H.583: AN ACT RELATING TO HEALTH CARE FINANCIAL TRANSACTIONS AND CLINICAL DECISION MAKING

The Office of the Health Care Advocate (HCA)

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VERMONT LEGAL AID
WORKING TOGETHER FOR JUSTICE

AGENDA

- Background:
  - What is private equity?
  - What is the corporate practice of medicine?
  - Recent research
- Why Do We Need This Bill?
- What Does the Bill Actually Do?
- Addressing Misconceptions & Critiques
- Provider Stories
- Recommendations & Next Steps

FROM LEVERAGED BUYOUTS & JUNK BONDS TO "PRIVATE EQUITY"

- In the 1980s, some private investment firms began raising low-grade "junk bonds" to lend to companies to take a publicly-traded company private. This is the origin of what is now commonly known as a "leveraged buyout".
- This led to the "junk bond" craze, which gave leveraged buyouts a bad name, as did its "king", Michael Milken
- Milken spent two years in prison for securities fraud before being pardoned by President Trump in 2020.
- After widespread public backlash and moral outrage, there was a concerted effort to rebrand from "leveraged buyout" to "private equity"

WHAT IS A LEVERAGED BUYOUT IN HEALTHCARE?

- What makes leveraged buyouts unique: the debt is assumed by the *acquired entity (ex. hospital, clinic)*, *not* the purchaser (PE firm)
- What this does is loads debt onto the **targets** balance sheet, **not** the PE firm's
- What this means is the clinic or hospital or provider often goes bankrupt or is stripped of major assets, forcing closure of services, etc.

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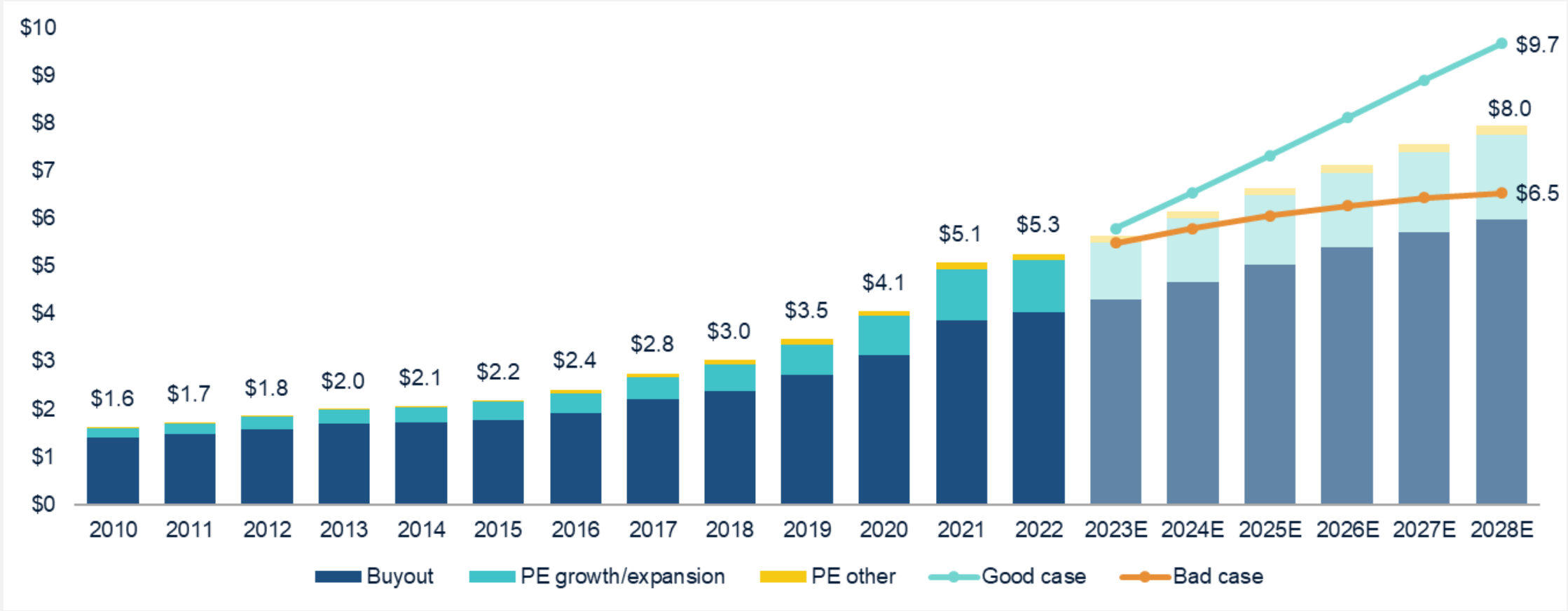
The purpose of the dealmaking is to enrich the owners as quickly as possible, and then get out and move on to your next conquest.

