

Strategies to Address Corporate Consolidation in Health Care:

Ownership Transparency & the
Corporate Practice of Medicine Doctrine
in Rhode Island

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*Strategies to Address Corporate Consolidation in Health Care:
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²The 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 Murray and members of the Senate Committee on Health and Human Services, thank you for

the opportunity to provide testimony on S.2459. My name is Erin Fuse Brown, and I am a professor of health policy at the Brown University School of Public Health. As an attorney, I work with policymakers at the state and federal levels to regulate corporatization and consolidation in health care systems. As part of this work, I have worked with the National Academy for State Health Policy to develop model legislation for states to address health care consolidation and corporatization.³ S.2459, which was built off that model legislation, would ensure that the state has visibility into the financial forces at play in the health care system, while also strengthening Rhode Island’s prohibition on the corporate practice of medicine.

I. Health Care Consolidation and Its Impacts

Today, nearly 80% of physicians are employed by hospitals or other corporate entities, including private equity firms, insurance companies, retailers, and publicly traded companies.⁴ UnitedHealth Group, through its Optum subsidiary, now controls about 1 in 10 U.S. physicians.⁵ Private equity (PE) firms have acquired large numbers of physician practices, sometimes controlling 30–50% of a specialty in a single market.⁶

³ *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/>.

⁴ 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>.

⁵ 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/>.

⁶ 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>.

Evidence shows that health care consolidation results in higher costs,^{7,8,9,10,11,12,13,14,15} changes in staffing composition, reduced wages,^{16,17,18} worse or no-better outcomes,^{19,20} and reduced access^{21,22,23,24}—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

⁷ 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>.

⁸ 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>.

⁹ 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>.

¹⁰ 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>.

¹¹ 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>.

¹² 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>.

¹³ 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>.

¹⁴ 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>.

¹⁵ 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>.

¹⁶ Arnold and Whaley, “Who Pays for Health Care Costs?”

¹⁷ 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>.

¹⁸ 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>.

¹⁹ 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>.

²⁰ 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>.

²¹ 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.

²² Kannan et al., “Changes in Hospital Adverse Events and Patient Outcomes Associated With Private Equity Acquisition.”

²³ 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>.

²⁴ 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).^{25,26} 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,²⁷ and by 70% for neonatology.²⁸

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.^{29,30} There is a lack of evidence, however, that PE investment systematically improves quality of care in physician practices.³¹

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.^{32,33} Together with survey evidence of physicians' poor satisfaction and negative perceptions of private equity,³⁴ 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.

II. Ownership Transparency in a Consolidated Health Care System

Despite this dramatic shift in care delivery, the web of corporate owners, shell companies, and investors remains almost entirely opaque. Private equity firms use management services organizations (MSOs), to gain control over practices without technically owning them. As a result, patients and policymakers often have no way to identify who owns their provider. And the state cannot regulate what it cannot see.

²⁵ 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>.

²⁶ Kannan et al., "Changes in Hospital Adverse Events and Patient Outcomes Associated With Private Equity Acquisition."

²⁷ Singh et al., "Association of Private Equity Acquisition of Physician Practices With Changes in Health Care Spending and Utilization."

²⁸ 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.

²⁹ Kannan et al., "Changes in Hospital Adverse Events and Patient Outcomes Associated With Private Equity Acquisition."

³⁰ Gupta et al., *Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes*.

³¹ 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>.

³² Bruch et al., "Workforce Composition In Private Equity–Acquired Versus Non–Private Equity–Acquired Physician Practices."

³³ 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>.

³⁴ 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>.

S.2459 would change this. The bill improves transparency by requiring health care entities to disclose ownership and control structures, including relationships with investors. This is critical to understanding and overseeing the health care landscape. Other states (including Massachusetts and Indiana) have already enacted similar policies, and more states (including Minnesota and Vermont) are considering adopting similar legislation this legislative session. If enacted, S.2459 would make Rhode Island a national leader in health care ownership transparency.

