

# The Corporatization of Health Care

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*Lowell General Hospital Grand Rounds*

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# Overview

- Health Care Corporatization
  - Definition & Concept
  - Examples
- Policy concerns
- Policy options – particularly for states
- Discussion



Perspective  
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THE CORPORATIZATION OF U.S. HEALTH CARE

## Defining Health Care “Corporatization”

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**W**hat is corporatization in health care? Paul Starr’s seminal 1982 work, *The Social Transformation of American Medicine*, offers a conceptual guide.<sup>1</sup> In Book One, Starr described

how a sovereign medical profession gained extraordinary social and political power to organize and govern the health care system during the first half of the 20th century. In Book Two, he observed that health care was on the cusp of another major transformation, shifting toward a future in which corporations consolidate ownership and control until the health care system becomes “an industry dominated by huge health care conglomerates.” In short, Starr predicted health care corporatization.

Starr observed the corporatization of health care proceeding along five dimensions: the shift from nonprofit and government organization to for-profit compa-

nies; horizontal consolidation of locally controlled entities to nationally or regionally controlled corporations; the shift from single-unit and single-market firms to conglomerate enterprises; vertical consolidation among levels of care delivery and payers; and increasing concentration, size, and scope of organizations.

In the four decades since the publication of this work, the U.S. health care system has progressed further along every one of these dimensions toward greater corporatization. According to the American Hospital Association, the share of for-profit community hospitals increased from 13.1% in 1983 to 23.7% in 2023. Meanwhile, health care entities have expanded their

size, scope, and market concentration by means of a combination of horizontal and vertical consolidation. The percentage of hospitals owned by companies controlling three or more hospitals increased from 11.6% in the 1980s to 56.1% today, according to the Department of Health and Human Services, and now nine megahospital chains own more than 50 hospitals each. In the early 1980s, three quarters of U.S. physicians owned their practice, whereas in 2023 a similar proportion of physicians was employed by hospitals or corporate entities, including private equity funds.

Insurance conglomerates, such as UnitedHealthcare and CVS-Aetna, now control physicians, home care, pharmacies, and pharmacy benefit managers (PBMs). Horizontal hospital consolidation has been pursued for the promise of economies of scale and market power. And vertical consolidation

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# Overview

*Corporatization* refers to the general trend throughout the health care industry toward higher levels of integrated control by consolidated profit-seeking enterprises.

*Two key features:*

- Profit maximization, not patient care, is the primary goal
- Consolidation – from individual entities to large conglomerates

*Health care “financialization”* refers to the shift in the primary objective of health care institutions from the production of patient and community health to the extractive production of wealth for equity owners (shareholders, investors) and management.

# Example: Private Equity

- **Highly leveraged:** debt loaded onto target companies
- **Financial engineering:** REIT sale-leasebacks, staffing cuts, asset stripping
- **Short-term:** exit in 3-7 years
- **Moral hazard:** PE willing to take risks without reputational or financial consequence (heads I win, tails you lose)



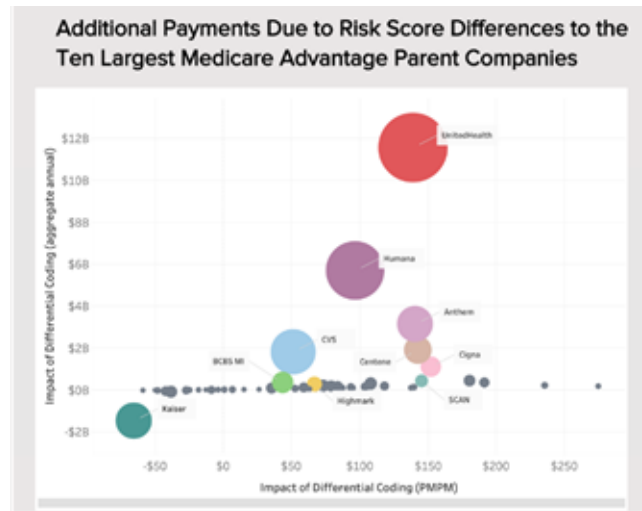
# Example: Vertically Consolidated Medicare Advantage Entities