– John McDonough, Harvard T.H. Chan School of Public Health

WHAT IS THE CORPORATE PRACTICE OF MEDICINE DOCTRINE?

- The Corporate Practice of Medicine (CPOM) doctrine is a legal principle that aims to **prohibit** standard business corporations and non-physician entities from the following:
  - owning or controlling medical practices and employing providers
  - controlling or influencing medical decisions by providers
  - controlling the patient-physician relationship
  - restricting provider rights and autonomy, including but not limited to non-competes and non-disclosure agreements
  - Attempts to prevent medical decisions from being controlled by profit-motive

CORPORATIZATION & PRIVATIZATION OF HEALTHCARE IS RAPIDLY ACCELERATING



KNOWN PRIVATE EQUITY ACTIVITY IN VERMONT

- Nursing Homes: ~25% are owned or controlled by PE firms
- New England Collaborative Health Network: Contract with Ovation (PE Owned Firm)
  - Brattleboro, Springfield, Copley, Northwestern, Grace Cottage, Gifford, and several other community providers are members
- Medicare Only Accountable Care Organizations
  - Contracts with PE firms, scope and scale unknown due to lack of reporting and oversight requirements for investments & contracts with PE firms
- Independent Provider Contracts
  - Scope and scale unknown due to lack of reporting and oversight requirements for investments & contracts with PE firms

RECENT RESEARCH ON PRIVATE EQUITY IMPACT ON COSTS & HEALTH OUTCOMES

- A systematic literature review of studies between 2000 and 2023 found that private equity ownership of U.S providers increased health care costs to patients and payers in 9 of 12 cases—and decreased costs in none.

- MIT Sloan School of Management found that negotiated prices between hospitals and insurers increased 32 percent after private equity investment.

- Nearly 90 percent of the health care entities in the United States that Moody's Investors Service rated as having a high risk of default were owned by private equity firms.

RECENT RESEARCH ON PRIVATE EQUITY IMPACT ON COSTS & HEALTH OUTCOMES

- A 2023 evaluation of hospital quality and outcomes found private equity ownership to be associated with a 25% increase in hospital-acquired conditions, such as falls and central line-associated infections
- Patient harms can translate into lives lost: A 2021 study from the National Bureau of Economic Research found the 90-day mortality rate for Medicare patients was 10 percent higher for private equity-owned nursing homes than for skilled nursing facilities overall.
- A 2020 report calculated approximately 21,000 lives lost over 12 years due to private equity ownership of nursing homes

