staffing levels or a shift towards lower nursing skill mix."[126] Of the eight studies examined as part of this review, "two found beneficial impacts, and three found harmful impacts, and in three the findings were neutral."[127] In conclusion, the study found "[n]o consistently beneficial impacts of PE ownership."[128]

Additional studies have found adverse patient outcomes in the nursing home context,[129] harms that result in increased emergency room visits and hospitalizations for PE-owned nursing home residents, and, unsurprisingly, higher Medicare costs.[130] In fact, in one of those studies, "the patient mortality rate during a nursing home stay and the subsequent 90 days [was] 10[%] higher at facilities owned by private equity firms than at skilled nursing facilities overall."[131] These studies build support for a recent

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121. Jha, *supra* note 52 ("[T]wo key things drive safety in hospitals: The first is staffing levels (particularly nursing), and the second is detailed patient safety protocols and processes to prevent errors. Both cost money, and it is not a stretch to connect cuts in staffing and a reduced focus on patient safety with an increased risk of harm for patients.").

122. *See, e.g.*, Gao, *supra* note 98, at 32 (finding no decline in health care quality following PE acquisition).

123. Blumenthal, *supra* note 80.

124. *See* Marcelo Cerullo, Kelly Yang, & Karen E. Joynt Maddox, *Association Between Hospital Private Equity Acquisition and Outcome of Acute Medical Conditions Among Medicare Beneficiaries*, JAMA NETWORK OPEN, Apr. 29, 2022, at 1, 2, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2791727 [https://perma.cc/6KA5-NHPB].

125. *Id.*

126. Borsa, *supra* note 115, at 1.

127. *Id.* at 7 (footnotes omitted).

128. *Id.* at 1.

129. *See* Gupta et al., *supra* note 105.

130. *See* Braun et al., *supra* note 105, at 1 ("Residents of private equity nursing homes experienced relative increases in ACS [(ambulatory care-sensitive)] emergency department visits of 11.1% . . . and in ACS hospitalizations of 8.7% . . . compared with residents in other for-profit homes . . . .").

131. Steve Maas, *How Patients Fare When Private Equity Funds Acquire Nursing Homes*, NAT'L BUREAU ECON. RSCH. DIG., Apr. 2021, at 2, 2, https://live-nber.pantheonsite.io/sites/default/files/2021-03/apr21.pdf [https://perma.cc/7KBA-3UTR].

report that concluded that "[t]he private equity business model is fundamentally incompatible with sound healthcare that serves patients."[132]

Bearing this out further, a study published in JAMA late last year found increased hospital-acquired adverse events following PE acquisition, "suggesting poorer quality of inpatient care."[133] The study examined nearly five million hospitalizations, and found "private equity acquisition was associated with a 25.4% increase in hospital-acquired conditions, which was driven by falls and central line-associated bloodstream infections."[134] This was the case, even though the Medicare beneficiaries examined as part of the study who were part of the PE-acquired hospitals examined were *younger* than those in the non-PE-acquired hospitals.[135] The study "pretty strongly suggest[ed] that there is a quality problem when private equity takes over."[136]

The authors further found that those receiving care at PE-acquired hospitals had higher surgical site infections, at 0.216%, compared with 0.108% in non-PE-acquired hospitals.[137] Overall, the study found a 27% increase in falls and a 38% increase in central line infections in individuals who were patients at a PE-owned hospital.[138] According to the study authors, "[t]hese findings heighten concerns about the implications of private equity on health care delivery."[139]

Finally, some PE-backed hospitals have suffered from poor quality ratings,[140] due to unsafe conditions in their facilities and high readmission rates.[141] In one example, a hospital's Medicare payments were threatened following an "immediate jeopardy" designation for the hospital due to quality deficiencies.[142] In another, ER waits ballooned, and serious allegations of unsafe conditions for patients—allegations of sexual assaults perpetrated by a nurse practitioner—were leveled.[143] The allegations that PE-backed hospitals have led to unsafe conditions for patients visiting these

132. Scheffler et al., *Soaring Private Equity*, *supra* note 60, at 2.

133. Sneha Kannan, Joseph Dov Bruch & Zirui Song, *Changes in Hospital Adverse Events and Patient Outcomes Associated With Private Equity Acquisition*, 330 JAMA 2365, 2366 (2023).

134. *Id.*

135. *Id.* at 2365.

136. Reed Abelson & Margot Sanger-Katz, *Serious Medical Errors Rose After Private Equity Firms Bought Hospitals*, N.Y. TIMES (Dec. 26, 2023) [hereinafter Abelson & Sanger-Katz, *Serious Medical Errors*], https://www.nytimes.com/2023/12/26/upshot/hospitals-medical-errors.html (quoting Dr. Ashish Jha, the dean of the Brown University School of Public Health).

137. Kannan et al., *supra* note 133, at 2365; *see also* Morgenson, *Patients at Private-Equity-Owned Hospitals*, *supra* note 89.

138. Morgenson, *Patients at Private-Equity-Owned Hospitals*, *supra* note 89.

139. Kannan et al., *supra* note 133, at 2365.

140. *See* Alan Condon, *Apollo's 220-Hospital "Stranglehold" Harms Patients and Workers, Report Alleges*, BECKER'S HOSP. REV., https://www.beckershospitalreview.com/finance/apollos-hospital-stranglehold-harms-patients-and-workers-report-alleges.html [https://perma.cc/ZW64-T4HY] (Jan. 17, 2024) ("Many of the hospitals have experienced service cuts, layoffs, poor quality ratings and regulatory investigations . . . .").

141. *See* Eileen O'Grady, *Apollo's Stranglehold on Hospitals Harms Patients and Healthcare Workers*, PRIV. EQUITY STAKEHOLDER PROJECT 7 (Jan. 2024), https://pestakeholder.org/wp-content/uploads/2024/01/PESP__Report_Apollo_Lifepoint_2024.pdf [https://perma.cc/DZJ8-SW86] (noting examples of PE-backed facilities cutting and limiting services, including pediatric clinics, OB-GYN services, and psychiatric services).

142. *Id.* at 8.

143. *Id.* at 9–10.

facilities are not specific to just one institution.[144] Allegations have also included infection control failures and disrepair in the facilities themselves.[145]

For example, in Connecticut, three PE-owned facilities have experienced deteriorating conditions and are behind on paying their bills, owing "millions to vendors and physicians contracted to provide care at the hospitals."[146] Surgeries have been postponed due to a lack of anesthesia services available in the hospitals.[147] This was after several alleged quality lapses by the PE-backed ownership at one of its hospitals.[148]

In addition to these impacts on cost, utilization, and quality, portfolio health care companies that have been taken over by PE have been engaged in aggressive bill collection tactics against their patients.[149] These are shown by both increasing patient bills to grow profit and suing patients for unpaid medical bills, such as those following emergency room visits.[150] Lawsuits against patients lead to all sorts of negative health and health policy effects.[151]

C. Reduced and Shifted Staffing

One effect that follows PE takeover is the restructuring of the labor allotment,[152] which can result in shrinking services.[153] Layoffs also sometimes follow.[154] Indeed,

144. *See id.* at 9–11.

145. *Id.* at 11.

146. Jenna Carlesso & Dave Altimari, *Medical Staff, CT Legislators Rally for Prospect Hospitals' Sale to Yale New Haven Health*, CT MIRROR (Nov. 13, 2023, 5:43 PM), https://ctmirror.org/2023/11/13/ct-prospect-medical-hospitals-yale-health-sale/ [https://perma.cc/6RGM-SLSY].

147. *Id.*

148. *See* Josh Kovner, *After 2 Deaths and a Series of Medical Errors, the For-Profit Owner of Waterbury and Manchester Hospitals Faces Protests, Major Sanctions*, HARTFORD COURANT (June 2, 2019, 12:46 PM), https://www.courant.com/2019/06/02/after-2-deaths-and-a-series-of-medical-errors-the-for-profit-owner-of-waterbury-and-manchester-hospitals-faces-protests-major-sanctions/.

149. *See* Wendi C. Thomas, Maya Miller, Beena Raghavendran & Doris Burke, *A Private Equity-Owned Doctors' Group Sued Poor Patients Until It Came Under Scrutiny*, NPR (Nov. 27, 2019, 7:57 PM), https://www.npr.org/sections/health-shots/2019/11/27/783449133/a-private-equity-owned-doctors-group-sued-poor-patients-until-it-came-under-scru [https://perma.cc/F3JJ-SQC4].

150. *See* Morran & Petty, *supra* note 70.

151. *See* Isaac D. Buck, *When Hospitals Sue Patients*, 73 HASTINGS L.J. 191, 217–29 (2022).

152. *See* Merrill Goozner, *Private Equity and Its Hospitals*, WASH. MONTHLY (Mar. 24, 2023), https://washingtonmonthly.com/2023/03/24/private-equity-and-its-hospitals-a-case-study/ [https://perma.cc/H9XU-QMH5] ("If you want to know what happens after a private equity firm plunders one of its hospital acquisitions, visit Delaware County in southeast Pennsylvania. Earlier this month, Crozer Health laid off 215 workers, or 4[%] of the workforce, at its four hospitals in the suburban Philadelphia county amid reports it is late paying its bills, including rent on its hospitals."); Anna Claire Vollers, *When Private Equity Comes to Town, Hospitals Can See Cutbacks, Closures*, N.J. MONITOR (Jan. 18, 2024, 12:32 PM), https://newjerseymonitor.com/2024/01/18/shell-game-when-private-equity-comes-to-town-hospitals-can-see-cutbacks-closures/ [https://perma.cc/2R58-MDXZ]; Katherine Davis, *Layoffs and Other Cutbacks Follow Executive Shakeup at Debt-Heavy Doc Group*, CRAIN'S CHI. BUS. (Sept. 28, 2023, 1:54 PM), https://www.chicagobusiness.com/health-care/duly-health-physicians-group-layoffs-cutbacks.

153. Goozner, *supra* note 152 ("In addition to the new layoffs, Crozer announced plans to end drug and alcohol treatment at its 313-bed flagship teaching hospital in Chester . . . ."); *see also* O'Grady, *supra* note 141, at 7 (noting examples of PE-backed facilities cutting and limiting services, including pediatric clinics,

"because the major 'cost' in a medical setting is the salaries of personnel, they will seek to substitute lower-paid staff: [Licensed Practical Nurses] for [Registered Nurses], minimally trained 'medical assistants' for nurses."[155]

In one example, a nurse practitioner who worked for PE-owned American Physician Partners, a medical staffing company, experienced a dramatic change in staffing at the Kentucky hospital where he worked.[156] The ER had been restructured, "reducing shifts from two doctors to one doctor."[157] "'I guess we're the first guinea pigs for our ER,' he said. 'If we do have a major trauma and multiple victims come in, there's only one doctor there. . . . We need to be prepared.'"[158] Indeed, American Physician Partners "estimated it could cut almost $6 million by shifting more staffing from physicians to midlevel practitioners" in a nonpublic document.[159]

PE-backed hospitals can also hire fewer physicians in the first place.[160] This can create job insecurity—and increase the angst—for the more expensive physicians.[161] Within the emergency room setting, it is common for advanced practice providers (like nurse practitioners) to bill at 85% of the rate of a physician but cost the institution about 40% of what a physician would cost in salary.[162]

> This staffing strategy has permeated hospitals, and particularly emergency rooms, that seek to reduce their top expense: physician labor. While diagnosing and treating patients was once doctors' domain, they are increasingly being replaced by nurse practitioners and physician assistants, collectively known as "midlevel practitioners," who can perform many of the same duties and generate much of the same revenue for less than half the pay.[163]

A recent study has borne this out: PE-owned physician practices "experience greater replacement of the workforce and rely more heavily on advanced practice providers—such as physician assistants and nurse practitioners—rather than physicians."[164] One study found that the number of emergency room visits with a nonphysician practitioner as the primary clinician increased from 6.1% in 2005 to

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OB-GYN services, and psychiatric services); Condon, *supra* note 140 (noting how one PE company's ownership of two large health systems "downgrades hospital services" and "hurts workers").