→ Medicare Advantage (MA): 54% of Medicare beneficiaries

- Capitated risk-adjusted payments: more diagnoses = more \$
- Risk score upcoding ~\$30-50 billion annually

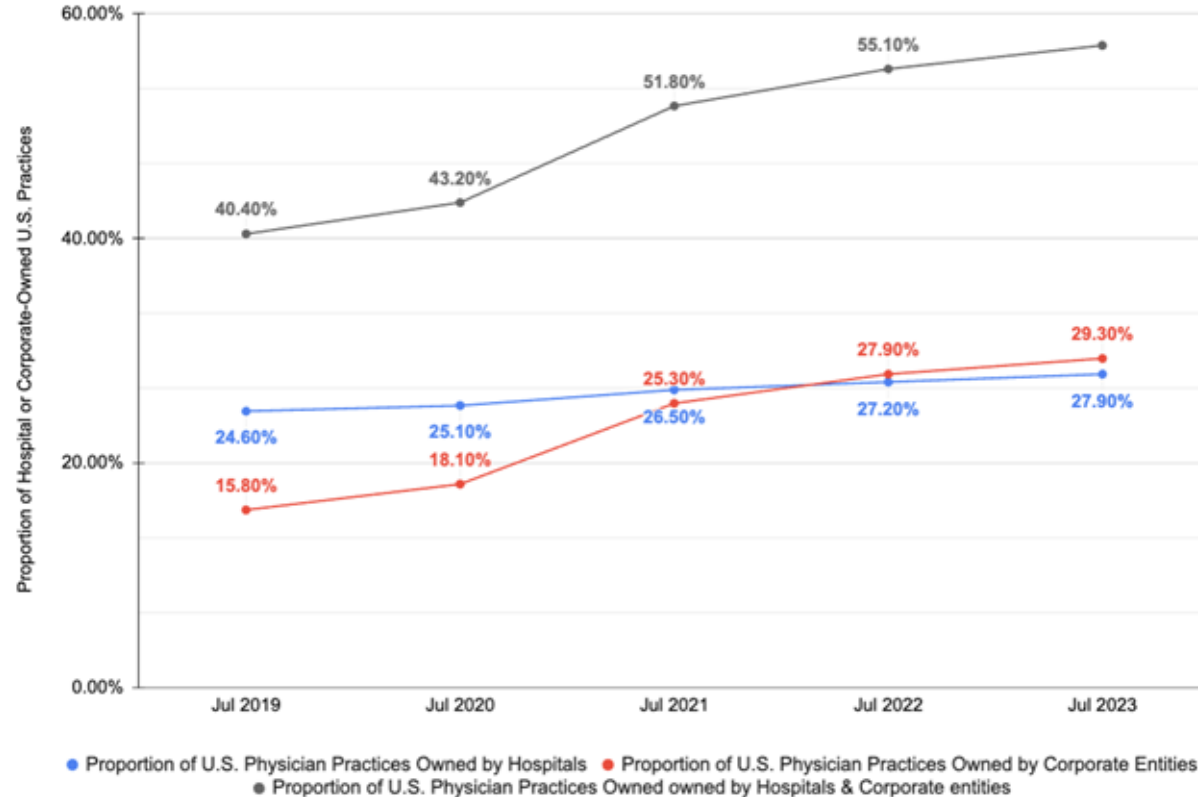
→ MA insurers' vertical consolidation playbook:

- Buy provider groups (PCPs, home care) for their MA “book of business,” control EHR and pressure docs to upcode diagnoses
- Use health risk assessments and chart reviews to document diagnoses to inflate MA payments
- Use intercompany transfer payments to tunnel profits to related parties (MLR gaming)
- Capture or steer patients to own PBM, pharmacy, MA plan



