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Strategies to Address Corporate Consolidation in Health Care:

Material Health Care Transaction Oversight

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Testimony of Erin C. Fuse Brown submitted to the House Health Committee on HB 944: An Act concerning Maryland Health Care Commission - Certificates of Need and Material Change Transactions

Strategies to Address Corporate Consolidation in Health Care:
Material Health Care Transaction Oversight

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[1]The opinions and conclusions expressed in this testimony are the author's alone and do not necessarily reflect those of Brown University, the Brown University School of Public Health, or any of the research sponsors.

[2]The Center for Advancing Health Policy through Research (CAHPR) at the Brown University School of Public Health is dedicated to generating research that informs policies aimed at reducing costs, improving patient well-being, and driving meaningful transformations in U.S. health care delivery. Our work focuses on the design of insurance plans and their interactions within the health care market, employing a unique approach that integrates quantitative policy analysis with legal evaluation. This combined methodology helps identify the most effective legal and regulatory changes to create a significant impact. While this testimony is not a research publication, it is informed by relevant research conducted by CAHPR and its affiliates.

Chair Bagnall and members of the House Health Committee, thank you for the opportunity to

provide testimony on HB 944. My name is Erin Fuse Brown, and I am a professor of health policy at the Brown University School of Public Health. I was part of the team of researchers that conducted a 2025 study of the effect of private equity investment on Maryland's physician markets for the Maryland Health Care Commission.[3] In addition, I have worked with the National Academy for State Health Policy to develop model legislation for states to address health care consolidation and corporatization.[4] This model legislation, like HB 944, strengthens state oversight of material health care transactions involving health care entities, including consolidation of provider organizations by health systems, insurance companies, and private equity investors.

States are urgently seeking tools to address rampant health care consolidation, which is the main driver of rising prices and spending in health care. Increasingly, consolidation is led by for-profit corporate investors, including private equity firms, large insurance companies, and retail chains. These transactions often escape federal antitrust review, so states are stepping up to fill the gap, providing critical oversight of major ownership changes that affect local health care markets.[5]

Trends in the Consolidation of Physician Practices, Private Equity Investment

Today, nearly 80% of physicians are employed by hospitals or other corporate entities, including private equity firms, insurance companies, retailers, and publicly traded companies.[6] UnitedHealth Group, through its Optum subsidiary, now controls about 1 in 10 U.S. physicians.[7] Private equity firms have acquired large numbers of physician practices, sometimes controlling 30–50% of a specialty in a single market.[8]

Private equity (PE) refers to firms that invest in companies not listed on public exchanges, with the goal of restructuring, improving profitability, and then selling the businesses for a profit. In general, PE firms commonly use the leveraged buyout model using large amounts of debt to acquire majority ownership

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[3] Yashaswini Singh et al., *Private Equity Investments in Physician Practices in Maryland*, January 2025, https://doi.org/10.26300/S7GH-WT25.
[4] *Comprehensive Consolidation Model Addressing Transaction Oversight, Corporate Practice of Medicine and Transparency* (National Academy for State Health Policy, 2024), https://nashp.org/a-model-act-for-state-oversight-of-proposed-health-care-mergers/.
[5] Erin Fuse Brown and Katherine Gudiksen, *Models for Enhanced Health Care Market Oversight — State Attorneys General, Health Departments, and Independent Oversight Entities* (Milbank Memorial Fund, 2024), https://www.milbank.org/publications/models-for-enhanced-health-care-market-oversight-state-attorneys-general-health-departments-and-independent-oversight-entities/.
[6] Physicians Advocacy Institute and Avalere Health, *PAI-Avalere Report on Physician Employment Trends and Acquisitions of Medical Practices: 2019-2023* (2024), https://www.physiciansadvocacyinstitute.org/PAI-Research/PAI-Avalere-Study-on-Physician-Employment-Practice-Ownership-Trends-2019-2023.
[7] Bob Herman, "UnitedHealth Group Now Employs or Is Affiliated with 10% of All Physicians in the U.S.," *Stat+*, November 29, 2023, https://www.statnews.com/2023/11/29/unitedhealth-doctors-workforce/.
[8] Ola Abdelhadi et al., "Private Equity–Acquired Physician Practices And Market Penetration Increased Substantially, 2012–21: Study Examines Private Equity-Acquired Physician Practices and Market Penetration," *Health Affairs* 43, no. 3 (2024): 354–62, https://doi.org/10.1377/hlthaff.2023.00152.

stakes in their investment targets. The goal of PE investments is to generate above market returns for investors upon selling the entity (i.e., "the exit"), typically within three to seven years.[9] While PE acquisitions may bring capital infusions to facilitate technological investments and greater efficiency of care, PE's short-term, for-profit incentives may result in undesirable effects on the cost and quality of care for patients, payers, and health care workers.