154. *See* Ballou, *supra* note 53 ("ManorCare soon instituted various cost-cutting programs and laid off hundreds of workers.").

155. Hoffer, *supra* note 55, at 6.

156. *See* Brett Kelman & Blake Farmer, *ERs Staffed by Private Equity Firms Aim To Cut Costs by Hiring Fewer Doctors*, NPR (Feb. 11, 2023, 7:00 AM), https://www.npr.org/sections/health-shots/2023/02/11/1154962356/ers-hiring-fewer-doctors [https://perma.cc/9FNA-8WFM].

157. *Id.*

158. *Id.* (omission in original).

159. *Id.*

160. *Id.*

161. *See* Jamtgaard & Lewis, *supra* note 34, at 172–73.

162. *See id.* at 174; Kelman & Farmer, *supra* note 156.

163. *See* Kelman & Farmer, *supra* note 156.

164. Robinson, *supra* note 59.

16.6% in 2020.[165] This amounts to a 172% increase in ER interactions where the primary clinician was a nonphysician professional over fifteen years.[166]

Generally, cutbacks on staff can impact the quality of care at the facility and may serve as the explanation for increased errors following PE acquisition.[167] In one hospital in Montana, "[h]undreds of unionized nurses" have demanded that PE-backed management "address a range of patient care issues" after more than sixty nursing positions were left unfilled.[168] Researchers have also noted a connection between PE acquisition, staff reduction, and quality of care concerns within the nursing home context.[169]

While it is true that examples of hospital layoffs have been covered in the popular press as a general trend,[170] PE ownership makes these trends more acute.[171] Indeed, "the use of [advanced practice providers (non-physicians)] in the emergency department . . . precedes the ascent of private equity in emergency medicine," but "the drive to maximize profits inherent to the private equity business model[] has exacerbated this trend into potentially problematic models of care."[172]

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165. *See* Eric W. Christensen et al., *Association of State Share of Nonphysician Practitioners with Diagnostic Imaging Ordering Among Emergency Department Visits for Medicare Beneficiaries*, JAMA NETWORK OPEN, Nov. 10, 2022, at 1, 5, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2798248 [https://perma.cc/VPP9-BHTY].

166. Kelman & Farmer, *supra* note 156.

167. *See* Abelson & Sanger-Katz, *Serious Medical Errors*, *supra* note 136.

168. Matt Parr, *New Report Details Harm Caused to Healthcare Industry by Apollo*, PRIV. EQUITY STAKEHOLDER PROJECT (Jan. 11, 2024), https://pestakeholder.org/news/new-report-details-harm-caused-to-healthcare-industry-by-apollo/ [https://perma.cc/59FR-UUXQ]; *see also* Vollers, *supra* note 152 ("Physicians, nurses and legislators rallied at the Connecticut Capitol in November to urge the state to speed up its review of Prospect's sale of three Connecticut hospitals to Yale New Haven Health.").

169. *See* Yasmin Rafiei, *When Private Equity Takes Over a Nursing Home*, NEW YORKER (Aug. 25, 2022), https://www.newyorker.com/news/dispatch/when-private-equity-takes-over-a-nursing-home [https://perma.cc/N7FU-7D6L] ("Within two weeks, management laid out plans to significantly cut back nurse staffing. Some mornings, there were only two nursing aides working at the seventy-two-bed facility."); David Brancaccio & Jarrett Dang, *Private Equity Bought a Nursing Home, Leading to Staff Cuts and a Decline in Care*, MARKETPLACE (Sept. 8, 2022), https://www.marketplace.org/2022/09/08/private-equity-bought-a-nursing-home-leading-to-staff-cuts-and-a-decline-in-care/ [https://perma.cc/LVV5-5ALV] (noting that staffing cuts are often related to care quality outcomes).

170. *See* Dave Muoio, *Layoffs Are Ramping Up Among Hospitals and Health Systems. Here Are 100 Examples from 2023*, FIERCE HEALTHCARE (Dec. 22, 2023, 8:25 AM), https://www.fiercehealthcare.com/providers/layoffs-ramping-among-hospitals-and-health-systems-heres-34-examples-2023 [https://perma.cc/6FTS-FEDQ] (listing one hundred institutions with layoffs); Dave Muoio, *Hospital and Health Systems' Dire Finances Are Spurring Layoffs-Here Are 35 Examples from 2022*, FIERCE HEALTHCARE (Nov. 21, 2022, 11:00 AM), https://www.fiercehealthcare.com/providers/hospital-and-health-systems-dire-finances-are-spurring-layoffs-heres-23-examples-2022 [https://perma.cc/N43A-BKFJ] (listing thirty-five institutions with layoffs).

171. *See* Lydia DePillis, *Rich Investors May Have Let a Hospital Go Bankrupt. Now, They Could Profit from the Land*, CNN (July 29, 2019, 3:17 PM), https://www.cnn.com/2019/07/29/economy/hahnemann-hospital-closing-philadelphia/index.html [https://perma.cc/BQ7Y-YSQM] (relaying the story of Hahnemann hospital, which was purchased by a PE firm and then closed, resulting in the loss of more than 2,500 jobs at the inner-city Philadelphia safety-net hospital).

172. Jamtgaard & Lewis, *supra* note 34, at 173 ("The expected growth rate of [nurse practitioners] in non-primary care settings is expected to reach 141% by 2025, whereas the corresponding growth rate of physicians is expected only to rise by 21%.").

II. BREACHING THE INNER SANCTUM: PE AND PROVIDERS

As has been seen, PE may ramp up pressures on health care providers to maximize profits[173] through "increasing prices and volume."[174] Price regulation—what each procedure costs—is an ongoing concern of antitrust regulation.[175] Indeed, as Professor Fuse Brown has argued, the entry of PE into the health law field and the anticompetitive behavior it promotes "builds the case for strong antitrust tools" to be used to try and arrest some of these trends.[176]

Beyond the impact of pricing, a firm influencing the clinical practice patterns of physicians invades providers' inner sanctum. The concern is justified, specifically that "the pressure to turn big profits will influence life-or-death decisions that were once left solely to medical professionals."[177] PE ownership may pressure providers, the gatekeepers of American health care, to increase volume and "ancillary revenue streams (e.g., imaging or procedures)."[178] It is this pressure and the law's ability to prevent it that are the focus of this instant analysis and it is the *provider* who stands in the breach between the PE owners and patients.

It is one thing to conclude that PE worsens quality of care, but it is another to hypothesize how PE ownership *caused* these outcomes.[179] The author of one of the recent studies identified three potential causes: (1) reduced staffing that follows PE-acquisition, (2) PE's replacement of highly paid workers with lower-paid ones, and (3) an impact on clinical decision-making by the PE firm.[180] He called for "more research on how financial considerations linked to private equity ownership may impact clinical decision-making."[181]

On that front, anecdotal evidence exists that PE-owned facilities change the pressure gradient on providers on the ground level and impact their clinical decision-making. These stories suggest that PE ownership places more acute pressure on entities and providers to become more profitable based on increased volume and utilization.[182] And these pressures have negative impacts on patients.[183]

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173. Robinson, *supra* note 59.

174. Suhas Gondi & Zirui Song, *Potential Implications of Private Equity Investments in Health Care Delivery*, 321 JAMA 1047, 1047–48 (Feb. 28, 2019).

175. *See* Abelson & Sanger-Katz, *Who Employs Your Doctor?*, *supra* note 52.

176. *See id.*

177. Kelman & Farmer, *supra* note 156.

178. Gondi & Song, *supra* note 174, at 1047.

179. *See supra* notes 123–139 and accompanying text.

180. Brenda Goodman, *Private Equity Ownership of Hospitals Made Care Riskier for Patients, a New Study Finds*, CNN (Dec. 27, 2023, 11:12 AM), https://www.cnn.com/2023/12/26/health/private-equity-hospitals-riskier-health-care/index.html [https://perma.cc/BMF5-U2L6].

181. *Id.*

182. *See, e.g.*, Paul Hsieh, *Does Your Doctor Work for a Private Equity Company—and Should You Care?*, FORBES (Feb. 1, 2022, 8:01 AM), https://www.forbes.com/sites/paulhsieh/2022/01/31/does-your-doctor-work-for-a-private-equity-company---and-should-you-care/ [https://perma.cc/Y5GA-H5QW] ("Critics of private equity argue that the new owners may be driven more by revenue rather than providing quality care. They may cut corners or try to pressure physicians to squeeze in more patients in a workday to maintain the income stream."); Jha, *supra* note 52 (documenting a physician who "started noticing small changes" following PE acquisition, like "the gentle nudge to bill more intensively for visits, to send more patients to the hospital for additional tests").

For sure, physicians believe that non-physician ownership results in a lower quality of care.[184] Based on recent survey results, "[o]ver half of employed physicians reported that changes in practice ownership reduced the quality of patient care, citing an erosion in clinical autonomy and a greater focus on financial incentives."[185] Overall, about "[70%] of physicians indicated that their employers use incentives to impact the volume of patients they should see,"[186] encouraging them to see more patients.[187]

Notably, 14% of physicians employed by venture capital or PE-owned practices "were more likely to say that their employer had punitive incentives, such as payment deductions, compared to physicians employed by a hospital or health system-owned practice (7%)."[188] Similarly, only 18% of the physicians surveyed responded that they believed "corporate ownership of medical practices has improved quality of care."[189] Indeed, doctors themselves believe that PE ownership is bad for American health care and American patients.

What PE ownership's influence threatens is the destruction of the sanctity of the patient-physician relationship. These pressures on physicians can cause a decline in trust from patients.[190] It is obvious that "[p]atient-physician trust may be breached when patient care decisions are influenced by income considerations or when the undue influence of corporate investors, shareholders, and compensation models leads to the prioritization of financial gain over patient care. This risk may be particularly prevalent in investor-owned health care organizations."[191]

It is no surprise that a lack of trust is likely to lead to health-related harms.[192] These harms include harm to the individual, like leading citizens to skip

183. *See supra* notes 1–8 and accompanying text.

184. *See* Claire Wallace, *Nonphysician Practice Ownership Worsens Quality of Care*, BECKER'S PHYSICIAN LEADERSHIP (Dec. 4, 2023), https://www.beckersphysicianleadership.com/private-equity/nonphysician-practice-ownership-worsens-quality-of-care.html [https://perma.cc/YBJ8-FDYB].

185. Physicians Advocacy Inst., *The Impact of Practice Acquisitions and Employment on Physician Experience and Care Delivery*, NORC AT THE UNIV. OF CHI. 2 (Nov. 2023), https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/NORC-Employed-Physician-Survey-Report-Final.pdf [https://perma.cc/7C99-A626].

186. *Id.* at 25.

187. *The Impact of Practice Acquisitions and Employment on Physician Experience and Care Delivery*, PHYSICIANS ADVOC. INST., https://www.physiciansadvocacyinstitute.org/PAI-Research/Employed-Physician-Survey [https://perma.cc/4LR4-5H22] (last visited Mar. 15, 2025).

188. Physicians Advocacy Inst., *supra* note 185, at 25.

189. Wallace, *supra* note 184.

190. Americans' trust of physicians has radically declined over the last fifty years. *See* Dhruv Kullar, *Do You Trust the Medical Profession?*, N.Y. TIMES (Jan. 23, 2018), https://www.nytimes.com/2018/01/23/upshot/do-you-trust-the-medical-profession.html ("In 1966, more than three-fourths of Americans had great confidence in medical leaders; today, only 34[%] do. Compared with people in other developed countries, Americans are considerably less likely to trust doctors, and only a quarter express confidence in the health system.").