	Impacts			
	Health outcomes	Costs to patients or payers	Costs to operator	Quality
Borsa and Bruch 2022[36]	Neutral			Neutral
Bos and Harrington 2017[37]				Harmful
Bos et al 2020[38]				Harmful
Braun et al 2021[39]		Harmful		
Braun et al 2021[60]	Harmful	Harmful		Neutral
Braun et al 2020[40]	Harmful			Mixed
Broms et al 2023[61]				Harmful
Bruch et al 2023[62]				Harmful
Bruch et al 2022[63]	Neutral	Neutral		
Bruch et al 2021[41]		Neutral		Harmful
Bruch et al 2020[42]		Harmful		Beneficial
Cerullo et al 2022[43]			Beneficial	Harmful
Cerullo et al 2022[44]	Beneficial	Neutral		Neutral
Cerullo et al 2021[45]				Mixed
Creadore et al 2021[46]				Beneficial
Gandhi et al 2020[22]				Mixed
Gandhi et al 2020[47]	Beneficial			Beneficial
Gupta et al 2021[48]	Harmful	Harmful	Harmful	Harmful
Harrington et al 2012[49]				Harmful
Huang and Bowblis 2019[50]				Mixed
La Forgia et al 2022[51]		Harmful		
La France et al 2021[52]				Harmful
Liu 2021[53]	Neutral	Harmful	Beneficial	Mixed
Nie et al 2022[66]		Harmful		Harmful
Nie et al 2022[54]				Mixed
Offodile et al 2021[55]		Harmful	Beneficial	Harmful
Patwardhan et al 2022[64]				Harmful
Pradhan et al 2014[56]				Mixed
Pradhan et al 2013[57]			Harmful	
Singh et al 2022[65]		Harmful		
Stevenson and Grabowski 2008[58]				Mixed
Winblad et al 2017[59]				Mixed

COMMON THEMES OF PRIVATE EQUITY DISASTERS IN HEALTHCARE

- **Debt Loading:** PE firms add significant debt to hospitals, extracting value through fees and dividends.

- **Asset Stripping:** Selling hospital real estate (sale-leasebacks) to related entities, creating massive rent obligations.

- **Service Cuts & Quality Decline:** Cost-cutting leads to understaffing, reduced services, and higher patient risk.

- **Bankruptcy & Abandonment:** Firms exit, leaving struggling facilities that often close or require state intervention.