In 2025, my colleagues at Brown completed a study of private equity investment in physician practices in Maryland under Chapter 78 of the 2024 Laws of Maryland,[10] which directed the Maryland Health Care Commission to contract with a private consultant to "study the effect of private equity firms on the health care market in the State." In this study,[11] we found that PE firms have invested in a growing share of physician practices in Maryland, with notable variation across different regions and specialties. Key findings included:

- Private equity penetration in Maryland increased from 1.8% in 2014 to 15.5% by 2021.
- Specialties with the highest private equity penetration as of 2021 were gastroenterology (16.7%), ophthalmology (25.2%), primary care (27.3%), dermatology (36.2%), and urology (63.3%).
- Private equity expansion is geographically uneven. As of 2021, PE penetration was highest in Prince George's County (53.2%), suggesting that half of all physicians seen by residents of Prince George's County were PE-affiliated. By contrast, seven rural counties had no PE penetration across the evaluated physician specialties (Garrett, Kent, Cecil, Caroline, Calvert, Dorchester, and Somerset Counties).
- Overall, PE penetration in physician practices in Maryland is greater than national estimates across evaluated specialties.

Impacts of Consolidation of Physician Markets by Private Equity and Others

[9] 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 Forum* 2, no. 11 (2021): e213817, https://doi.org/10.1001/jamahealthforum.2021.3817.
[10] Labor and Employment – Noncompete and Conflict of Interest Clauses for Veterinary and Health Care Professionals and Study of the Health Care Market, House Bill 1388, The General Assembly of Maryland 2024, Chapter 378, https://mgaleg.maryland.gov/2024RS/Chapters_noln/CH_378_hb1388e.pdf.
[11] Yashaswini Singh et al., *Private Equity Investments in Physician Practices in Maryland*.

Evidence shows that health care consolidation results in higher costs,[12,13,14,15,16,17,18,19,20] changes in staffing composition, reduced wages,[21,22,23] worse or no-better outcomes,[24,25] and reduced access[26,27,28,29] —especially in underserved communities.

Private equity investment consolidates the physician market, which can lead to higher health care costs and spending. PE firms use a "platform and roll-up" strategy to grow physician practices. First, PE firms may acquire a large, well-established practice (the platform) and then gradually increase market share

