Coalition for Patient-Centered Care

May 27, 2025

The Honorable Abigail Slater
Assistant Attorney General
Antitrust Division,
U.S. Department of Justice
950 Pennsylvania Avenue, NW
Washington, DC 20530-0001

The Honorable Andrew Ferguson
Chairman
Federal Trade Commission
600 Pennsylvania Avenue, NW
Washington, D.C. 20580

Re: Response to Request for Information on Reducing Anticompetitive Regulatory Barriers (Docket Nos. ATR-2025-0001; FTC-2025-0028-0001)

Dear Assistant Attorney General Slater and Chairman Ferguson:

The Coalition for Patient-Centered Care (CPCC) appreciates that the Department of Justice and the Federal Trade Commission are reviewing anticompetitive state and federal laws that undermine the economic freedom and dignity of consumers, workers, and small businesses. We urge you to consider some of the laws that have allowed private equity investment in the administration of healthcare to proliferate, and the negative impacts on patient care and the wellbeing of workers— in addition to the unfair economic impacts.

CPCC represents a diverse group of healthcare industry stakeholders who stand together in opposition to private equity's acquisition and influence over independent physicians that can result in an emphasis on profits and revenue growth over patient interests. Currently, our coalition is comprised of over 13,000 physicians from all 50 states, as well as other stakeholders who share the views set forth in this statement.

Overall, our member groups face many federal and state policy issues that impact their ability to provide quality and cost-effective care to their patients. In response to this, we are committed to developing and supporting policies that serve to strengthen and defend the independent practice of medicine. In doing so, we place the highest priority on patient access, efficient treatment processes, and reduced costs.

We believe that everyone benefits when physicians have the freedom to exercise their best judgment as to the delivery of care and can work directly with their patients to make medical decisions to deliver patient-centered care. Private equity firms do not share this ideal. Their goal is to maximize investor profits. Private equity firms have been particularly active in acquiring independent physician groups. More than half of all specialists in several U.S. markets are owned by private equity firms, according to a recent study by the American Antitrust Institute, the Petris Center at the University of

Coalition for Patient-Centered Care

California, Berkeley, and the Washington Center for Equitable Growth.[1] As the New York Times summarized, the study found that "[i]n more than a quarter of local markets — in places like Tucson, Ariz.; Columbus, Ohio; and Providence, R.I. — a single private equity firm owned more than 30 percent of practices in a given specialty in 2021."[2] The article added, "[i]n 13 percent of the markets, the firms owned groups employing more than half the local specialists."[3] CPCC members' experience—consistent with independent research, public reports, and even a recent investigation by the FTC[4]—is that, after a private equity firm takes over an independent physician group there are generally adverse effects. These effects often include decreased quality of care for patients, increased cost of care and decreased employee satisfaction.

CPCC believes there are a number of both state and federal laws that create an anti-competitive atmosphere and give a disadvantage to independent medical practices, despite the fact that they provide demonstrably better quality care with better outcomes.[5] We urge you to consider supporting policy changes in these areas to ensure independent practitioners are at least on equal footing with their private equity-backed competitors.

I. Close the Carried Interest Loophole for Healthcare Entities

The carried interest loophole is one statutory incentive that promotes anticompetitive behavior by giving private equity owned healthcare a tax advantage over independently owned practices. Carried interest is a type of compensation paid to general partners of private equity investment funds.[6] Typically, general partners receive two types of compensation: 1. Management fees, tied to some percentage of the value of managed assets, and 2. Carried interest, tied to some percentage of the profits generated by those assets.[7]

[1] Richard M. Scheffler et al., *Monetizing Medicine: Private Equity and Competition in Physician Practice Markets* (July 10, 2023), https://www.antitrustinstitute.org/wp-content/uploads/2023/07/AAI-UCB-EG_Private-Equity-IPhysician-Practice-Report_FINAL.pdf.

[2] Reed Abelson & Margot Sanger-Katz, *Who Employs Your Doctor? Increasingly, a Private Equity Firm*., The New York Times (July 10, 2023), https://www.nytimes.com/2023/07/10/upshot/private-equity-doctorsoffices.html?auth=login-google1tap.