191. Crowley et al., *supra* note 68, at 1447.

192. *See* Kullar, *supra* note 190.

health-protective behaviors, to societal harms, like hamstringing the state's response to epidemics,[193] to systemic harms, like holistically chilling innovation.[194]

A lack of trust may not manifest itself as a comment on the expert's specific technical knowledge but instead reflects the perception that "experts do not act in good faith,"[195] and one in which the public believes that physicians are acting to help themselves and not the patient.[196] If the system feels corrupt, patients are not likely to heed its demands and may withdraw from it altogether. In effect, the success of medicine and its ability to command authority depends upon its ability to maintain a positive perception from the public.[197]

Thus, the regulatory mechanism that seeks to protect and facilitate patient trust must construct guardrails that protect the provider's clinical decision-making process from untoward influence. In theory, its structure must seek both to deter profit from corrupting a provider's clinical decision-making before care has been administered to prevent patient harm,[198] and to punish those providers who have been corrupted by its influence following an episode of care that was ultimately unnecessary.[199] It must also seek to hold those actors who are corrupting medical judgment responsible.

The challenge, of course, is that a regulatory mechanism in this space must also comply with a set of deeply held societal values—like respect for provider autonomy. Many of these societal values conflict with one another, complicating the effort to build a coherent regulatory system. These pressures also ultimately lead to the reliance on the

193. The damage of mistrust was on display during the COVID-19 pandemic. *See* Krista Conger, *How Misinformation, Medical Mistrust Fuel Vaccine Hesitancy*, STAN. MED. NEWS CTR. (Sept. 2, 2021), https://med.stanford.edu/news/all-news/2021/09/infodemic-covid-19.html [https://perma.cc/8MS6-QZZ5].

194. *See* Kullar, *supra* note 190.

195. *Enhancing Public Trust in COVID-19 Vaccination: The Role of Governments*, OECD 19 (May 10, 2021), https://www.oecd.org/en/publications/enhancing-public-trust-in-covid-19-vaccination-the-role-of-governments_eae0ec5a-en/full-report.html [https://perma.cc/CQ9F-C8A7].

196. *See* Kullar, *supra* note 190 ("People's trust depends fundamentally on three questions: Do you know what you're doing? Will you tell me what you're doing? Are you doing it to help me or help yourself?").

197. *See* Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463, 470–85 (2002) (noting the importance of trust in medicine and in the doctor-patient relationship); *see also* U.S. Dep't of Health & Hum. Servs., *A Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse*, OFF. OF INSPECTOR GEN. 2, https://oig.hhs.gov/documents/physicians-resources/947/roadmap_web_version.pdf [https://perma.cc/2AAM-BQQL] (last visited Dec. 29, 2024) ("Society places enormous trust in physicians, and rightly so. Trust is at the core of the physician-patient relationship.").

198. *See* Press Release, U.S. Dep't of Just., Justice Department's False Claims Act Settlements and Judgments Exceed $5.6 Billion in Fiscal Year 2021 (Feb. 1, 2022) [hereinafter FCA Press Release], https://www.justice.gov/opa/pr/justice-department-s-false-claims-act-settlements-and-judgments-exceed-56-billion-fiscal-year [https://perma.cc/C7MA-CHH3] ("[T]he department's vigorous pursuit of health care fraud prevents billions more in losses by deterring others who might try to cheat the system for their own gain. In many cases, the department's efforts also protect patients from medically unnecessary or potentially harmful actions."). Indeed, these dual goals of the fraud and abuse enforcement mechanism may complicate priorities in various cases.

199. *See Quick Facts: Health Care Fraud Offenses*, U.S. SENT'G COMM'N (2021), https://www.ussc.gov/sites/default/files/pdf/research-and-publications/quick-facts/Health_Care_Fraud_FY21.pdf [https://perma.cc/2P2H-7FZM] (noting that there were 336 health care fraud offenders sentenced in 2021 reported to the federal U.S. Sentencing Commission, down nearly 29% since 2017); FCA Press Release, *supra* note 198 (noting that the DOJ recovered more than $5 billion from health care fraud settlements and judgments).

conception of *medical necessity* as a demarcation point between legitimate and illegitimate care and often place the physician in the middle of the regulatory mechanism. With the increased financialization of health care, however, a physician at the center of a regulatory regime begins to look outdated. Problematically, for health care policymakers and government officials with patient protection in mind, there is no ready-made and obvious regulatory response to prevent the worst excesses of PE ownership.[200] Of course, part of the reason why PE has been able to infiltrate the health care marketplace is due to conflicting values within the health care system. On their own, these values are defensible, or even laudable, but they end up combining to create a system rife with regulatory confusion. A few of these competing values may include:

1. the desire to maintain the autonomy and independence of the American health care provider by encouraging expertise and innovation,[201]
2. the effort to foster trust so that patients follow their doctors' orders,
3. the necessity of protecting patients from harm,
4. a concern to protect the finances of public programs and ensure the fiscal sustainability of publicly financed insurance programs,
5. a focus to keep down the cost of care where it negatively impacts patients,
6. the (perhaps misguided)[202] commitment to try—where possible—to treat the patient as a consumer in an effort to allow for patient autonomy and choice, and
7. a willingness to allow the health care enterprise to attain profit and stay lucrative to attract additional investment.

This "consumer-first" perspective attempts to unlock the power of the private market and protect patients' agency to make health care decisions for themselves and their families.

At bottom, and through many iterations, the law has generally attempted to insulate American medicine from the toxic influence of profit. Examples include external legislative constraints—from the corporate practice of medicine doctrine that limits hospitals' ability to employ or control physicians,[203] to certificate of need

200. *See* Abelson & Sanger-Katz, *Who Employs Your Doctor?*, *supra* note 52 (noting that law and business professor Barak Richman said that PE "firms are skilled at exploiting loopholes in existing regulations to maximize their profits").

201. *See, e.g.*, Wendy Netter Epstein, *The Health Insurer Nudge*, 91 S. CAL. L. REV. 593, 629–30 (2018) (noting that "physician autonomy means the freedom to make decisions on the basis of professional judgment and specialized knowledge," that it is "colloquially synonymous with clinical freedom and is highly valued by physicians," and that "[t]he autonomy value has a special moral importance in health care"); Jolene S. Fernandes, Note, *Perfecting Pregnancy Via Preimplantation Genetic Screening: The Quest for an Elusive Standard*, 4 U.C. IRVINE L. REV. 1295, 1303 (2014) (noting that a reinterpretation of certain legal frameworks would promote patient autonomy and foster innovation).

202. *See* Paul Krugman, Opinion, *Patients Are Not Consumers*, N.Y. TIMES (Apr. 21, 2011), https://www.nytimes.com/2011/04/22/opinion/22krugman.html.

203. ARI J. MARKENSON & ANGELA HUMPHREYS, WHAT IS … THE CORPORATE PRACTICE OF MEDICINE AND FEE-SPLITTING? 22 (2021) (ebook).

> The corporate practice of medicine doctrine prohibits a nonlicensed entity or individual from employing or otherwise controlling the professional activities of a licensed physician. The prohibition generally bans nonlicensed persons, or certain business entities, including corporations, from employing or contracting with physicians to provide medical professional services.

regulation that limits providers' ability to expand services,[204] to the aggressive use of fraud and abuse tools,[205] to strict marketing rules and their enforcement.[206] Others include tools that operate on the provider's internal decision-making and influence the specific delivery of care, like the doctrine of informed consent,[207] new payment models that seek to encourage efficiency and savings,[208] or the adoption of national standards of care in medical malpractice cases that had the effect of moving the standard of care away from insular, provider-protective, custom-based norms.[209] Additionally, the field of bioethics has been used as a bulwark against the potential corrupting influence of profit.[210] The American Medical Association (AMA) Principles of Medical Ethics have

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> . . . [T]he basic underlying rationale for the rule is to prevent nonmedical, and specifically commercial, factors from interfering with a physician's independent medical judgment.

Id.

204. Emily Whelan Parento, *Certificate of Need in the Post-Affordable Care Act Era*, 105 KY. L.J. 201, 205 (2017).

> When [certificate of need] programs were first conceived, they were largely envisioned as cost-containment mechanisms, slowing healthcare cost increases by preventing unfettered entry of new healthcare providers, particularly hospitals. Development of these programs was heavily influenced by the theory of Milton Roemer that "a built bed is a filled bed." Thus, by preventing more beds from being built, and later by preventing proliferation of other services deemed "unnecessary," states—and, for a time, the federal government—hoped to slow the alarming rise in healthcare expenditures.

Id. (footnotes omitted).

205. *See, e.g.*, Press Release, U.S. Dep't of Just., Justice Department Charges Dozens for $1.2 Billion in Health Care Fraud, https://www.justice.gov/opa/pr/justice-department-charges-dozens-12-billion-health-care-fraud [https://perma.cc/L625-MEB8] (Feb. 6, 2025).

206. *See* Press Release, U.S. Dep't of Just., Federal Indictments and Law Enforcement Actions in One of the Largest Health Care Fraud Schemes Involving Telemedicine and Durable Medical Equipment Marketing Executives Results in Charges Against 24 Individuals Responsible for Over $1.2 Billion in Losses, https://www.justice.gov/opa/pr/federal-indictments-and-law-enforcement-actions-one-largest-health-care-fraud-schemes [https://perma.cc/XVH6-L6K7] (Feb. 5, 2025) (announcing the prosecution of twenty-four individuals related to alleged fraudulent telemedicine and durable medical equipment marketing); Press Release, U.S. Dep't of Just., Opioid Manufacturer Purdue Pharma Pleads Guilty to Fraud and Kickback Conspiracies, https://www.justice.gov/opa/pr/opioid-manufacturer-purdue-pharma-pleads-guilty-fraud-and-kickback-conspiracies [https://perma.cc/DPN8-MNX3] (Feb. 5, 2025) (noting the guilty plea of Purdue Pharma, settling various allegations including that "Purdue continued to market its opioid products to more than 100 health care providers whom the company had good reason to believe were diverting opioids" and that it "reported misleading information to the DEA to boost [its] manufacturing quotas").

207. *See* Canterbury v. Spence, 464 F.2d 772 (D.C. Cir. 1972) (recognizing, for the first time in a major federal court decision, the patient-protective doctrine of informed consent).

208. *See Shared Savings Program*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/medicare/medicare-fee-for-service-payment/sharedsavingsprogram [https://perma.cc/V5ZS-8YVM] (Jan. 15, 2025, 1:35 PM).

209. *See* Hall v. Hilbun, 466 So.2d 856 (Miss. 1985) (abolishing the so-called locality rule and moving the standard of care to a national-based standard).