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[12] Daniel Arnold and Christopher Whaley, "Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages," *SSRN Electronic Journal*, ahead of print, 2024, https://doi.org/10.2139/ssrn.4959256.
[13] Daniel R. Arnold et al., "New Evidence on the Impacts of Cross‐market Hospital Mergers on Commercial Prices and Measures of Quality," *Health Services Research* 60, no. 1 (2025): e14291, https://doi.org/10.1111/1475-6773.14291.
[14] Leemore Dafny et al., "The Price Effects of Cross‐market Mergers: Theory and Evidence from the Hospital Industry," *The RAND Journal of Economics* 50, no. 2 (2019): 286–325, https://doi.org/10.1111/1756-2171.12270.
[15] Haizhen Lin et al., "Hospital Pricing Following Integration with Physician Practices," *Journal of Health Economics* 77 (May 2021): 102444, https://doi.org/10.1016/j.jhealeco.2021.102444.
[16] Christopher M. Whaley et al., "Higher Medicare Spending On Imaging And Lab Services After Primary Care Physician Group Vertical Integration," *Health Affairs* 40, no. 5 (2021): 702–9, https://doi.org/10.1377/hlthaff.2020.01006.
[17] Yashaswini Singh et al., "Increases In Physician Professional Fees In Private Equity–Owned Gastroenterology Practices: Article Examines Increases in Physician Professional Fees in Private Equity-Owned Gastroenterology Practices," *Health Affairs* 44, no. 2 (2025): 215–23, https://doi.org/10.1377/hlthaff.2024.00190.
[18] Yashaswini Singh et al., "Association of Private Equity Acquisition of Physician Practices With Changes in Health Care Spending and Utilization," *JAMA Health Forum* 3, no. 9 (2022): e222886, https://doi.org/10.1001/jamahealthforum.2022.2886.
[19] Jiani Yu et al., "Physician Management Companies and Neonatology Prices, Utilization, and Clinical Outcomes," *Pediatrics* 151, no. 4 (2023): e2022057931, https://doi.org/10.1542/peds.2022-057931.
[20] Yashaswini Singh et al., "Increases in Medicare Spending and Use after Private Equity Acquisition of Retina Practices," *Ophthalmology* 131, no. 2 (2024): 150–58, https://doi.org/10.1016/j.ophtha.2023.07.031.
[21] Arnold and Whaley, "Who Pays for Health Care Costs?"
[22] Elena Prager and Matt Schmitt, "Employer Consolidation and Wages: Evidence from Hospitals," *American Economic Review* 111, no. 2 (2021): 397–427, https://doi.org/10.1257/aer.20190690.
[23] Joseph Dov Bruch et al., "Workforce Composition In Private Equity–Acquired Versus Non–Private Equity–Acquired Physician Practices: Study Examines Physician Workforce Composition Comparing Private Equity-Acquired with Non-Private Equity-Acquired Practices.," *Health Affairs* 42, no. 1 (2023): 121–29, https://doi.org/10.1377/hlthaff.2022.00308.
[24] Atul Gupta et al., *Owner Incentives and Performance in Healthcare: Private Equity Investment in Nursing Homes*, no. w28474 (National Bureau of Economic Research, 2021), https://doi.org/10.3386/w28474.
[25] Sneha Kannan et al., "Changes in Hospital Adverse Events and Patient Outcomes Associated With Private Equity Acquisition," *JAMA* 330, no. 24 (2023): 2365, https://doi.org/10.1001/jama.2023.23147.
[26] Eileen Appelbaum and Rosemary Batt, *Private Equity Buyouts in Healthcare: Who Wins, Who Loses?*, Working Paper (Center for Economic and Policy Research, 2020), https://www.ineteconomics.org/uploads/papers/WP_118-Appelbaum-and-Batt-2-rb-Clean.pdf.
[27] Kannan et al., "Changes in Hospital Adverse Events and Patient Outcomes Associated With Private Equity Acquisition."
[28] Atul Gupta et al., *Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes*, Working Paper No. 28474 (National Bureau of Economic Research, 2021), https://www.nber.org/papers/w28474.
[29] Karyn Schwartz et al., *What We Know About Provider Consolidation* (KFF, 2020), https://www.kff.org/health-costs/what-we-know-about-provider-consolidation/.

through subsequent acquisitions of smaller practices (add-ons).[30,31] In our study, we found examples of PE firms using the platform and roll-up strategy in Maryland.[32] Empirical evidence has found that PE acquisitions of physician practices are associated with increases in commercial prices by 11% for certain procedural specialties, including dermatology, ophthalmology, and gastroenterology,[33] and by 70% for neonatology.[34]

While private equity investment increases health care costs, it does so without commensurate increases in quality, efficiency, or health care outcomes. In facility settings, PE investment has been associated with increased mortality and morbidity. In the physician setting, PE investment's effect on quality is more mixed.[35,36] There is a lack of evidence, however, that PE investment systematically improves quality of care in physician practices.[37]

Private equity acquisitions of physician practices also affect the health care workforce. Empirical evidence has shown that PE acquisitions change the workforce composition by increasing the hiring of advanced practice providers (APPs) like nurse practitioners and physician assistants while increasing the rate at which physicians enter and exit practices.[38,39] Together with survey evidence of physicians' poor satisfaction and negative perceptions of private equity,[40] these findings suggest that corporate acquisition of physician groups may damage the morale and supply of the physician workforce and threaten to disrupt the physician-patient relationship as physicians churn through these practices.

Other forms of physician consolidation also lead to increased health care costs. Hospitals that integrated with physician practices experienced a 3-5% price increase, attributed to greater bargaining power[41], and