[3] *Id*.

[4] *FTC Challenges Private Equity Firm's Scheme to Suppress Competition in Anesthesiology Practices Across Texas*, Federal Trade Commission (Sept. 21, 2023), https://www.ftc.gov/news-events/news/press-releases/2023/09/ftc-challenges-private-equity-firms-scheme-suppress-competition-anesthesiology-practices-across.

[5] Anjali Bhatla et al., *Changes in Patient Care Experience After Private Equity Acquisition of US Hospitals* (Feb. 11 2023), https://pubmed.ncbi.nlm.nih.gov/39786740/.

[6] Erin C. Fuse Brown & Mark A. Hall, *Private Equity and the Corporatization of Health Care* (Mar. 2024), https://review.law.stanford.edu/wp-content/uploads/sites/3/2024/03/Fuse-Brown-Hall-76-Stan.-L.-Rev.-527.pdf.

[7] *Id*.

The "interest" refers to the share of profit which is "carried" over to the fund manager: the general partner.[8] While a management fee is taxed as ordinary income, at a top marginal rate of thirty seven percent, carried interest on assets held for more than three years is often treated as long-term capital gains, with a top rate of twenty percent (investment income may also be subject to an additional 3.8 tax).[9] And because it is taxed as capital income rather than compensation, carried interest is also not subject to the 15.3 percent self-employment tax, which is equivalent to payroll taxes paid by employees and their employers to finance Social Security and Medicare.[10] This tax provision results in a large, anti-competitive disparity between private equity owned healthcare and everyone else. It has been estimated that the carried interest loophole can cut tax obligations in half.[11] Closing the carried interest loophole would lessen the tax incentives that favor PE over independently owned healthcare and favor corporate profit over physicians' professional independence.

II. State Anti-Corporate Practice of Medicine Statutes Are Largely Ineffective

Additionally, Corporate Practice of Medicine (CPOM) statutes have largely been ineffective at protecting patients and physician autonomy, again exacerbating a distinctly uneven playing field. For example, California-- which is widely considered to have one of the strongest CPOM laws in the country-- has seen acquisitions of outpatient providers increase from two in 2005 to seventy in 2022 and private equity firms currently own twenty-two hospitals in California.[12]

Currently, thirty-three states have enacted CPOM laws to prohibit corporations (or other non-physician entities) from practicing medicine or employing practicing physicians. The primary goal of these laws is to ensure that medical decisions are made by a doctor or other healthcare provider and their patient and not influenced by corporate interests. However, through alternative business structures, most of these laws have not been effective.

More specifically, there has a been rise in the ownership structure that are often referred to as "PC-Friendly" or "MSO-PC" models. They are typically structured as a Management Services Organization (MSO) that is backed by a private equity fund or other non-clinical investor or lender which provides administrative support, and a physician-owned Professional Corporation (PC) that handles the clinical

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[8] *Id*.

[9] The Peter G. Peterson Foundation, *What is the Carried Interest Loophole and Why Is It So Hard to Close?* (September 11, 2024), https://www.pgpf.org/article/what-is-the-carried-interest-loophole-and-why-is-it-so-difficult-to-close/.

[10] Americans for Financial Reform, *Close the carried interest loophole that is a tax dodge for super-rich private equity executives* (October, 2021), https://ourfinancialsecurity.org/2021/10/close-the-carried-interest-loophole-that-is-a-tax-dodge-for-super-rich-private-equity-executives/.

[11] *Id*.

[12] Christopher Cai & Zirui Song, *Private Equity in Healthcare: Prevalence, Impact, and Policy Options for California and the US* (May 2024), https://www.chcf.org/wp-content/uploads/2024/05/PrivateEquityPrevalenceImpactPolicy.pdf.