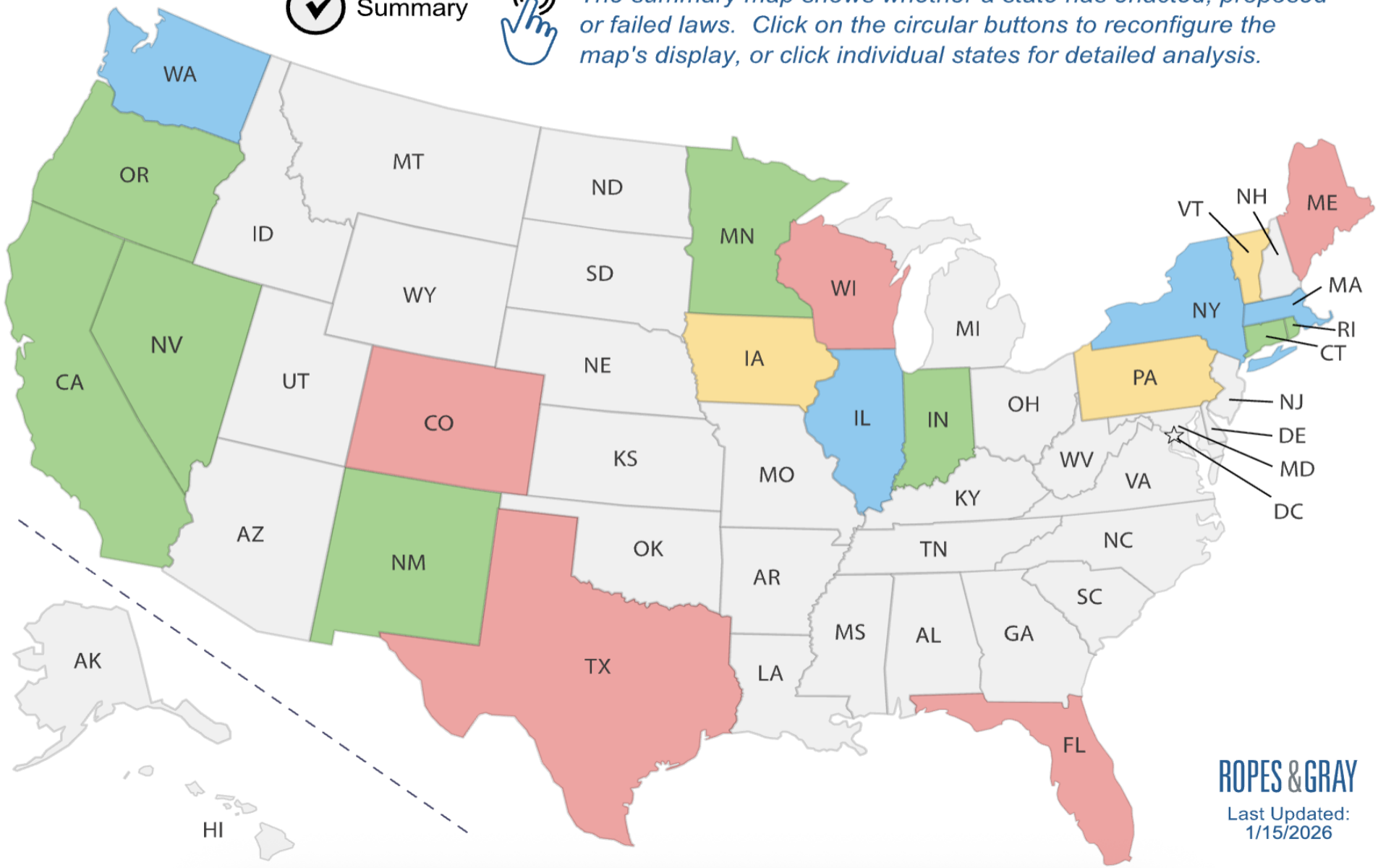
WHY DO WE NEED THIS BILL NOW?

- **California:** Passed 2 PE regulation and transaction laws last session
- **Oregon:** Passed PE regulation and transaction law last session
- **Steward Healthcare in Massachusetts: Led to PE regulation bill passing last session**
  - Sold hospital real estate for quick cash, leaving hospitals with massive rent (leasebacks) and debt, leading to closures (Carney, Nashoba), staffing cuts, and unsafe conditions, ultimately filing for bankruptcy
- **Prospect Medical Holdings in Connecticut: PE regulation bill pending this session**
  - Debt-fueled growth led to increased liabilities, service cuts, and eventual bankruptcy, with investigations alleging asset stripping and quality decline
- **Hahnemann University Hospital in Pennslyvania: PE regulation bill pending this session**
  - Acquisition loaded hospital with debt, leading to service cuts and eventual closure. A chaotic closure process that saw the cutting of vital trauma and surgical services.

LAWS Enacted Laws | Enacted & Proposed Laws | Proposed Laws | Failed Laws

Summary

The summary map shows whether a state has enacted, proposed or failed laws. Click on the circular buttons to reconfigure the map's display, or click individual states for detailed analysis.