III. Bolstering the Corporate Practice of Medicine Doctrine

In addition, S.2459 would strengthen the state’s restrictions surrounding the corporate practice of medicine (CPOM). CPOM laws are state-level regulations that prohibit unlicensed lay-corporations from owning or controlling medical practices, or employing physicians.³⁵ These laws stem from the prohibition on the unlicensed practice of medicine, and they aim to preserve the independent medical judgment of physicians and prevent undue corporate influence on patient care.

The use of MSOs by PE firms and other corporate investors raises concerns about compliance with CPOM laws and the professional dissatisfaction of physicians. CPOM laws generally prohibit lay-owned corporations from owning medical practices or employing physicians and require medical practices to be majority or exclusively owned by licensed professionals. The MSO structure is designed to separate clinical and business operations: a professional corporation (PC) — owned by licensed physicians — retains ownership of the medical practices, while the MSO — owned by corporate entities — can support certain non-clinical functions such as administration, billing, and revenue collection.

The concern, however, is that the MSO, if it assumes too much control over the business and administrative functions of the practice, will impede the nature and quality of clinical care delivered. A powerful MSO may begin to invert the PC-MSO relationship, effectively subordinating the PC’s physician owners to the MSO, rendering them functional employees of a corporate entity. This can easily present a clash of interests: If the MSO is singularly interested in pursuing profits, its motives may conflict with physicians’ commitment to patient care.

The structure that presents the greatest risk of this inversion of control is the “friendly” physician model. Here, the MSO installs a physician to act as the PC’s nominal owner. This arrangement enables the MSO to control the practice via the friendly physician owner, who is a licensed physician, albeit one who answers to the corporate MSO. The physician is often a direct employee of the MSO, such as its chief medical officer, who becomes licensed in states across the country and then can serve as the sole owner of all the entities’ medical practices in the state. If not a direct employee, the friendly physician can be controlled by the MSO via contracting. In either case, the MSO can construct these arrangements to effectively act as shadow owners of the practice while remaining CPOM compliant on paper.

To close the loopholes in the state’s CPOM doctrine, Rhode Island can target the ways in which MSOs threaten the autonomy of physicians. This bill would do so, by:

³⁵ Hayden Rooke-Ley, Megha Reddy, Nei Mehta, Yashaswini Singh, Erin Fuse Brown Brown. “The Corporate Backdoor to Medicine: How MSOs Are Reshaping Physician Practices.” *The Milbank Memorial Fund*. 2025. <https://www.milbank.org/publications/the-corporate-backdoor-to-medicine-how-msos-are-reshaping-physician-practices/>.

- Barring conflicts of interest in which an individual has financial interests in both a practice and its affiliated MSO;
- Banning contractual provisions that limit the autonomy of doctors, such as non-disclosure agreements, non-disparagement clauses, and stock transfer restriction agreements; and
- Requiring owners of physician practices to be active providers who are directly involved in delivering care.

It is important to note that S.2459 would *not* bar all MSOs from operating in Rhode Island or continuing to provide administrative services to practices. Nor would it prevent medical practices from obtaining investment or other capital financing in arrangements with MSOs. What it would do is limit the extent to which the MSO can control the practice's operations and clinical decisions, and restore ultimate control to licensed professionals who are authorized to practice medicine under state law.

In doing this, Rhode Island would be joining a number of other states who are addressing this issue. Oregon and California have recently enacted legislation to strengthen their CPOM laws. And a variety of other states — including Massachusetts, New York, North Carolina, Vermont, and Washington — are considering similar legislation this session.

In closing, Rhode Island has seen firsthand the dangers of corporatization and private equity in health care. You all know better than anyone how private equity nearly caused the closure of the Roger Williams and Fatima hospitals. As we are finally closing the chapter on that saga, now is a wise time for the state to consider what safeguards we should put in place to protect our health care system from future threats. If enacted, S.2459 would provide the state with a robust set of tools to monitor consolidation in the health care system and protect physician autonomy.