Coalition for Patient-Centered Care

decisions.[13] In the PC-Friendly Model, PE installs a physician to act as the PC's nominal owner.[14] 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.[15] The physician is often a direct employee of the MSO, such as its chief medical officer, and becomes licensed in states across the country and then can serve as the sole owner of all the entities' medical practices in the state.[16] If not a direct employee, the friendly physician can be controlled by the MSO via contracting.[17]

Despite the theoretical separation between the MSO and the clinical decision making, the PC-Friendly model has been found to inject a level of corporate control of medical decision making that is harmful. For example, the PE managers typically mandate cost-cutting measures that can adversely affect the quality of care, such as replacing highly qualified workers with lower paid staff and reducing operational costs.[18] PE managers also often place intense pressure on physicians "to perform more profitable procedures or to shift the business focus from a less profitable practice to a more profitable practice."[19]

PE firms operating under the PC-Friendly model also produce financial harm by engaging in consolidation strategies to dominate markets, thereby increasing their pricing power and leveraging acquired companies for further growth.[20] These practices can lead to increased market concentration, higher prices, and potentially lower quality of care.[21] CPCC believes CPOM laws should be strengthened so that they in fact limit corporate influence on medical decision making.

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[13] Hayden Rooke-Ley et al., *The Corporate Backdoor to Medicine: How MSOs Are Reshaping Physician Practices* (Apr. 28, 2025), https://www.milbank.org/publications/the-corporate-backdoor-to-medicine-how-msos-are-reshaping-physician-practices/.

[14] *Id*.

[15] *Id*.

[16] *Id*.

[17] *Id*.

[18] Joseph Dov Bruch et al., *Workforce Composition In Private Equity-Acquired Versus Non-Private Equity-Acquired Physician Practices* (Jan. 2023), https://pubmed.ncbi.nlm.nih.gov/36623222/.

[19] Richard M. Scheffler et al., *Monetizing Medicine : Private Equity And Competition In Physician Practice Markets* (July 10, 2023), https://www.antitrustinstitute.org/wp-content/uploads/2023/07/AAI-UCB-EG_Private-Equity-I-Physician-Practice-Report_FINAL.pdf.

[20] Alexander Borsa et al., *Evaluating Trends In Private Equity Ownership And Impacts On Health Outcomes, Costs, And Quality: Systematic Review* (July 19, 2023), https://pubmed.ncbi.nlm.nih.gov/37468157/.

[21] *Id*.

Coalition for Patient-Centered Care

III. More Transparency in Private Equity Owned Healthcare Will Enable Better Decision Making

PE firms often create intricate webs of subsidiaries and partnerships to own and manage acquired healthcare entities.[22] This makes it difficult to trace the ultimate ownership and financial relationships or pinpoint responsibility for potential issues or to assess the true financial health of the organization.[23] In addition, both the Securities and Exchange Commission and the Federal Trade Commission have relatively high thresholds for deal scrutiny that private equity is often able to avoid.[24] They also use a number of other creative tactics to keep their ownership structure and financial information opaque. Meanwhile truly physician-owned healthcare entities, for a variety of reasons, are much more publicly accountable. Practicing physicians have medical and ethical obligations that require them to be transparent about ownership and financial information. They also must disclose information under the Corporate Transparency Act and other state laws. They are not able to hide behind a maze of entities. This disparity in transparency allows PE backed healthcare to operate with high debt levels, outsized executive compensation and dubious financial health while starving patient care. Independent practices are far less likely to operate in that way because they are subject to far more disclosure. This is just another way the playing field is uneven in favor of PE and against independent physicians and their patients. Both types of practices should be required to disclosure certain ownership and financial information. We recommend that both the FTC and the SEC review and revise their disclosure requirements specifically for health and private equities issues and revise them accordingly.

IV. Conclusion

CPCC commends DOJ and the FTC for critically examining anticompetitive regulatory barriers. We believe one of the most critical areas in need of reform is private equity- backed healthcare. CPCC is eager to continue this conversation and would be pleased to serve as a resource. Please do not hesitate to contact us.

Sincerely,

Stephen McCollam

Stephen M. McCollam, MD
Chair of the Coalition for Patient-Centered Care

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[22] *Id*.

[23] *Id*.

[24] *See* supra note 1.