210. The bioethical tenets of nonmaleficence, beneficence, autonomy, justice, and truth telling seek to ensure that the physician is both respecting the agency of the patient and that the physician's decision-making is driven by the patient's best interests.

made clear that the physician's duty to the patient and their well-being supersedes any and all other goals the provider may have.[211]

Not only have the contours of American health law been shaped by the effort to maintain adequate distance between profit and patients, but the profit-influence concern has changed the *application* of the law itself. Creative doctrinal links between the nation's robust fraud laws and medical treatment have been forged.[212] A Civil War-era statute is used to ferret out and prevent health care fraud in the nation's modern public health insurance programs.[213]

Further, federal prosecutors have used a unique feature (and the financial inducements) of the "health care relator" to uncover examples of fraud and unnecessary care.[214] The law, passed to prevent military fraud during the Civil War, has been wielded by modern prosecutors against actors seeking to defraud America's byzantine health care system. Finally, courts have rediscovered a doctrine—the responsible corporate officer doctrine[215]—and used it to punish staggering and galling instances of corporate greed within health care.[216]

Both the design and application of American health law have been dexterous and shape-shifting, creatively deployed and redeployed by public servants, and heeded by providers in an effort to keep *too much* financial influence at arm's length. Granted, many of these efforts have not been without criticism[217] and confusion.[218] With new corporate entrants into the health care space,[219] it is reasonable to question whether

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211. *See AMA Principles of Medical Ethics*, AMA CODE OF MED. ETHICS, Principle VIII, https://code-medical-ethics.ama-assn.org/principles [https://perma.cc/YUJ5-3WZ2] (last visited Mar. 15, 2025) ("A physician shall, while caring for a patient, regard responsibility to the patient as paramount.").

212. In some cases, the federal government has argued that the care provided is so substandard that billing for reimbursement is equated to billing for completely worthless services—which constitutes submitting a false claim under the FCA. *See, e.g.*, U.S. *ex rel.* Aranda v. Cmty. Psychiatric Ctrs. of Okla., 945 F. Supp. 1485, 1488–89 (W.D. Okla. 1996).

213. The civil FCA is also known as "Lincoln's Law." *See* Christopher L. Martin, Jr., Note, *Reining in Lincoln's Law: A Call To Limit the Implied Certification Theory of Liability Under the False Claims Act*, 101 CALIF. L. REV. 227, 229 (2013).

214. *See, e.g.*, Isaac D. Buck, *Breaking the Fever: A New Construct for Regulating Overtreatment*, 48 U.C. DAVIS L. REV. 1261, 1293 (2015) (noting, following a relator's lawsuit, a fraud investigation of the North Ohio Heart Center for allegedly administering unnecessary angioplasties and cardiac stents).

215. Kathleen M. Boozang, *Responsible Corporate Officer Doctrine: When Is Falling Down on the Job a Crime?*, 6 ST. LOUIS U. J. HEALTH L. & POL'Y 77, 97–104 (2012).

216. *See* Friedman v. Sebelius, 686 F.3d 813, 814 (D.C. Cir. 2012) (reversing a twelve-year exclusion period but upholding an exclusion for convictions under the Food, Drug, and Cosmetic Act).

217. *See* Isaac D. Buck, *Caring Too Much: Misapplying the False Claims Act To Target Overtreatment*, 74 OHIO ST. L.J. 463, 495–513 (2013) (criticizing the federal prosecutors' uses of the powerful anti-fraud tools to regulate differences in standards of care); Nicole Huberfeld, *Be Not Afraid of Change: Time To Eliminate the Corporate Practice of Medicine Doctrine*, 14 HEALTH MATRIX 243, 244 (2004) ("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.").

218. *See* Pamela Ballou-Nelson, *Prevent Fraud in Your Medical Practice*, MED. GRP. MGMT. ASS'N (Oct. 13, 2016), https://www.mgma.com/risk-compliance/prevent-fraud-in-your-medical-practice [https://perma.cc/ST4M-8ECM] ("Fraud, waste and abuse are prominent topics of discussion as well as significant sources of confusion among individual physician or small group practices.").

219. The entrants in the PE space have the potential to radically change the American health care system—and not for the better. *See supra* notes 1–8 and accompanying text.

these guardrails can continue to hold and to identify their shortcomings—particularly in the fraud and abuse space.

Four phenomena both complicate this effort and raise its stakes. In addition to the societal values that lead to conflicting interests, these factors result in the construction of a regulatory system that tries to rely on the physician's decision-making—the center of American health care—to try to protect patients and payers. But when the decision-making entity—a for-profit and transiently committed PE firm—is no longer a medical professional, these tensions are exacerbated and the system's distortion seems undeniable.

The four complicating factors should be apparent to any American patient: (1) the intractable necessity and pervasiveness of profit and its direct conflict with the central thesis of the social good of health care, (2) the reactionary nature of the regulatory mechanism within American health care, (3) the foundational importance of health care as a societal good, and (4) the complexity and individuality of each patient's presentation and provider's delivery of care. All four of these phenomena—which have allowed PE firms to silently infiltrate the health care space with limited attention—are explored more deeply below.

A. Inescapable Profit and Its Conflict with Medicine

While the law tries to shield a provider's clinical decision-making process from the influence of profit, money is at the center of any enterprise, and medicine is clearly no exception.[220] To an external observer, money appears to be the name of the game.[221] It is obvious why: As of 2023, health care spending in the United States reached $4.9 trillion annually.[222] Four of the top ten largest corporations in the United States are health care corporations,[223] and even though many health care organizations are nonprofits, forty-six health care companies made the 2022 Fortune 500 list.[224] Further,

220. *See* Eli Y. Adashi, *Money and Medicine: Indivisible and Irreconcilable*, 17 AMA J. ETHICS 780, 781 (2015) (noting, within the context of individual physicians, that "the practice of medicine, not unlike the provision of any other service, is deserving of professional remuneration," and that "medicine and money are sensibly interrelated and by extension indivisible," but observing that "[l]ess clarity exists . . . about the question of whether medicine should be a conduit to wealth accumulation").

221. Indeed, "[t]o its detractors, the notion of self-enrichment from the practice of medicine represents an example of capitalism gone awry." *Id.*

222. *Historical*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical [https://perma.cc/8H5H-62Q7] (Dec. 18, 2024, 4:28 PM).

223. Amanda D'Ambrosio, *These Healthcare Companies Made This Year's Fortune 500 List*, MEDPAGE TODAY (July 12, 2022), https://www.medpagetoday.com/special-reports/features/99680 [https://perma.cc/E77Y-P6VA] (noting that CVS Health, UnitedHealth Group, McKesson, and AmerisourceBergen ranked in the top ten of largest corporations overall).

224. *Daily Briefing: The 46 Health Care Companies on This Year's Fortune 500*, ADVISORY BD. (May 25, 2022), https://www.advisory.com/daily-briefing/2022/05/25/fortune-500 [https://perma.cc/8XL6-X2NK] (including medical facilities, health insurance companies, pharmaceutical companies, food and drug stores, medical product and equipment companies, pharmacy and health care service companies, wholesalers, and scientific equipment companies).

health care accounts for 17.3% of the United States' overall Gross Domestic Product.[225]

Costs within the health care system do not mirror profit trends in other industries. Revenue of a hospital is often determined by its ability to summon monopolistic power,[226] not necessarily the quality of the health care product it provides. Insurance status matters, leading to often substantial differential pricing—even if the care provided to two different patients is identical.[227] Further, hospitals across town from one another may have widely disparate cost schedules.[228] And technological advancements lead to increased costs.[229]

Public funding programs, and specifically Medicare and Medicaid—preeminent public programs funded by America's taxpayers[230]—are responsible for a substantial

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225. *Historical*, *supra* note 222.

226. *See* Greg Rosalsky, *The Untamed Rise of Hospital Monopolies*, NPR: PLANET MONEY (July 20, 2021, 9:40 AM), https://www.npr.org/sections/money/2021/07/20/1017631111/the-untamed-rise-of-hospital-monopolies [https://perma.cc/5GVK-WEKL] (noting that markets are highly concentrated and that when markets "are dominated by just one or two hospitals" they have "market power to suck extra money from communities for health procedures and emergencies").

227. *See* Eric Lopez, Tricia Neuman, Gretchen Jacobsen & Larry Levitt, *How Much More than Medicare Do Private Insurers Pay? A Review of the Literature*, KAISER FAM. FOUND. (Apr. 15, 2020), https://www.kff.org/medicare/issue-brief/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature/ [https://perma.cc/L9T4-V3W9] ("Private insurers paid nearly double Medicare rates for all hospital services . . . ranging from 141% to 259% of Medicare rates across the reviewed studies. . . . Across all studies, payments from private insurers are much higher than Medicare payments for both hospital and physician services, although the magnitude of the difference varies."); Barry Meier, Jo Craven McGinty & Julie Creswell, *Hospital Billing Varies Wildly, Government Data Shows*, N.Y. TIMES (May 8, 2013), https://www.nytimes.com/2013/05/08/business/hospital-billing-varies-wildly-us-data-shows.html ("[H]ospitals charge Medicare wildly differing amounts—sometimes 10 to 20 times what Medicare typically reimburses—for the same procedure . . . .").

228. *See* James Benedict, Anna Wilde Matthews, Tom McGinty & Melanie Evans, *Three Miles and $400 Apart: Hospital Prices Vary Wildly Even in the Same City*, WALL ST. J. (Dec. 15, 2021), https://www.wsj.com/articles/boston-hospital-prices-healthcare-insurance-cost-11639576524 (noting that, for a hypothetical patient, an ER visit at Massachusetts General Hospital's Main Campus would cost $946, while, three miles away, the same type of visit at Boston Medical Center would cost $577); Meier et al., *supra* note 227. The price differences are inexplicable:

> A hospital in Livingston, N.J., charged $70,712 on average to implant a pacemaker, while a hospital in nearby Rahway, N.J., charged $101,945.
>
> In Saint Augustine, Fla., one hospital typically billed nearly $40,000 to remove a gallbladder using minimally invasive surgery, while one in Orange Park, Fla., charged $91,000.
>
> In one hospital in Dallas, the average bill for treating simple pneumonia was $14,610, while another there charged over $38,000.

Id.

229. *See Snapshots: How Changes in Medical Technology Affect Health Care Costs*, KAISER FAM. FOUND. (Mar. 2, 2007), https://www.kff.org/health-costs/issue-brief/snapshots-how-changes-in-medical-technology-affect/ [https://perma.cc/N9WE-FS4U] ("Health care experts point to the development and diffusion of medical technology as primary factors in explaining the persistent difference between health spending and overall economic growth, with some arguing that new medical technology may account for about one-half or more of real long-term spending growth.").

230. *Policy Basics: Where Do Our Federal Tax Dollars Go?*, CTR. ON BUDGET & POL'Y PRIORITIES (July 18, 2024), https://www.cbpp.org/sites/default/files/4-14-08tax_rev7-18-24.pdf [https://perma.cc/7C8K-SHK2] ("Four health insurance programs—Medicare, Medicaid, the Children's Health Insurance

percentage of the funding that makes its way to providers.[231] In addition to constituting the patients who seek care in this system, this gives the taxpaying populace a substantial financial interest in ensuring the programs are not fleeced.[232] As a result, taxpayers have a direct interest in protecting the Medicare trust fund to ensure the program is solvent by the time they and their loved ones qualify for the program.[233]

But financial impacts are not limited to the publicly funded programs. In addition to this country's major entitlement programs, private-pay health care is impacted by the problem of cost. Privately insured patients pay for an increasing percentage of their care, as private insurance becomes less effective at shielding them from its true cost.[234] Family premiums for health insurance have risen 47% in one decade.[235] And deductibles in private health insurance have risen 68.4% from 2011 to 2021.[236] But besides just injecting unnecessary and increased costs into the system, illegitimate and inefficient care—delivered with an eye on profit—damages clinical decision-making and medicine's professional reputation.[237]

At the same time, America's profit-centric health care system demands that health care suppliers and deliverers make enough money to continue to operate. Where health care entities fail to remain profitable enough, they close.[238] Hospital systems curtail services at public hospitals only to expand them in more affluent neighborhoods.[239] At

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Program (CHIP), and Affordable Care Act (ACA) marketplace health insurance subsidies—together accounted for 24[%] of the budget in 2023, or $1.6 trillion.").