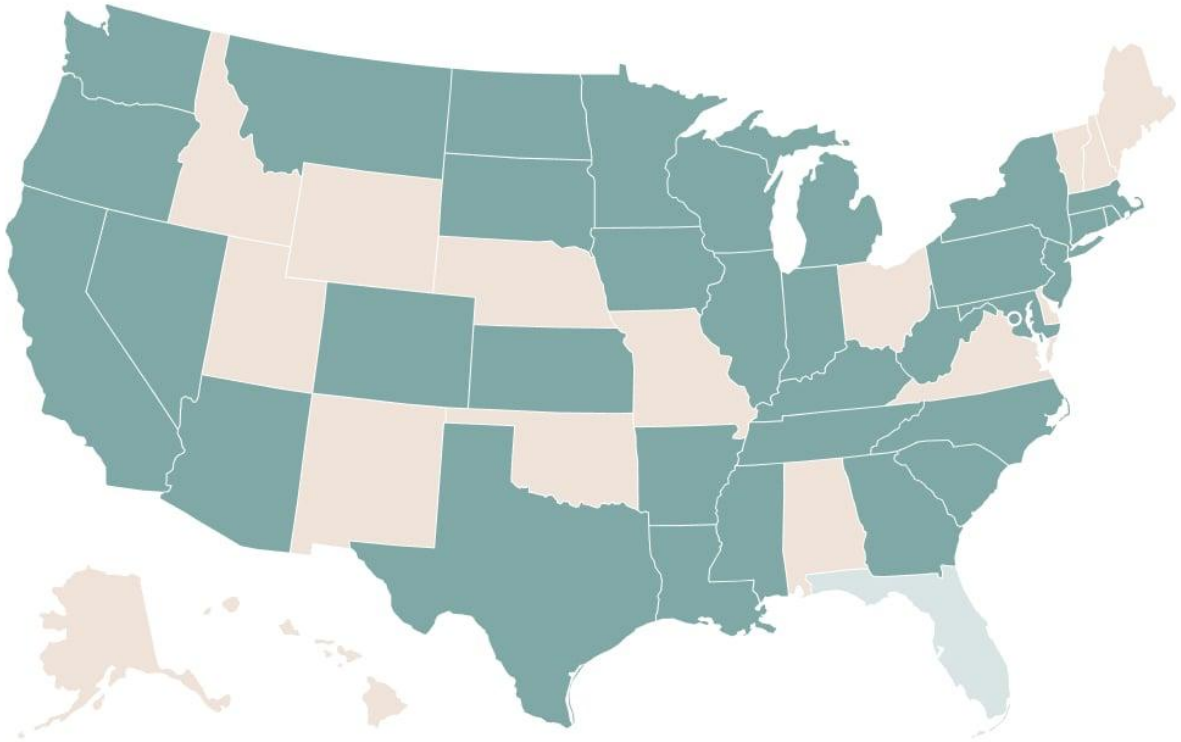


ROPES & GRAY

Last Updated: 1/15/2026

CPOM States and Non-CPOM States: A Guide by **Permit**

Permit Health's guide to prohibitions on the corporate practice of medicine (CPOM)



CPOM STATE

The state prohibits the corporate practice of medicine.

NON-CPOM STATE

There's not a ban on the corporate practice of medicine.

IT'S COMPLICATED

While there's not a formal CPOM ban, other restrictions can apply.

WHAT ARE THE GOALS OF H.583?

- Protect health care providers and patients from corporate control
- Prevent further declines in health outcomes and care quality
- Prevent cuts to essential services and care deserts
- Establish "rules of the road" for private equity investment in Vermont
  - Require PE firms and provider partners to demonstrate investment is "good" through transparent disclosure
  - Prohibit "bad" PE investment

WHAT DOES THE BILL DO?
PLAIN LANGUAGE

1. Corporations/PE firms cannot own medical practices or essential providers in VT.
2. Corporations/PE firms cannot control provider decision-making.
3. Corporations/PE firms cannot require providers to sign non-compete agreements (NCAs).
4. Corporations/PE firms cannot require providers to sign non-disclosure agreements (NDA)s.
5. Corporations/PE firms cannot take over control of a hospital or community provider (FQHC).
6. Corporations/PE firms cannot extract money from a hospital or community provider using debt that becomes an obligation of the provider.
7. Corporations/PE firms cannot pay themselves bonuses using money from provider transactions.
8. Corporations/PE firms cannot restrict providers from seeing patients because of what insurance they have.
9. Corporations/PE firms cannot form shell companies to extract money from hospital or community providers.