Source: Medicode, a Medicare Advantage Coding Intensity Report Card [coming soon from CAHPR]

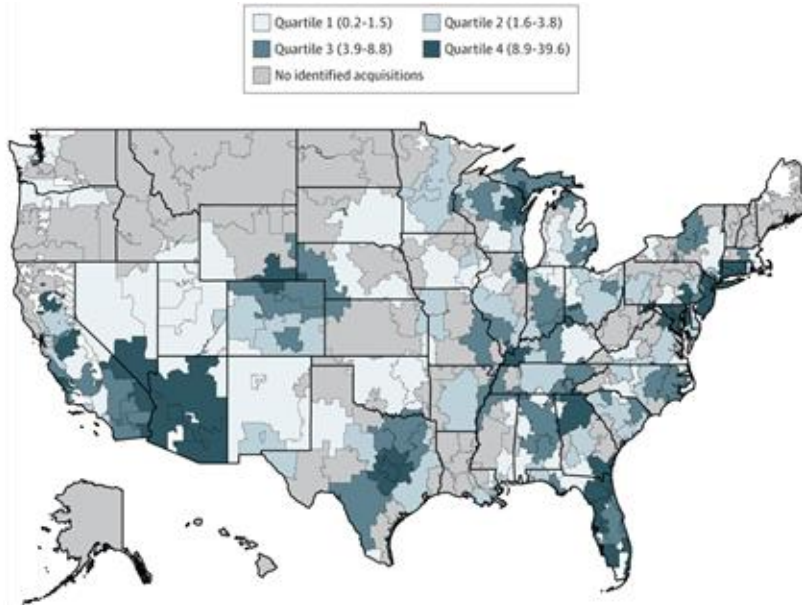
# Trends



- The majority of physician practices are **owned** by hospitals or corporate entities (private equity, insurance companies, retailers)
- Corporate acquisition is growing
- Few physicians remain in independent practice
- 77.6% percent of physicians are **employed** by hospitals or corporate entities as of 2024

# Evidence suggests that PE increases prices and utilization, also affects workforce composition

PE penetration across 6 office-based specialties, 2019



From: Singh, Y., Zhu, J. M., Polsky, D., & Song, Z. (2022, April). Geographic variation in private equity penetration across select office-based physician specialties in the US. *In JAMA health forum* (Vol. 3, No. 4, pp. e220825-e220825). American Medical Association.

- Nationally, PE acquisitions concentrated in FL, TX, AZ, Northeast (Singh et al., 2022)
- PE increases health care spending by increasing health care prices by 10–26% and service utilization (Singh et al., 2022, LaForgia et al., 2022, Braun et al., 2021)
- PE changes workforce composition by increasing hiring of physician assistants and nurse practitioners, increasing physician turnover (Singh et al., 2025, Bruch et al., 2023)
- PE has mixed effects on quality (Gupta et al., 2024, Kannan et al., 2024, Cerullo et al., 2022, Braun et al., 2021)

# Corporatization and Physician Practice: The MSO

**Definition:** An MSO is an entity that provides non-clinical services to physician practices. MSOs are the primary vehicle through which lay-corporations acquire control over medical practices

MSOs originally provided back-office administrative support. The MSO worked for the practice.

MSOs now facilitate corporate investment and exert control over practices. The practice works for the MSO.

MSOs bypass state prohibitions on the corporate practice of medicine (CPOM), allowing corporations to functionally own medical practices and influence clinical care.