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[30] Anaeze C. Offodile Ii et al., "Private Equity Investments In Health Care: An Overview Of Hospital And Health System Leveraged Buyouts, 2003–17," *Health Affairs* 40, no. 5 (2021): 719–26, https://doi.org/10.1377/hlthaff.2020.01535.
[31] Kannan et al., "Changes in Hospital Adverse Events and Patient Outcomes Associated With Private Equity Acquisition."
[32] Yashaswini Singh et al., *Private Equity Investments in Physician Practices in Maryland*.
[33] Singh et al., "Association of Private Equity Acquisition of Physician Practices With Changes in Health Care Spending and Utilization."
[34] Richard Scheffler et al., *Monetizing Medicine: Private Equity and Competition in Physician Practice Markets* (American Antitrust Institute, 2023), https://www.antitrustinstitute.org/wp-content/uploads/2023/07/AAI-UCB-EG_Private-Equity-I-Physician-Practice-Report_FINAL.pdf.
[35] Kannan et al., "Changes in Hospital Adverse Events and Patient Outcomes Associated With Private Equity Acquisition."
[36] Gupta et al., *Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes*.
[37] Alexander Borsa et al., "Evaluating Trends in Private Equity Ownership and Impacts on Health Outcomes, Costs, and Quality: Systematic Review," *BMJ* 382 (July 2023): e075244, https://doi.org/10.1136/bmj-2023-075244.
[38] Bruch et al., "Workforce Composition In Private Equity–Acquired Versus Non–Private Equity–Acquired Physician Practices."
[39] Yashaswini Singh et al., "Physician Turnover Increased In Private Equity–Acquired Physician Practices: Article Examines Private Equity-Acquired Physician Practices," *Health Affairs* 44, no. 3 (2025): 280–87, https://doi.org/10.1377/hlthaff.2024.00974.
[40] Jane M. Zhu et al., "Physician Perspectives on Private Equity Investment in Health Care," *JAMA Internal Medicine* 184, no. 5 (2024): 579, https://doi.org/10.1001/jamainternmed.2024.0062.
[41] Lin et al., "Hospital Pricing Following Integration with Physician Practices."

more intensive coding practices.[42] By aligning physician practices with hospital systems, these entities manipulate referral patterns, directing patients to more expensive in-system providers for follow-up care and ancillary services.[43,44,45,46,47] This strategy exploits the "site of service differential," where outpatient services are reimbursed at higher rates in hospital settings compared to non-hospital settings, further inflating healthcare costs.[48,49,50,51]

States Are Increasing Oversight of Material Health Care Transactions

Despite this dramatic shift in care delivery, consolidation of physician markets into health systems or via acquisition by corporate owners and investors remains almost entirely opaque and unreviewed.[52] Existing federal and state oversight mechanisms are limited. Physician practice acquisitions typically fall below federal Hart-Scott-Rodino Act reporting thresholds ($133.8 million in 2026)[53] and escape antitrust scrutiny.[54]

Historically, reviews by state attorneys general have tended to focus on nonprofit hospital mergers and have not captured physician practice acquisitions or corporate consolidation involving for-profit investors, especially those using management services organizations (MSO) models that involve contractual controls instead of formal acquisition.[55] Even when state authorities do review transactions, this review

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[42] Brady Post et al., “Hospital‐physician Integration and Risk‐coding Intensity,” *Health Economics* 31, no. 7 (2022): 1423–37, https://doi.org/10.1002/hec.4516.
[43] Laurence C. Baker et al., “Vertical Integration: Hospital Ownership Of Physician Practices Is Associated With Higher Prices And Spending,” *Health Affairs* 33, no. 5 (2014): 756–63, https://doi.org/10.1377/hlthaff.2013.1279.
[44] Jodi Liu et al., *Environmental Scan on Consolidation Trends and Impacts in Health Care Markets* (RAND, 2022), https://www.rand.org/pubs/research_reports/RRA1820-1.html.
[45] Richard M. Scheffler et al., “Consolidation Trends In California’s Health Care System: Impacts On ACA Premiums And Outpatient Visit Prices,” *Health Affairs* 37, no. 9 (2018): 1409–16, https://doi.org/10.1377/hlthaff.2018.0472.
[46] Michael Richards et al., *Treatment Consolidation after Vertical Integration*, Working Paper (2020), https://www.rand.org/pubs/working_papers/WRA621-1.html.
[47] Whaley et al., “Higher Medicare Spending On Imaging And Lab Services After Primary Care Physician Group Vertical Integration.”
[48] Erin Fuse Brown and Mark Hall, “Private Equity and the Corporatization of Health Care,” *Stanford Law Review* 76, no. 3 (2024): 527.
[49] Hannah T. Neprash et al., “Association of Financial Integration Between Physicians and Hospitals With Commercial Health Care Prices,” *JAMA Internal Medicine* 175, no. 12 (2015): 1932, https://doi.org/10.1001/jamainternmed.2015.4610.
[50] Cory Capps et al., “The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending,” *Journal of Health Economics* 59 (May 2018): 139–52, https://doi.org/10.1016/j.jhealeco.2018.04.001.
[51] Christopher M. Whaley and Xiaoxi Zhao, “The Effects of Physician Vertical Integration on Referral Patterns, Patient Welfare, and Market Dynamics,” *Journal of Public Economics* 238 (October 2024): 105175, https://doi.org/10.1016/j.jpubeco.2024.105175.
[52] Yashaswini Singh and Erin Fuse Brown, “The Missing Piece In Health Care Transparency: Ownership Transparency,” September 22, 2023, https://doi.org/10.1377/forefront.20230921.886842.
[53] “FTC Announces 2026 Update of Jurisdictional and Fee Thresholds for Premerger Notification Filings,” Federal Trade Commission, January 14, 2026, https://www.ftc.gov/news-events/news/press-releases/2026/01/ftc-announces-2026-update-jurisdictional-fee-thresholds-premerger-notification-filings.
[54] Thomas Wollmann, *How to Get Away with Merger: Stealth Consolidation and Its Effects on US Healthcare*, no. w27274 (National Bureau of Economic Research, 2020), w27274, https://doi.org/10.3386/w27274.
[55] Fuse Brown and Gudiksen, *Models for Enhanced Health Care Market Oversight — State Attorneys General, Health Departments, and Independent Oversight Entities*.