ADDRESSING MISCONCEPTIONS & CRITIQUES

SHOULDN'T THIS ISSUE BE DEALT WITH FEDERALLY?

- Many private equity transactions are not subject to government antitrust oversight because the value of the deals falls under the threshold for premerger review, which is $133.9 million.

- The federal government has taken a number of steps in recent years to investigate the impact of private equity in health care, including through congressional hearings and investigations scrutinizing private equity ownership of health care institutions.

- Because private equity funds do not have to comply with the same rules that public companies and investment funds do, the industry remains largely opaque unless there are clear reporting and disclosure requirements.

ISN'T PRIVATE EQUITY BASICALLY THE SAME AS OTHER FORMS OF INVESTMENT?

- Private equity is very different from other forms of investment, such as bank loans, foundation grants, venture capital / angel investing
- Private equity firms often employ a tactic called "leveraged buyouts" which is rare outside the industry
  - Private equity (PE) firms move debt onto targets primarily through Leveraged Buyouts (LBOs) by using the target company's own assets and cash flow as collateral to secure massive loans for the acquisition
  - What this does is loads debt onto the **targets** balance sheet, **not the PE firm's**
- Unlike other investing approaches, private equity often has a stated financial obligation to its shareholders to deliver returns with 3-5 years
- Not all PE firms use leveraged buyouts in their business model

Investment Type	Typical Duration of Investment	Impact to Patients & Providers
Private Equity leveraged buyouts	3-5 years maximum before selling asset, often resulting in bankruptcy or closure of practice or hospital	**Negative**: worse health outcomes, higher prices, cuts to essential services, control of provider decision-making, unsafe staffing levels
Capital Link non-profit foundations corporate giving Some venture and angel capital Management consultants	Long-term	**Positive:** measurable positive impacts like expanded patient care, cost savings for the system, and community economic growth, as seen in projects that boost uninsured/Medicaid visits and create local jobs
State and local investments	Long-term	**Positive:** retain staff and independence

PRIVATE EQUITY CAN'T MAKE MONEY HERE, WE HAVE NOTHING TO FEAR

- PE firms are especially adept at identifying assets within a struggling health care provider or hospital and then extracting profit from it, leaving the provider left just as a "husk"

WAS THIS BILL LANGUAGE PULLED FROM THIN AIR?

- The HCA worked directly the following experts (and others) in developing this bill:

1. Maureen Hensley-Quinn, National Association for State Health Policy: provided advice and model language in collaboration with Brown University (ex. Erin Fuse Brown, Dr. Singh)
2. Zirui Song, Harvard Medical School: Provided technical advice and research
3. Nancy Kane, Harvard School of Public Health & Chair of Finance Board at Umass Hospital: provided technical advice and language
4. John McDonough, Harvard School of Public Health & architect of Massachusetts health insurance mandate: provided technical advice
5. Private Equity Stakeholder Project: national non-profit subject matter expert, provided technical advice

H.583 WILL "KILL" OR "CHILL" INVESTMENT THAT IS NEEDED IN VERMONT

- The bill does not ban private equity firms from operating in Vermont
- The bill does not ban the use of debt to finance a health care transaction in Vermont
- There are many other less extractive and destructive ways to invest in Vermont healthcare providers and Vermont's health care system.
- "Good" investors are willing to follow public disclosure rules like other publicly traded companies
- "Good" investors have business plans that involve mutual benefits
- "Good" investors make long-term, non-extractive commitment to Vermont providers and patients

AREN'T SOME PE FIRMS "GOOD"?

- There are examples of arguably beneficial transactions that involve PE firms in healthcare, such as joint ventures
- We are not aware of any "good" investors / PE firms that insist on needing to use a leveraged buyout or refuse to take Medicaid patients to make money.
- Not all PE firms use leveraged buyouts
- Many business leaders believe leveraged buyouts should be strictly regulated or illegal

DON'T WE NEED PE FIRMS TO KEEP OUR SYSTEM SOLVENT, INNOVATIVE, AND EFFICIENT LONG-TERM?