231. *See* Reed Abelson & Sarah Cohen, *Sliver of Medicare Doctors Get Big Share of Payouts*, N.Y. TIMES (Apr. 9, 2014), https://www.nytimes.com/2014/04/09/business/sliver-of-medicare-doctors-get-big-share-of-payouts.html (noting that $77 billion are paid to doctors and providers from the Medicare program).

232. Nonetheless, programs, such as Medicare Advantage, have cost taxpayers billions in additional expenditures. *See* Fred Schulte, *Medicare Advantage's Cost to Taxpayers Has Soared in Recent Years, Research Finds*, NPR (Nov. 11, 2021, 5:00 AM), https://www.npr.org/sections/health-shots/2021/11/11/1054281885/medicare-advantage-overcharges-exploding [https://perma.cc/535Q-F7S6].

233. As of 2021, Medicare's Part A (hospital) trust fund was expected to run out beginning in 2026. Alan Rappeport & Margot Sanger-Katz, *Social Security Is Projected To Be Insolvent a Year Earlier than Previously Forecasted*, N.Y. TIMES (Sept. 24, 2021), https://www.nytimes.com/2021/08/31/business/economy/social-security-funding.html.

234. *See* Sarah O'Brien, *Average Family Premiums for Employer-Based Health Insurance Have Jumped 47% in the Last Decade, Outpacing Wage Growth and Inflation*, CNBC (Nov. 11, 2021, 3:27 PM), https://www.cnbc.com/2021/11/11/premiums-for-employer-health-insurance-have-jumped-47percent-in-10-years.html [https://perma.cc/CN5F-8KE4].

235. *Id.*

236. *Id.*

237. *See* Adashi, *supra* note 220, at 781 ("[S]triving for riches in the healing professions is rife with financial conflicts of interest, with clouded clinical judgments, and with a compromised professional posture.").

238. *See* Isaac D. Buck, *Financing Rural Health Care*, 124 W. VA. L. REV. 801, 803–09 (2022) (observing the crisis of rural hospital closures, and their resulting health impacts, as a financial crisis).

239. *See* Sabrina Tavernise & Jessica Silver-Greenberg, *How Nonprofit Hospitals Put Profits Over Patients*, N.Y. TIMES: THE DAILY (Oct. 4, 2023), https://www.nytimes.com/2023/01/25/podcasts/the-daily/nonprofit-hospitals-investigation.html (highlighting the phenomenon of hospital systems cutting services at the inner-city community hospital); Melanie Evans, Max Rust & Tom McGinty, *Big Nonprofit Hospitals Expand in Wealthier Areas, Shun Poorer Ones*, WALL ST. J. (Dec. 26, 2022, 11:20 AM), https://www.wsj.com/articles/nonprofit-hospitals-deals-tax-breaks-11672068264 ("Many of the nation's

the same time, rural hospitals close because they do not maintain a sufficient payer mix.[240]

As a result, a tenuous line exists between what type of profit-driven corporate action is *necessary* to sustain the business model and what type of profit-driven action is too *excessive* in that it harms public trust. It seems rather noncontroversial for a hospital to seek to develop new efficiencies to become more profitable. Pushing a provider to administer more high-cost and medically questionable care to increase the hospital's bottom line, however, seems at least morally questionable and likely immoral. Requiring a provider to administer care that has no clinical indication sure seems like fraud. Distinguishing between all these categories of actors has become as difficult as it has become important. The complexity involved in enforcing these distinctions may create cover for corporate actors to increasingly seek part of the profit—in examples that seem unrelated to improving the quality of care for patients. Into this space PE has stepped.

In the American system, hospitals "have grown wealthy, spending lavishly on advertising, team sponsorships, and even spas, while patients are squeezed by skyrocketing medical prices and rising deductibles."[241] Sending these patients, and even those insured patients, bills for amounts larger than the patients can afford seems generally allowable and surely is legal.[242] Indeed, some hospitals will garnish a patient's wages,[243] sell a patient's debt, or report a patient who cannot pay to a credit

largest nonprofit hospital systems, which give aid to poorer communities to earn tax breaks, have been leaving those areas and moving into wealthier ones as they have added and shed hospitals in the last two decades.").

240. *See* Helen Ouyang, *Your Next Hospital Bed Might Be at Home*, N.Y. TIMES (Jan. 27, 2023), https://www.nytimes.com/2023/01/26/magazine/hospital-at-home.html ("Nearly 30[%] of all rural hospitals are at risk of closing, especially tiny, stand-alone facilities. These circumstances are likely to get worse as the baby-boomer generation continues to age, in part because of the staggering expense of hospital construction . . . ."); Blake Stevens, *Counties in Crisis: We Know Why Rural Hospitals in Tennessee Are Closing. Can We Save Them?*, WATE 6 NEWS (Dec. 16, 2019, 4:36 PM), https://www.wate.com/news/counties-in-crisis-we-know-why-rural-hospitals-in-tennessee-are-closing-can-we-save-them/ [https://perma.cc/J6MR-RDXF] (noting that payer mix is often quite challenging in rural areas and that, due to the low insurance rate, revenues are not enough to cover costs).

241. Noam Levey, *Some Hospitals Rake in High Profits While Their Patients Are Loaded with Medical Debt*, NPR (Sept. 28, 2022, 5:01 AM), https://www.npr.org/sections/health-shots/2022/09/28/1125176699/some-hospitals-rake-in-high-profits-while-their-patients-are-loaded-with-medical [https://perma.cc/4QKZ-UM8F] ("Industry experts say the most profitable medical centers—like those around Dallas-Fort Worth—have developed business models that allow them to prosper even if their patients can't pay.").

242. *See* Helaine Olen, *Even the Insured Often Can't Afford Their Medical Bills*, ATLANTIC (June 18, 2017), https://www.theatlantic.com/business/archive/2017/06/medical-bills/530679/ [https://perma.cc/JD4H-4NZZ].

243. *See* William E. Bruhn et al., *Prevalence and Characteristics of Virginia Hospitals Suing Patients and Garnishing Wages for Unpaid Medical Bills*, 322 JAMA 691, 691–92 (2019) (finding that, in 2017, 36% of Virginia hospitals—71% of which were nonprofit—garnished wages of patients); Selena Simmons-Duffin, *When Hospitals Sue for Unpaid Bills, It Can Be 'Ruinous' for Patients*, NPR (June 25, 2019, 2:37 PM), https://www.npr.org/sections/health-shots/2019/06/25/735385283/hospitals-earn-little-from-suing-for-unpaid-bills-for-patients-it-can-be-ruinous [https://perma.cc/UM2Y-9J8J] ("Not every hospital sues over unpaid bills, but a few sue a lot. . . . There are no good national data on the practice, but journalists have reported on hospitals suing patients all over the United States, from North Carolina to Nebraska to Ohio.").

agency.[244] But suing the patient for unpaid medical bills may be a step too far (at least in the court of public opinion).[245] Indeed, such lawsuits have slowed or stopped following unfavorable media coverage.[246] Unfortunately, as recent reporting has shown, patient lawsuits are seemingly still not off the table for all hospitals.[247] And, while perhaps morally questionable and socially odious, they are clearly legal.

B. The Reactionary Character of Regulation

Like an immune response, the health care regulatory effort is triggered by some new external threat. New corporate arrangements and for-profit structures proliferate in American health care, often kicking off a new systemic effort to both rebalance and seek regulatory redress. The law realigns, responding to institutional behavior.[248] And then institutions respond to the new laws; the cycle continues.

Such a life cycle seemingly gives the regulatory project a "race against time" and "whack-a-mole" quality, one in which policy-based answers are constructed in response to some new creative corporate arrangement. In short, the regulatory structure flexes to respond to some sort of new negative externality, followed by the next new profit-driven corporate endeavor. Of course, the regulatory endeavor—patient protective, public facing—is likely always going to be a step or two behind the profit-driven corporate behavior of the health care industry. It is the slow and reactive nature of the regulatory response that makes devising regulatory solutions to PE so challenging.

An example such as the problem of surprise billing is relevant here.[249] First, creative corporate entities or "entrepreneurial" providers increase profit and undertake

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244. Noam N. Levey, *Hundreds of Hospitals Sue Patients or Threaten Their Credit, a KHN Investigation Finds. Does Yours?*, KAISER HEALTH NEWS (Dec. 21, 2022) [hereinafter Levey, *Hundreds of Hospitals*], khn.org/news/article/medical-debt-hospitals-sue-patients-threaten-credit-khn-investigation/.

245. *See* Brian Rosenthal, *The Largest Hospital System in New York Sued 2,500 Patients for Unpaid Medical Bills After the Pandemic Hit.*, N.Y. TIMES (Jan. 6, 2021), https://www.nytimes.com/2021/01/06/world/the-largest-hospital-system-in-new-york-sued-2500-patients-for-unpaid-medical-bills-after-the-pandemic-hit.html ("After a New York Times article was published Tuesday morning about the lawsuits, Northwell abruptly announced it would stop suing patients during the pandemic and would rescind all legal claims it filed in 2020.").

246. *See* Joseph Giuseppe R. Paturzo et al., *Trends in Hospital Lawsuits Filed Against Patients for Unpaid Bills Following Published Research About This Activity*, JAMA NETWORK OPEN, Aug. 23, 2021, at 1, 1, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2783297 [https://perma.cc/8ZA3-2A8Y] ("Virginia hospitals filed 59% fewer lawsuits in the year after a research article and subsequent media coverage exposed the practice compared with the year before publication."); Rosenthal, *supra* note 245.

247. *See* Levey, *Hundreds of Hospitals*, *supra* note 244 ("[M]ore than two-thirds of policies obtained by KHN allow hospitals to sue patients or take other legal actions against them, such as garnishing wages or placing liens on property."); Noam Levey, *Medical Debt Affects Millions, and Advocates Push IRS, Consumer Agency for Relief*, NPR (Mar. 7, 2023, 5:00 AM), https://www.npr.org/sections/health-shots/2023/03/07/1161473744/medical-debt-affects-millions-and-advocates-push-irs-consumer-agency-for-relief [https://perma.cc/XGF4-SB57].

248. From the proliferation of certificate of need laws, to the modern expansion of fraud and abuse statutes, to the regulations associated with the Patient Protection and Affordable Care Act of 2010, to the No Surprises Act, there are many examples of this phenomenon.

249. *See* Sarah Kliff, *New Rule on Surprise Billing Aims To Take Patients Out of the 'Food Fight,'* N.Y. TIMES: THE UPSHOT (Oct. 1, 2021), https://www.nytimes.com/2021/09/30/upshot/surprise-billing-biden.html.

some new course of action.[250] Next, these actions are recognized as causing a negative externality and are broadly identified in academic discourse and the national media,[251] often complete with a moral valence.[252] Finally, the regulatory structure (often slowly and tediously) manufactures an (often unsatisfying) administrative or legislative solution.[253]

But generating these solutions is not easy. The process of data collection, democratic debate and iterative discourse, and, finally, policy architecture, can take years. In the end, a process that features a yearslong slog to finally regulate the corporate action out of existence may only mitigate it.[254] And lamentably, often, even then, a seemingly never-ending new battle—one fought over the legality of the newly created policy solution—begins.[255] Even when the solution survives challenges by vested interests, loopholes are left behind, threatening to allow the conduct to continue under certain conditions.[256] Corporate interests fight to protect their pieces of the pie, leaving an even more complicated and convoluted regulatory structure in their wake.[257]

C. Health Care as a Foundational Good

Health care as a societal good is foundational. Individuals who lack good health are unable to attain many other necessities for human flourishing.[258] Health care may

250. *See* Julie Creswell, Reed Abelson & Margo Sanger-Katz, *The Company Behind Many Surprise Emergency Room Bills*, N.Y. TIMES: THE UPSHOT (July 24, 2017), https://www.nytimes.com/2017/07/24/upshot/the-company-behind-many-surprise-emergency-room-bills.html.