tends to focus on antitrust factors and not on the broader effects of transactions on quality, access, workers, or equity. Litigation is costly, so only the largest deals are challenged.

Further, corporate investors use management services organizations, or MSOs, to gain control over practices without technically owning them.[56] As a result, patients, purchasers, and regulators often have no notice of physician practice acquisitions and no way to identify who owns or controls their provider. States cannot regulate what they cannot see.

Maryland's HB 944 would change this. This bill expands oversight to a broader array of transactions involving health care entities, including mergers, acquisitions, joint ventures, real estate sales or leasebacks, and management or other contracts that result in a change of control of the health care entity or a substantial portion of its assets. Importantly, the oversight extends to physician practice acquisitions via MSOs, which are the prevailing vehicle that corporate investors such as private equity firms use to gain control over physician practices. The bill vests review authority with the Maryland Health Care Commission, so that high-risk transactions will be evaluated for their impact on health care quality, safety, cost, accessibility, equity, and the public interest.

This legislation would directly target the issues raised in our study, giving Maryland the tools to prevent harmful consolidation before it occurs. And the sooner that the state expands its oversight authority, the sooner Maryland will be able to have a say over future expansions of private equity in the state's health care system.

In the face of a deepening affordability crisis and budgetary pressures, states are taking meaningful steps to address rampant consolidation, rising costs, and increased corporatization of health care markets. Other states—including Oregon, Massachusetts, and New Mexico—have enacted similar policies to strengthen and expand health care transaction oversight authority.[57] And a variety of other states are seeking to follow suit in 2026. Legislation is being considered in Colorado,[58] Hawaii,[59] Pennsylvania,[60] and Vermont[61] to require similar prior notification and review of significant health care transactions.

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[56] Hayden Rooke-Ley et al., *The Corporate Backdoor to Medicine: How MSOs Are Reshaping Physician Practices* (Milbank Memorial Fund, 2025), https://www.milbank.org/publications/the-corporate-backdoor-to-medicine-how-msos-are-reshaping-physician-practices/.

[57] Nathan Hostert, *How States Strengthened Their Health Care Markets in the 2025 Legislative Session* (Milbank Memorial Fund, 2025), https://www.milbank.org/publications/how-states-strengthened-their-health-care-markets-in-the-2025-legislative-session/.

[58] Consumer Protections Medical Care Entities, SB26-041, Colorado State Legislature, 2026 Regular Session, https://leg.colorado.gov/bills/SB26-041

[59] Relating to Health Care Market Oversight, SB NO 3175, Hawai'i State Legislature Thirty-Third Legislature 2026, https://www.capitol.hawaii.gov/session/measure_indiv.aspx?billtype=SB&billnumber=3175&year=2026.

[60] An Act Providing for Approval from the Department of Health and the Office of Attorney General before Certain Transactions Involving Health Care Entities within This Commonwealth., Senate Bill 322, Pennsylvania General Assembly 2025-2026 Regular Session, https://www.palegis.us/legislation/bills/2025/sb322.

[61] An Act Relating to Health Care Entity Transaction Oversight and Clinical Decision Making, H. 71, Vermont General Assembly (2025), https://legislature.vermont.gov/bill/status/2026/H.71.

Oregon's Health Care Market Oversight program is perhaps the closest example of what Maryland is proposing. Oregon's Office of Health Care Affordability is authorized to review and approve, disapprove, or impose conditions on a broad range of health care transactions, including those involving physician practices. Oregon has used its review process to scrutinize potentially harmful transactions and impose conditions to protect the public interest. Oregon's process is working smoothly, with the state approving 14 transactions in 2025 alone.

If enacted, HB 944 would make Maryland a national leader in health care transaction oversight and provide the state with a robust set of tools to monitor and regulate the consolidation of the health care market, including by private equity and other corporate investors. Without this action, the state would be blind to many emerging forms of corporate consolidation of its health care markets.