- **Vermont providers and patients need sustained, committed, and non-extractive investment in our health care system.**

- PE very often is concerned with **short-term** return.
- A recent analysis of 807 acquisitions, over half (51.6%) of PE-acquired practices underwent an exit within 3 years of initial investment.
- In nearly all instances (97.8%), PE firms exited investments through secondary buyouts, where physician practices were resold to other PE firms with larger investment funds.
- PE firms do not have a monopoly on innovation or efficiency – there are many other sources for this type of advice and guidance that do not involve PE firms

BUSINESS LEADER OPPOSITION TO PRIVATE EQUITY LEVERAGED BUYOUTS

"I've seen more people fail because of liquor and leverage — leverage being borrowed money.

It is not as good as it looks."

– Warren Buffett

"All they are doing is lying a little bit to make the money come in."

-Charles Munger

DON'T WE ALREADY HAVE LAWS THAT KEEP US SAFE?

- Vermont has no explicit corporate practice of medicine doctrine or laws. We are one of a unique group of only 13 states without one.

- No common extractive activities of PE firms – which are widely considered to be detrimental to health outcomes and the financial health of providers - are defined or prohibited in current VT law, nor are they explicitly regulated by the GMCB.

- Many of the types of financial transactions used by PE firms to exert control and/or extract profit from hospitals are actually *explicitly exempt* from review under VT law.

- *The Commonwealth Fund and Ropes Gray also regularly review new proposed legislation and existing statutes in this area. They independently concluded that Vermont effectively does not directly regulate private equity transactions in healthcare.*

DOESN'T CON COVER THIS?

- GMCB CON is designed as a process primarily to review, modify, approve, or deny new projects, it does not address material change transactions.
- GMCB CON review does not apply to nursing homes, which are governed by a separate state review process led by AHS that uses different criteria.
- GMCB CON conditions expire after final implementation reports are submitted.
- Current VT law does not explicitly prevent a hospital that currently offers home health services from injecting private equity financing into these existing services and significantly altering or reducing those services. Such changes would not require a CON review.

CAN'T WE JUST PASS A CORPORATE PRACTICE OF MEDICINE BILL?

- Passing a CPOM bill without any reporting or oversight requirements would not go far enough to prevent harmful business practices in Vermont
- It is very difficult to enforce potential violations without some level of information from PE firms and the providers they contract
- California did pass a CPOM bill last session with strong provisions
- California also had a strong enforcement authority with clear oversight authority and passed a bill last session to strengthen it.

- Vermont does not (yet) have sufficient enforcement and oversight authority in this area.

CAN'T WE JUST PASS A CORPORATE PRACTICE OF MEDICINE BILL?

- Many states that *only* have CPOM language (33) failed to deter some of the worst PE activities
- Many of these states passed or are proposing new legislation similar to ours to require reporting and transparency and prohibit certain types of harmful transactions
- You cannot regulate or control something when you have limited information about it.
- Our bill attempts to address only the most harmful PE practices that have no evidence of value to patients and providers at the root.

WHAT CHANGED FROM H.71?

- Significant reduction in administrative burden for regulators and providers
  - Cut the bill down from 45 pages to 26 pages
- Kept prohibited transactions
- Kept corporate practice of medicine doctrine
- Reduced workload of GMCB
- Shifted enforcement to Attorney General

PROVIDER PERSPECTIVES: JAMA SURVEY OF PROVIDERS

- Most respondents [60.8%] viewed PE involvement in health care negatively. Only (10.5%) viewed it as positive or somewhat positive.
- The majority of providers viewed PE ownership as worse or much worse compared with independent ownership.
- Respondents viewed PE most unfavorably as it pertained to physician well-being (303 [57.7%]), health care prices or spending (299 [57.0%]), and health equity (269 [51.2%])
- Compared with the non-PE–employed group, PE-employed physicians were less likely to report high professional satisfaction ([44.8%] vs [74.4%] extremely or somewhat satisfied) and autonomy ([48.3%] vs 329 [66.3%]) compared with non-PE physicians
- Fewer physicians at PE employed groups reported being extremely likely or somewhat likely to remain with their employer (13 [44.8%] vs 386 [77.8%]).