251. *See* Hunter Kellett, Alexandra Spratt & Mark E. Miller, *Surprise Billing: Choose Patients Over Profits*, HEALTH AFFS. (Aug. 12, 2019), https://www.healthaffairs.org/do/10.1377/forefront.20190808.585050/full/ [https://perma.cc/B43A-4ES8]; Creswell et al., *supra* note 250.

252. *See, e.g.*, Ashish K. Jha, Opinion, *Ending Surprise Billing: A Moral Test for Physicians*, BOS. GLOBE (Dec. 9, 2019, 4:30 AM), https://www.bostonglobe.com/2019/12/09/opinion/ending-surprise-billing-moral-test-physicians/ [https://perma.cc/DE6B-QMSE].

253. *See* Rajesh Reddy & Erin L. Duffy, *Congress Ends Surprise Billing: Implications for Payers, Providers, and Patients*, 27 AM. J. MANAGED CARE e248, e248–50 (2021).

254. *See, e.g.*, Margot Sanger-Katz, Julie Creswell & Reed Abelson, *Mystery Solved: Private-Equity-Backed Firms Are Behind Ad Blitz on 'Surprise Billing'*, N.Y. TIMES (Sept. 30, 2021), https://www.nytimes.com/2019/09/13/upshot/surprise-billing-laws-ad-spending-doctor-patient-unity.html.

255. *See* Bob Herman, *The Doctor Who Is Trying To Bring Back Surprise Billing*, STAT (Apr. 27, 2022), https://www.statnews.com/2022/04/27/the-doctor-who-is-trying-to-bring-back-balance-billing/ [https://perma.cc/2QE8-LPQQ] ("Haller, an acute-care surgeon on Long Island in New York, is suing the federal government over the No Surprises Act, a new law that protects people from receiving unexpected bills from out-of-network doctors.").

256. *See* Jay Hancock, *An $80,000 Tab for Newborns Lays Out a Loophole in the New Law To Curb Surprise Bills*, KAISER HEALTH NEWS (Feb. 23, 2022), https://khn.org/news/article/nicu-surprise-bill-loophole-no-surprises-act/ [https://perma.cc/7JQG-JCAR] (covering an episode of care where the insurance company lacked documentation that an emergency was at issue, exempting the visit from the No Surprises Act's regulatory protections). Indeed, where an insurance company denies that the care administered was for an emergency, the new Act's provisions do not apply. *Id.*

257. *Id.*

258. *See* Mary Gerisch, *Health Care as a Human Right*, 43 A.B.A., no. 3, 2018, at 2, 2 ("Among all the rights to which we are entitled, health care may be the most intersectional and crucial. . . . Without our health we—literally—do not live, let alone live with dignity.").

be the most necessary of social goods, making its regulation particularly sensitive and important. Health care, to put it simply, is frequently about life and death.[259]

Specifically, regulation in this space protects patients from receiving health care that may harm them and could very well kill them.[260] Ensuring that health care providers are not focused on expanding their bottom lines and instead on patient welfare becomes a regulatory effort whose importance cannot be overstated. This would seem to indicate that the regulatory mechanism might be overwhelmingly pro-patient, but that is not the only response to this kind of recognition. This societal good is *so* important that there may be hesitancy to fully attempt to prevent the negative externality at issue because of a fear of unintended and unforeseen consequences. The regulatory stakes are very high.

In addition to a recognition of its seriousness, the necessity and complexity of health care often robs patients of the ability to avoid bad doctors and bad care *on their own*. Specifically, its necessity—that is, that patients cannot walk away from certain scenarios like they can in other industries—makes the customer-based paradigm inapposite.[261] The fact that the care at issue is so complicated also hamstrings the patient; they are unable, on their own, to determine which type of care is appropriate. This makes the existence of a well-resourced and easily implementable set of rules even more important. It also requires the aggressive intervention of a regulatory structure that seeks to adequately protect their interests. Failure to regulate means that there is no remedy to dangerous care.

Further, simply relying on medical malpractice—that is, waiting for each patient to sue providers who are engaged in administering care that is influenced solely by profit for example—is likely to be ineffective. Patients may not know they have been harmed when the care is unnecessary, nor would they know that the provider who administered the care at issue was engaged in conduct that constituted a breach of the standard of care.[262] Without clearly discernable harm, it becomes difficult to regulate through litigation.

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259. *See* Steffie Woolhandler & David U. Himmelstein, *The Relationship of Health Insurance and Mortality: Is Lack of Insurance Deadly?*, 167 ANNALS INTERNAL MED. 424, 429 (2017) (finding greater odds of death for those without insurance as compared to insured individuals).

260. *See* Mary Ann Roser, *Too Much Medical Care Can Kill, Author Warns in Texas*, AUSTIN AM.-STATESMAN (Dec. 12, 2018, 7:16 AM), https://www.statesman.com/story/news/2011/01/16/too-much-medical-care-can/6702113007/ [https://perma.cc/9948-NVF8] ("A third of all people who have heart bypass surgery don't need it. Tens of thousands of people with chronic back pain have surgery each year despite almost no evidence it will help. And 300,000 women a year have their ovaries removed unnecessarily.").

261. Nonetheless, U.S. Rep. Pramila Jayapal (D-WA) has proposed increased transparency from PE funds involved in health care. *Jayapal Introduces Bill To Improve Transparency in Health Care*, PARMILA JAYAPAL (Mar. 23, 2023), https://jayapal.house.gov/2023/03/23/jayapal-introduces-bill-to-improve-transparency-in-health-care/ [https://perma.cc/Z7RM-AU5A].

262. *See* Chris Outcalt, *'He Thought What He Was Doing Was Good for People*,*'* ATLANTIC (Aug. 13, 2021), https://www.theatlantic.com/politics/archive/2021/08/health-care-sherman-sorensen-pfo-closures/619649/ [https://perma.cc/6WRQ-6QNZ] (noting that the victim of the scheme did not know that the patent foramen ovale (PFO) closure was unnecessary until seeing a television commercial about a class action lawsuit against her doctor, Dr. Sorensen).

A regulatory mechanism that holds providers and corporate actors accountable for unnecessary care after the fact may well recover ill-gotten gains. It may also deter other actors from causing the same unnecessary care or even stimulate entities to be more attuned to their own compliance. But it does nothing to account for the harm that the patients subjected to unnecessary care endured.[263] Patients are left vulnerable to this regulatory hole, with only medical necessity, which is a determination made by the individual provider or corporate actor in a given case, protecting them from unnecessary and inappropriate care.

D. The Variability of Each Episode of Care

Finally, the complexity and variations within health care—a defining characteristic of the enterprise[264]—makes standard setting, rule enforcement, and predictability exceptionally difficult. Much of the variability is "likely explained in large part by differences in clinical decision-making."[265] This can be due to a number of different factors: the randomness of seeing one provider in lieu of another, or being a patient who is privately insured instead of publicly insured, or the inexplicability of the ambulance driver's decision to take the patient to one hospital over another.

There is also substantial geographic variability in the United States.[266] This can create a scenario where what is medically necessary in one part of the country may not be in another.[267] For sure, "[u]nwarranted variation is a ubiquitous feature of U.S.

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263. *See id.* (summarizing the story of Marian Simmons).

> Sorensen's appetite for the PFO procedure raises a fundamental question about how surgical interventions, and thus how surgeons and other specialists, are regulated—a topic that's often missing from the political debates about health care on Capitol Hill and in statehouses around the country. Those discussions tend to focus on two things: cost and access. Whether a person will benefit from any given treatment, so long as it's affordable and accessible, is given much less consideration.

Id.

264. *See* Zirui Song et al., *Physician Practice Pattern Variations in Common Clinical Scenarios Within 5 US Metropolitan Areas*, JAMA HEALTH F., Jan. 28, 2022, at 1, 2, https://jamanetwork.com/journals/jama-health-forum/fullarticle/2788513 [https://perma.cc/U2BQ-73TV] ("[S]izeable physician-level practice variations were found across common clinical scenarios and specialties."); Jake Miller, *Study Finds Significant Variations in Care Between Physician's*, HARV. GAZETTE (Feb. 10, 2022), https://news.harvard.edu/gazette/story/2022/02/study-finds-significant-variations-in-care-between-physicians/ [https://perma.cc/B4KQ-P22S].

265. Song et al., *supra* note 264, at 9–11 ("This evidence adds to the Institute of Medicine recommendation to focus on within-region variations in clinical decision-making as a target of policy and quality improvement.").

266. *See generally* John E. Wennberg, *Understanding Geographic Variations in Health Care Delivery*, 340 NEW ENG. J. MED. 48, 52 (1999) ("On a risk-adjusted basis, the researchers found significant variation in the discharge rates, the numbers of hospital days, and the outpatient-visit rates for all eight cohorts of patients . . . .").

267. *See* DANIEL SKINNER, MEDICAL NECESSITY: HEALTH CARE ACCESS AND THE POLITICS OF DECISION MAKING 33 (2019) ("[M]edical necessity is often less a function of expertise than a result of cultural phenomena that produce multiple supply-side biases. Here, physicians with specialized expertise tend to influence one another such that what tends to be deemed medically necessary in one region could be vastly different—even medically unnecessary—in another." (citation omitted)).

health care."[268] This creates the scenario where care that is deemed necessary in Boston is not necessary in Houston.[269] Even in situations that were not highly complex—indeed, ones in which providers were faced with "straightforward, simpler situations with a clear clinical decision and guideline-recommended pathway of care"—researchers have found that "physicians who made the most clinically appropriate decisions were five to [ten] times more likely to use the recommended standard of care than peers in the same specialties and cities whose decisions tended to be the least appropriate."[270]

Adding clinical complexity to such intense variability makes the regulatory task even more difficult. Punishing providers who intervene in a more aggressive manner—treating their care as fraud—would be unfair, or at least counterproductive. The regulatory regime must recognize the countervailing pressure, present in so many episodes of health care, of making sure—particularly in difficult cases—that no clinical stone is left unturned.[271] Exceptionally aggressive care may be required in certain clinical contexts, making the task of differentiating corrupt or fraudulent care from aggressive but heroic care more difficult.

For example, according to the Centers for Medicare and Medicaid Services, in some cases, magnetic resonance angiography (MRA) is medically necessary, but only when patients have "conditions of the head and neck for which surgery is anticipated and may be found to be appropriate."[272] These are conditions in which "medical necessity is the underlying determinant of the need for an MRA in specific diseases."[273]

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268. *See* John E. Wennberg, *Practice Variations and Health Care Reform: Connecting the Dots*, 23 HEALTH AFFS. var140, var140 (2004), https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.var.140 [https://perma.cc/TU7W-49YQ].

269. *See, e.g.*, Barry L. Rosenberg et al., *Quantifying Geographic Variation in Health Care Outcomes in the United States Before and After Risk-Adjustment*, PLOS ONE, Dec. 14, 2016, at 1, 2, https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0166762&type=printable [https://perma.cc/ELV9-CNUG].

270. Miller, *supra* note 264.

> With such clear-cut evidence, Song said he was surprised and concerned to see a marked variation in arthroscopic knee surgery rates on similar patients with new osteoarthritis among surgeons in the same cities.
>
> For the study, the researchers divided physicians into five quintiles based on how likely they were to follow the guidelines and provide the recommended care.
>
> In the arthroscopic surgery for new osteoarthritis scenario, the top 20[%] of surgeons in the study performed the surgery on only 2 to 3[%] of their patients. By contrast, between 26 and 31[%] of patients with the same condition in the same cities got surgery if they saw a surgeon from the bottom 20[%].