**Policy concerns:** erosion of morale and professional autonomy, conflicts of interest, burnout, exit, profits above patients, care continuity, clinicians unable to leave or speak out, loss of trust in profession

Issue Brief  
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Milbank  
Memorial Fund   
Using evidence to improve population health

## The Corporate Backdoor to Medicine: How MSOs Are Reshaping Physician Practices

Hayden Rooke-Ley, Megha Reddy, Neil Mehta, Yashaswini Singh, and Erin Fuse Brown, Center for Advancing Health Policy through Research, Brown University School of Public Health

### Policy Points

- > Require management service organizations (MSOs) and physician practices to disclose financial backers, ownership structures, and contractual affiliations to state regulators.
- > Strengthen state authority by requiring prior notice and review of MSO transactions, with power to block or place conditions on transactions without a court order and

### ABSTRACT

Management service organizations (MSOs) have evolved into powerful corporate vehicles for consolidating physician practices. Originally designed to handle billing, human resources, and other back-office administrative tasks, MSOs now aggregate medical groups, negotiate payer contracts, and facilitate corporate investment – often blurring the line between support and control. Increasingly, private equity firms, insurance companies, and other corporate entities are using MSOs to bypass state prohibitions on the corporate practice of medicine (CPOM), allowing large corporations to functionally own medical practices and influence clinical care.

This brief examines the expanding role of corporate MSOs, their impact on health care delivery and market consolidation, and the regulatory gaps that allow them to operate with minimal oversight. Though corporate-backed MSOs may offer enticing capital investments in physician practices, unchecked MSO influence threatens to prioritize profits over patient care, weaken competition, and erode physician independence within the health care system. To address these concerns, we explore state-level policy solutions to enhance financial transparency, strengthen oversight of MSO transac-

Source: <https://www.milbank.org/publications/the-corporate-backdoor-to-medicine-how-msos-are-reshaping-physician-practices/>

# Policy Concerns: Profits Over Patients




- Higher costs, spending, prices
- Worse access and quality
- Professional demoralization



The New York Times Magazine



# 3 State Policy Options to Regulate Corporate Medicine

| Policy Approach  | Policy Concerns  |
|--|--|
|  <b>Ownership Transparency</b>  | Opacity, lack of accountability  |
|  <b>Health Care Transaction Oversight Authority</b>                     | Consolidation, cost increases  |
|  <b>Strengthening the Prohibition on Corporate Practice of Medicine</b> | Professional autonomy, workforce effects, interference with clinical decision-making |

# Policy 1: Transparency of Ownership/Control



Require all existing health care entities to report information on owners, controlling entities, business structure, including the ultimate owners or controlling parent, subsidiaries, entities under common control, and any **management services organizations**



Require all health care entities to report any *changes* to ownership or control (would also constitute a material change transaction for notice and review purposes)



Make this information available to the public

# Policy 2: Enhanced Transaction Oversight

**Policy concern:** Traditional antitrust tools can be inadequate to address novel forms of health care consolidation, including private equity and other corporate investment

**Response:** Strengthen oversight authority over health care transactions in two primary ways

## **(1) Expanding the Oversight Authority:**

- Require **prior notice** of material transactions
- Expand **review** authority
- Enable authority to **block or impose conditions** upon the transaction without a court order

## **(2) Expanding role of state health agencies:**

vest another state health entity (in addition to the state attorney general) with the authority to review and report on a proposed transaction's broader health care market impact.



# Policy 2: Strengthening the Corporate Practice of Medicine Prohibition

## Policy Concern

Corporate control over physicians and other independent practitioners (e.g., PE, Optum, etc)

## What it is?

The Corporate Practice of Medicine (CPOM) doctrine generally bans unlicensed lay entities from owning, employing, or controlling medical practices. Stems from bans on the unlicensed practice of medicine.

**What it isn't:** CPOM does not address corporate/for-profit control of *hospitals* or other facilities

## Why strengthen it?

CPOM laws eroded over time, with exceptions (HMOs, Hospitals) and nonenforcement.