PROVIDER GROUPS EXPRESSING CONCERNS ABOUT PRIVATE EQUITY NEGATIVE IMPACT IN HEALTHCARE

- American Medical Association
- American Academy of Pediatrics
- American Nursing Association
- Physicians for a National Health Program
- American College of Physicians
- American Academy of Emergency Medicine
- AFL-CIO
- Take Medicine Back
- Oregon Medical Association
- California Medical Association
- Many others

STORIES FROM PROVIDERS AT PE OWNED FACILITIES

- **"We don't have enough staff. We don't have enough equipment. We are fighting every day to give good quality care to patients and we are not able to do it."** *— Nurse testifying to the U.S. Senate regarding Prospect Medical Holdings*

- **"We went from a cohesive, well run unit to one plagued with management cuts, intrusiveness by management and an attitude of 'if you don't like it, don't let the door hit you on the way out!'"** *— Connie Botke, retired critical care nurse*

- **"What we saw was a warzone, for the last 20 months, and it's not over. And we have not gotten support."** *— Nurse testifying regarding conditions in a PE-owned hospital*

PROVIDER STORIES

- **“It is not just Steward, private equity or other types of for-profit providers that need to be held accountable. Our state and federal agencies that are charged with regulating and ensuring the safety of our health care providers and facilities. It is our hope that this crisis can serve as a wake up call to all levels of government and to the public that the danger to our public health from the influence of the profit motive into health care is significant and that we all must do our part to change the system to protect our most valuable resource – the health and well being of all who live in this great nation.”**
- *— Ellen MacInnis, RN at Steward, Testifying to U.S. Senate HELP Committee*

RECOMMENDATIONS

- Attempt to find compromise on corporate practice of medicine doctrine language with VT provider groups
- Add nursing facilities to section 9532(b) clarify that the bill would not prohibit nursing homes from hiring physicians unless the nursing home is majority owned by physicians.
- Eliminate fine limits in section 9547(b) for maximum deterrent effect
- Expand language from physicians to include other licensees and provider owners (ex. ARPNs) to CPOM
- Consider removing GMCB requirement to do an analysis given resource and staff constraints
- Add prohibition on "Health care leaseback agreements" to leveraged buyouts language for clarity. Sale-leasebacks are transactions whereby a person sells, transfers, leases or otherwise encumbers a material amount of the assets or real property of a health care entity and enters into an agreement with another person to lease back the same assets or real property, often done through a real estate investment trust (REIT).

NEXT STEPS:
HCA POSITIONS ON KEY SECTIONS

- **Prohibited Activities**:
  - Open to adding more prohibitions (sale leaseback) and clarifying language
  - Closed to removing any prohibitions
- **Reporting Requirements:**
  - Open to changes and suggested language to address concerns and clarify intent.
  - Closed to significant or wholesale removal of reporting and transparency requirements
- **Corporate Practice of Medicine Language**:
  - Open to changes and additions to address concerns and clarify intent

RESOURCES

- https://pestakeholder.org/news/states-move-to-rein-in-pe-control-of-healthcare/
- https://www.ropesgray.com/en/sites/healthcare-transactions-laws
- https://nashp.org/new-model-legislation-on-corporatization-of-health-care-consolidation-and-closures/
- https://stateline.org/2025/11/21/new-state-laws-tackle-private-equitys-growing-role-in-health-care/
- https://www.healthaffairs.org/do/10.1377/hp20250220.753312/