Id.

271. *See* Ryan Levi & Dan Gorenstein, *When Routine Medical Tests Trigger a Cascade of Costly, Unnecessary Care*, NPR (Jun. 14, 2022, 6:30 PM), https://www.npr.org/sections/health-shots/2022/06/13/1104141886/cascade-of-care [https://perma.cc/LP8B-GZQ9].

272. *Magnetic Resonance Imaging*, CTRS. FOR MEDICARE & MEDICAID SERVS.: MEDICARE COVERAGE DATABASE (Dec. 10, 2018), https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=177&ncdver=6&= [https://perma.cc/FH9R-L858].

273. *Id.*

As another example, a surgery to close a patent foramen ovale (PFO)[274] (described by the Mayo Clinic as "a hole in the heart that didn't close the way it should after birth")[275] is sometimes appropriate, but only in certain limited and rare contexts,[276] and not in everyone.[277] Finally, coronary angioplasty and stent placement is appropriate in patients who have at least 70% of an artery occluded, but not 65%.[278]

These determinations are clinical in nature, not legal. They are driven by medical expertise. But if that clinical expertise is influenced, threatened, or limited by a PE firm, those medically vital decisions are not deserving of protection. It is in this context that the soft standard of medical necessity can be exploited by profit-driven corporate interests.

III. REANIMATING FRAUD AND ABUSE

Where there is evidence of pressuring physicians to administer excessive care, one could imagine that the most direct way to keep PE firms from extracting profits from the health care system and to protect the decisions of American doctors from the profit-based influences of PE, would be to deploy the health care fraud and abuse statutes. The FCA, the federal government's powerful anti-fraud tool in the health care space,[279] has been used by federal prosecutors to punish those presenting false claims to the government and is deeply relevant to an industry that relies on health care billing and Medicare funds. This 160-year-old law and anti-fraud tool makes it illegal to "knowingly present[] or cause[] to be presented, a false or fraudulent claim" to the federal government for payment.[280] Allegations that PE firms pressure providers to administer excessive care would seem to directly support application of the fraud and abuse statutes.[281]

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274. *See Patent Foramen Ovale*, MAYO CLINIC (Oct. 25, 2022) [hereinafter *PFO*, MAYO CLINIC], https://www.mayoclinic.org/diseases-conditions/patent-foramen-ovale/symptoms-causes/syc-20353487 [https://perma.cc/E3V9-JECS]. The concern is that a blood clot could form, and the PFO would allow the clot to "travel from the right to the left side of your heart." *Patent Foramen Ovale (PFO)*, CLEVELAND CLINIC, https://my.clevelandclinic.org/health/diseases/17326-patent-foramen-ovale-pfo [https://perma.cc/R2J8-DMVS] (July 15, 2022). Indeed, from there it could cause a stroke.

275. *PFO*, MAYO CLINIC, *supra* note 274.

276. Anicka Slachta, *Utah Supreme Court Paves Way for Thousands To Seek Legal Action Against Cardiologist*, CARDIOVASCULAR BUS. (Feb. 20, 2020), https://cardiovascularbusiness.com/topics/healthcare-management/healthcare-economics/court-paves-way-thousands-seek-legal-action [https://perma.cc/UZV6-5GU3].

277. *See* Outcalt, *supra* note 262.

278. *See* Joe Carlson, *Cardiologist Targeted Under 70% Rule Settles in Heart-Stent Case*, MOD. HEALTHCARE (July 3, 2013, 12:00 AM), https://www.modernhealthcare.com/article/20130703/MODERNPHYSICIAN/307039973/cardiologist-targeted-under-70-rule-settles-in-heart-stent-case.

279. *See* Joan H. Krause, *Health Care Providers and the Public Fisc: Paradigms of Government Harm Under the Civil False Claims Act*, 36 GA. L. REV. 121, 125 (2001) (referring to the FCA as "powerful"); Joan H. Krause, *Reflections on Certification, Interpretation, and the Quest for Fraud that "Counts" Under the False Claims Act*, 2017 ILL. L. REV. 1811, 1815 (2017) (same).

280. 31 U.S.C. § 3729(a).

281. Indeed, the primary criminal statute in the space, the Anti-Kickback Statute, seeks to prevent "[p]ayments tied to referrals" because of the "corrupt[ion]" of the health care system, the improper influence of profit, and the "increas[ed] . . . risk[] of overutilization of items and services." Medicare and State Health Care Programs: Fraud and Abuse, 67 Fed. Reg. 60202 (Sept. 25, 2002) (to be codified at 42 C.F.R. pt. 1001).

According to recent work that catalogs the use of the FCA against PE firms within the health care space, as of 2023, the FCA has been alleged to have been violated in five cases that have been resolved.[282] Even though this work has highlighted the potential uses of the FCA in the PE space, only one case has examined the FCA's use in the context of a PE company allegedly influencing medical decision-making and pressuring providers' clinical judgment.[283] And importantly, none have dealt with the PE company influencing the physician's medical decision-making outside of the fraud-ridden and widely covered hospice certification context.[284]

In the one case, *United States ex rel. Anderson v. Curo Health Services Holdings, Inc*., plaintiff-relators sued hospice providers, the parent company of the hospice providers, and a PE firm, alleging improper certification for hospice care and fraudulent eligibility for the hospice benefit.[285] Although the case has not advanced to trial, the court denied the defendant PE firm's motion to dismiss, finding that the PE firm's actions *could* have caused the filing of false claims.[286] This provides an example of the use of the FCA to penalize claims of a PE's pressure campaign—in particular where the firm "pressured [the hospice company] to admit patients into hospice, including through scrutinizing decisions not to admit patients, providing financial incentives for increased admissions, and training physicians to avoid phrases undermining a terminal prognosis."[287] Should a theory like this begin to win approval across the country, it is possible that the FCA could become a sharp tool to be used against PE intrusion in the health care space.

But, except for the potential resolution of the *Anderson* case (if it goes to trial or settles), the FCA has not been widely applied in the PE context. And this should not be a surprise. For sure, due to its idiosyncratic characteristics, the FCA poses challenges to prosecutors trying to punish PE firms who pressure providers in portfolio companies to excessively treat their patients. Three of those challenges are summarized immediately below.

A. Medical Necessity[288]

We know that the primacy of the physician in American health care leads to a system that elevates their decision-making. This has resulted in the construction of a reimbursement and regulatory system that relies upon the physician's determination of, and attestation to, medical necessity to differentiate between legitimate and illegitimate care. But where a PE firm is pushing or forcing its providers to increase utilization, the determination of medical necessity—otherwise a vital determination—is distorted and

282. *See* Field et al., *supra* note 22, at 869.

283. *Id.* at 876–77.

284. *See* Ava Kofman, *How Hospice Became a For-Profit Hustle*, NEW YORKER (Nov. 28, 2022), https://www.newyorker.com/magazine/2022/12/05/how-hospice-became-a-for-profit-hustle [https://perma.cc/DQ92-4HGQ].

285. No. 3:13-cv-00672, 2022 WL 842937, at *1 (M.D. Tenn. Mar. 21, 2022).

286. *Id.*

287. *See* Field et al., *supra* note 22, at 876–77.

288. *See* SKINNER, *supra* note 267, at 25 ("Medical necessity's context-dependence and interpretability are among the features that make it both useful and problematic as a gatekeeper concept for care.").

ineffectual because it is being influenced by an entity driven solely by profit generation.

Medicare defines "reasonable and necessary," which also equates with the standard of medical necessity, in its Program Integrity Manual.[289] There, Medicare, which provides the jurisdictional hook to federal prosecutors who are investigating cases of potential health care fraud,[290] defines reasonable and necessary care as care that is:

- Safe and effective;
- Not experimental or investigational . . . ; and
- Appropriate, including the duration and frequency that is considered appropriate for the item or service, in terms of whether it is:
    - Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member;
    - Furnished in a setting appropriate to the patient's medical needs and condition;
    - Ordered and furnished by qualified personnel;
    - One that meets, but does not exceed, the patient's medical need; and
    - At least as beneficial as an existing and available medically appropriate alternative.[291]

The definition encapsulates: (1) technical guidance (e.g., the type of care that must be ordered by qualified personnel), (2) somewhat vague notions of medical standards (e.g., "appropriate" settings and "accepted" standards), and (3) balancing and weighing by the provider (e.g., "meets, but does not exceed, the patient's medical need" and "[a]t least as beneficial as an existing and available medically appropriate alternative").[292] The definition is highly medicalized, reliant on the determination of the medical community and expertise. It also asks the treating provider to make important determinations about appropriateness. Where a controlling PE firm wants to pressure or demand those providers increase profit, there are corners within this broad definition that allow for exploitation.

This standard occupies a vitally important place in American health care. Medical necessity stands between the type of care that may be aggressive but reasonable, and the type of care that is not medically indicated and harmful. The construction of medical necessity—itself a term with an extensive and meandering history[293]—allows

289. *Medicare Program Integrity Manual*, *Chapter 13*, CTRS. FOR MEDICARE. & MEDICAID SVS. § 13.5.4 (Feb. 12, 2019), https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c13.pdf [https://perma.cc/VE64-4YQT].

290. For application of the health care fraud and abuse statutes, the government looks for a public funding hook. *See* 31 U.S.C. § 3729(a)(1)(A)–(B) (identifying the government as the actor defrauded); *Fraud & Abuse Laws*, U.S. DEP'T OF HEALTH & HUM. SERVS., OFF. OF INSPECTOR GEN., https://oig.hhs.gov/compliance/physician-education/fraud-abuse-laws/ [https://perma.cc/588P-Q64K] (last visited Mar. 15, 2025).

291. *See Medicare Program Integrity Manual*, *supra* note 289, § 13.5.4.

292. *Id.*

293. *See* Dolgin, *supra* note 31, at 447–51.

for different externalities to take hold. Payer reimbursement, standards of care, and even the difference between legal and illegal care (for purposes of health care fraud enforcement) boils down to whether the care administered was medically necessary. Care that is medically necessary is reimbursable and legal; care that is not medically necessary is wasteful and illegal. Medically necessary care is heroic, aggressive, and legitimate; unnecessary care is fraudulent.

In a system seeking to prevent unnecessary care in which physicians can determine the appropriate care to provide, a fraud regime that focuses itself on the determination of medical necessity can make some sense. It allows providers the space to determine the type of care that seems reasonable, consistent with their professional standards and clinical understanding. But where a PE firm is pressuring or influencing physicians to administer additional care, that system breaks down.

There are three features of medical necessity that make it a hard tool to rely upon when used as a basis of a fraud action for an overtreatment action against PE owners. First, PE owners who wish to earn additional reimbursement can, theoretically, encourage providers to adopt a broader notion of what care qualifies as necessary; corporate supervisors or PE owners may push to stretch the bounds of what qualifies as necessary in order to juice their profits.[294] Second, *what* qualifies as medically necessary may be subject to major shifts based on the individual presentation of the patient, and the state of medical knowledge at a specific point in time. This, of course, makes the standard very difficult to apply across multiple episodes of care, a necessity for an easily implementable regulatory regime. As argued above, it also is subject, in different contexts, to different limiting pressures of time and resources, which, along with geographic differences,[295] can cause variability. Finally, medical necessity may develop quickly, and a standard devised a decade ago may be outdated based on rapidly developing medical knowledge.[296]

An odd fit to begin with, the application of the 160-year-old FCA to the intricacies and complexities of medical necessity has been subject to recent shifts.[297]

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294. *See* Gliadkovskaya, *supra* note 109.