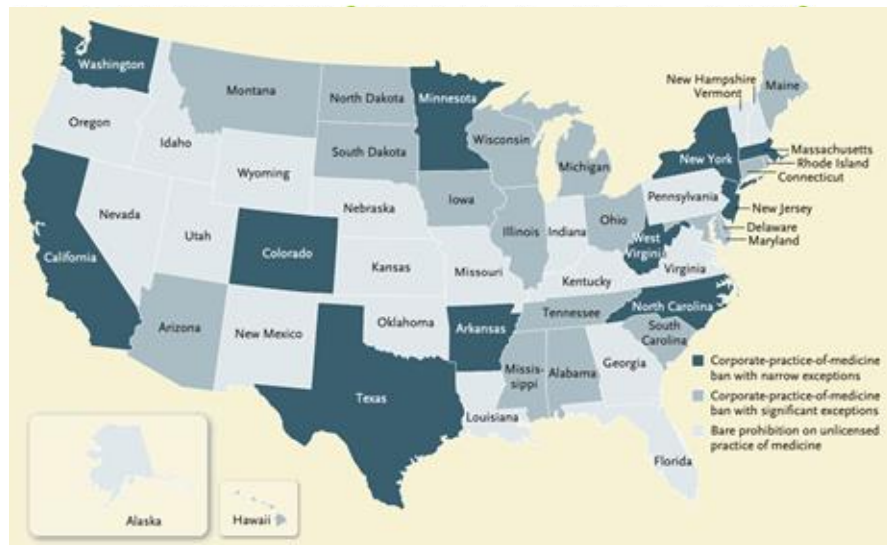
Corporations contractually circumvent CPOM bans to exert *de facto* control over a medical practice they did not formally own through MSOs and friendly physician.



PERSPECTIVE



## A Doctrine in Name Only — Strengthening Prohibitions against the Corporate Practice of Medicine



Source: Zhu J, Rooke-Ley H, Furse Brown E. 2023. *A doctrine in name only—strengthening prohibitions against the corporate practice of medicine.* NEJM 389(11): 965-968.

# Policy 3: Strengthening CPOM

## Add or clarify CPOM prohibition in statute:

Prohibit unlicensed lay-entities from owning, employing, or controlling medical practices

Prohibit any unlicensed lay-entities from interfering with clinical decisions

## Regulate Friendly PC/MSO structure (does not ban MSOs)

Restrict dual compensation / control of PC and MSO

Require that licensed professionals maintain ultimate control over clinical and business decisions in contracts with management services organizations (MSOs)

Enumerate types of clinical and business decisions that implicate CPOM

Ban or limit non-competes, gag-clauses

## Protections for employed physicians (e.g., by hospitals or other exempted entities)

Ban or limit non-competes, gag-clauses

Noninterference with clinical decisions

## Multiple routes of enforcement: AG, administrative agency, private actions

Private enforcement (by aggrieved employee or competitor) can supplement administrative enforcement, whistleblower as “private AG”

# Federal Policy Options to Address Corporatization

- Increase antitrust enforcement over corporate consolidation (FTC and DOJ have tried . . .)
- Ban physician non-competes (FTC tried . . .)
- Transparency of ownership and control
- Structural separation of payers and providers: insurers should not own physicians, PBMs should not own pharmacies
- Medicare Payment Policy
  - Crack down on risk upcoding in MA (eliminate health risk assessments, chart reviews, variable coding intensity adjustment)
  - Strengthen Traditional Medicare to make it more competitive with MA
  - Back off risk-based payment in Traditional Medicare (ACOs, APMs) – the admin burden is driving physicians to go corporate
  - Improve primary care payment – reform the RUC (RVUs Update Committee)

# Corporatization Takeaways

- **Health care “corporatization” is best understood as a shift in control and governance—not merely ownership—from clinicians to corporate entities,** including private equity firms and vertically integrated insurers. This shift changes decision-making authority and embeds financial logics into clinical and organizational priorities.
- **The core concern is how corporatization reorients incentives, often privileging revenue generation and growth over patient care and population health.** These incentive structures can erode professional norms, distort clinical decision-making, and contribute to higher spending without commensurate improvements in outcomes.
- **Current regulatory frameworks—focused on prices, competition, and fraud—are poorly matched to the structural and normative effects of corporatization.** Policymakers will likely need new tools that directly address ownership, control, and financial incentives to better align the health system with patient welfare and public health goals.

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