295. *See* Atul Gawande, *The Cost Conundrum*, NEW YORKER (May 25, 2009), https://www.newyorker.com/magazine/2009/06/01/the-cost-conundrum [https://perma.cc/88ST-NYGY].

> Between 2001 and 2005, critically ill Medicare patients received almost [50%] more specialist visits in McAllen than in El Paso, and were two-thirds more likely to see ten or more specialists in a six-month period. In 2005 and 2006, patients in McAllen received [20%] more abdominal ultrasounds, [30%] more bone-density studies, [60%] more stress tests with echocardiography, [200%] more nerve-conduction studies to diagnose carpal-tunnel syndrome, and [550%] more urine-flow studies to diagnose prostate troubles. They received one-fifth to two-thirds more gallbladder operations, knee replacements, breast biopsies, and bladder scopes. They also received two to three times as many pacemakers, implantable defibrillators, cardiac-bypass operations, carotid endarterectomies, and coronary-artery stents. And Medicare paid for five times as many home-nurse visits. The primary cause of McAllen's extreme costs was, very simply, the across-the-board overuse of medicine.

Id.

296. *See* Neda Laiteerapong & Elbert S. Huang, *The Pace of Change in Medical Practice and Health Policy: Collision or Coexistence?*, 30 J. GEN. INTERNAL MED. 848, 848–52 (2015).

297. *See generally* Isaac D. Buck, *A Farewell to Falsity: Shifting Standards in Medicare Fraud Enforcement*, 49 SETON HALL L. REV. 1 (2018).

The most analytically difficult part of the analysis seems to hinge on mapping the complexity of medicine, with all its complicating factors, onto the legal regime of fraud. To assist with this difficult project, courts have authored different doctrines—from express certification,[298] to implied certification,[299] to worthless services.[300] These doctrines serve to link health care that lacks sufficient quality with the ambit of the anti-fraud statutes, and, particularly, the FCA. In a recent opinion, the Supreme Court has explicitly recognized one of these theories.[301]

Nonetheless, the complexity inherent in the endeavor of medicine leads to different legal approaches. In a particularly important example, the Eleventh Circuit upheld a finding that, for purposes of the FCA, falsity—a key element for FCA liability—must be proven by more than just clinical disagreement.[302] Indeed, even where there are credible allegations that clinical decision-making seems to be influenced by a profit motive, a successful FCA action may require more proof of falsity than physician disagreement.

B. Process Complications

Under the *qui tam* provisions of the FCA,[303] the enforcement mechanism often relies on a whistleblower (maybe even a colleague or employee) to come forward to tell of their colleague's improper care. This, of course, exports much of the fact-gathering onto the colleague who has their own reputational concerns and intraprofessional pressures to worry about. As a result, the clarity of enforcement is complicated, with colleagues hesitant to blow the whistle on their peers or employers and incur real social costs.

This concern is heightened when the entity responsible for pushing its providers to provide care that is not medically necessary owns the portfolio company that employs the physician. Most prominently, providers, now employees subject to the control of the PE company, face major professional risks in coming forward.[304] Raising concerns about PE's profit-focused procedures—out of a worry to protect patients—can lead to termination.[305] Besides just being concerned about the social costs of blowing the whistle on a colleague, now providers have to worry about professional costs.[306] As a result, physicians are wary to even speak about the conditions they face.[307]

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298. *See* Isaac D. Buck, *Overtreatment and Informed Consent: A Fraud-Based Solution to Unwanted and Unnecessary Care*, 43 FLA. ST. L. REV. 901, 936–39 (2016).

299. *See id.* at 939–41.

300. *See id.* at 941–42.

301. *See, e.g.*, Universal Health Servs., Inc. v. U.S. *ex rel.* Escobar, 579 U.S. 176, 180–81 (2016) (recognizing implied false certification as a basis for liability under the FCA).

302. United States v. Aseracare, 153 F. Supp. 3d 1372, 1381 (2015), *aff'd in part, vacated in part*, 938 F.3d 1278 (11th Cir. 2019).

303. 31 U.S.C. § 3730(b)–(c).

304. *See* Morgenson, *'Get that Money!,' supra* note 17.

305. *Id.*

306. *See* Lynn Parramore, *ER Doctor: "Private Equity in Medicine is Dangerous to Patients*," INST. FOR NEW ECON. THINKING (June 22, 2023), https://www.ineteconomics.org/perspectives/blog/er-doctor-private-equity-in-medicine-is-dangerous-to-patients [https://perma.cc/D9PD-CBB6] ("In the past, doctors

> [T]he physicians I contacted were afraid to talk openly. "I have since reconsidered this and do not feel this is something I can do right now," one doctor wrote to me. Another texted, "Will need to be anon." 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 [PE] firms. In March 2020, an emergency-room doctor named Ming Lin was removed from the rotation at his hospital after airing concerns about its C[OVID]-19 safety protocols. Lin worked at St. Joseph Medical Center, in Bellingham, Wash.—but his actual employer was TeamHealth, a company owned by the Blackstone Group.[308]

Concern for job security—coupled with the incessant focus on profit that leads to internalized guilt, burnout, and even moral injury[309]—leaves physicians with little recourse.[310] It is within this landscape that one can understand how a fraud statute that is so often dependent upon whistleblowers to ferret out fraud and abuse[311] within the health care industry may run into difficulties in application.

C. Causation

The FCA requires causation. Liability under the FCA attaches when one "knowingly presents, or causes to be presented, a false or fraudulent claim" or a "false record or statement material to a false or fraudulent claim," among other provisions.[312] Historically, in medical necessity-based cases, it has been relatively easy to assert that, when physicians administer care that is lacking in medical necessity and then bills the government for that service, those physicians have allegedly committed wrongdoing.[313] The doctor who signs off on the medical necessity of the care at issue is the one who can easily be said to have presented the claim to the federal government for payment.

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would have been making the decisions about who should and shouldn't be admitted. But when a private equity company has a contract with the hospital, they will make the rules and you either follow them or you'll be terminated.").

307. *Id.* ("There are so many physicians who are afraid to speak out. In many cases, when they do they feel they have to do so anonymously."); Press, *supra* note 43.

308. Press, *supra* note 43.

309. *Id.* ("I think a lot of doctors are feeling like something is troubling them, something deep in their core that they committed themselves to.").

310. *See* Deborah Adams Kaplan, *Physicians Band Together To Fend Off Private-Equity Firms*, MANAGED HEALTHCARE EXEC., May 2023, at 40, 40 ("When private-equity firms buy up practices or takes [sic] contracts, 'there are very few options. You either have to leave the city or just work for them.'").

311. Whistleblower lawsuits are responsible for nearly 70% of all FCA recoveries since 1986. Pietragallo Gordon Alfano Bosick & Raspanti, LLP, *Federal False Claims Act*, FALSE CLAIMS ACT, https://www.falseclaimsact.com/federal-false-claims-act/ [https://perma.cc/GU29-BFNE] (last visited Mar. 15, 2025) (explaining that over $75 billion has been recovered by the FCA since the modern amendments took effect in 1986).

312. 31 U.S.C. § 3729(a)–(b).

313. *See, e.g.*, Press Release, U.S. Dep't of Just., Physician Partners of America To Pay $24.5 Million To Settle Allegations of Unnecessary Testing, Improper Remuneration to Physicians and a False Statement in Connection with COVID-19 Relief Funds (Apr. 12, 2022), https://www.justice.gov/opa/pr/physician-partners-america-pay-245-million-settle-allegations-unnecessary-testing-improper [https://perma.cc/56JD-GWNW].

What is difficult in the case of PE-based overtreatment is the firm's *distance* from both the provision of care and the physician who is administering the care at issue.

Some courts that have examined the issue have "looked past the structural barriers to the essence of the relationship between PE and portfolio and were satisfied" causation was met.[314] Nonetheless, lack of consistency in this space has led to confusion as to the appropriate causal standard—whether the court will require proof that the PE firm was directly involved in the claims or directly involved in the fraud.[315] In the case of medical necessity-based PE claims, this serves as a meaningful difference.[316]

Because of the dearth of cases in this space (and particularly, the absence of cases featuring medical necessity-based fraud claims), it is hard to generalize. However, the *Anderson* case is instructive.[317] As noted by Professor Robert Field and his coauthors,

> *Anderson* further holds that if the [PE] investor's policies, even if not independently unlawful, have the effect of incentivizing conduct that results in the submission of false claims, that may be sufficient to establish causation liability under the FCA.
>
> . . . [I]n *Anderson*, the incentives and trainings offered by Curo encouraged Avalon to admit hospice patients even if those patients did not meet Medicaid eligibility requirements.[318]

Nonetheless, that case did not focus on the PE investment as an important piece of the analysis,[319] but perhaps it should have.

Important work has made the argument that PE firms should be responsible under the FCA when they are directly involved in fraud that is committed by their portfolio company.[320] What becomes more difficult is the question of how or what type of causation these cases will require and where the courts will draw lines around causal theory. Indeed, in PE claims where the allegations focus on medical necessity and excessive treatment, but-for causation is clearly established: the claim would feature an argument that but for the pressure or intervention of the PE firm, the physician would not have administered the care at issue. Particularly where PE firms demand or strongly encourage physicians to administer more (worthless) care to patients, it becomes hard to make the argument that they did not cause the false claim to be presented. If they are able to cut staff and reassign personnel, then clearly, they have the ability to be said to impact medical care where they control the actions of the portfolio company.

One suggested solution has been to apply a causal standard that allows FCA action "when the [PE] firm played an *active role* in the fraud."[321] This "indirect involvement causation interpretation" would allow prosecutors to impose FCA liability

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314. Gregory F. Maczko, *Make Hay While the Sun Shines: Private Equity and the False Claims Act*, 74 VAND. L. REV. 797, 819 (2021).

315. *Id.* at 820.

316. *Id.*

317. *See* U.S. *ex rel.* Anderson v. Curo Health Servs. Holdings, Inc., No. 3:13-cv-00672, 2022 WL 842937 (M.D. Tenn. Mar. 21, 2022).

318. Field et al., *supra* note 22, at 878.

319. *Id.*

320. *See* Maczko, *supra* note 314.

321. *Id.* at 823 (emphasis added).

against PE companies when their portfolio companies commit fraud even where the PE company had no role in submitting the claims for reimbursement.[322] Indeed, federal courts that have analyzed the causation issue have refused to dismiss claims where the PE firm either "approv[ed] a fraudulent scheme" and "reject[ed] . . . recommendations to bring its staff into regulatory compliance, thus ratifying the policy of submitting false claims."[323]

The challenge, of course, of using the FCA in these medical necessity-based claims, is that medical necessity determinations are seen as within the domain of medical expertise. Where a PE firm is encouraging its physicians to administer care that is not medically necessary, there still could be an argument that the physician's expert decision-making provides the backstop to even the worst PE influence. What this account fails to consider, however, is the amount of control the PE firm can exert on those medical professionals—making the patient-protective anti-fraud statutes nearly impotent. As a result, for these cases, a causal doctrine closer to but-for causation—as it relates to the false claim—should be deployed to capture the PE's involvement in and responsibility for bills that reflect excessive care.

CONCLUSION

PE has entered the health care space. Its impacts are dramatic on health care costs and quality and on the experience and professional livelihoods of the nation's physicians. It spares no impact on providers, payers, and physicians themselves. But beyond these general impacts, it also affects the patient-physician relationship. As a result, anti-fraud tools, and particularly the FCA, must be marshalled to prevent its worst excesses. Old conceptions of causation, whistleblowing, and medical necessity must be challenged in a world of aggressive for-profit interests. At bottom, the financialization of American health care calls for increasingly creative regulatory solutions to protect its doctors and patients from an organizational and financial structure that does not.

322. *Id.* at 826–27.

323. *Id.* at 827.