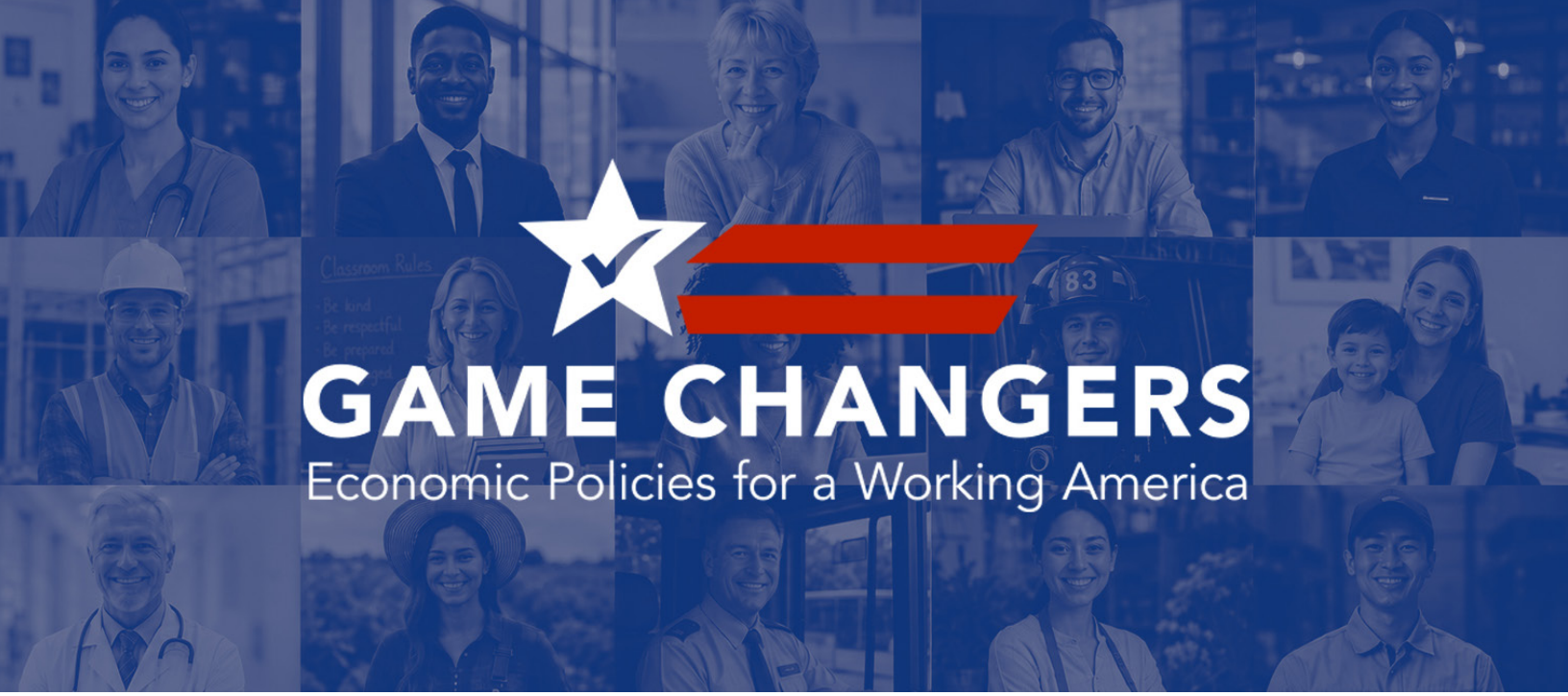

BACKGROUND PAPER / JULY 2026

End Profiteering in Healthcare

BY EILEEN APPELBAUM, ROSEMARY BATT,
AND BRANDON NOVICK

POLITICAL ECONOMY RESEARCH INSTITUTE
PERI
University of Massachusetts Amherst

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By Eileen Appelbaum, Rosemary Batt, and Brandon Novick

Executive Summary

Financialization in healthcare refers to the growth of financial actors, strategies, and calculations in healthcare organizations.[1] This policy paper focuses on the Wall Street owners and healthcare corporations that extract excessive wealth from healthcare services – profiteering at the expense of patients, communities, and taxpayers. It complements the Game Changer policies that support the provision of universal health insurance and those that identify policies to improve the care economy and the healthcare labor market.

The financialization of healthcare services began with the federal government's explicit efforts to expand the market for healthcare under the 1965 Medicare and Medicaid amendments to the Social Security Act. Since then, the expansion of for-profit activities in healthcare has increased and healthcare has become a market for profiteering in which activities that generate higher returns for investors and shareholders do not improve the quantity or quality of patient care. The financial mission increasingly dominates the healthcare mission.

The 1965 Medicare and Medicaid Acts provided health insurance coverage to millions of Americans for the first time – making it an historic expansion of social welfare policy. But it had a critical flaw: It provided millions in government funding to expand the 'market for healthcare' under the assumption that this would improve efficiency and quality. It didn't. Healthcare markets expanded dramatically through large taxpayer subsidies – hardly a classic market that rewards entrepreneurial risk-taking. And healthcare organizations do not function in standard markets as patients are particularly vulnerable to

[1] This policy paper is based on research from the forthcoming book, Rosemary Batt and Eileen Appelbaum, *Healthcare in the Age of Finance Capital: Public Funds for Private Gain* (Princeton University Press, 2026).

asymmetric information and even government and third-party payers don't know what the ultimate cost of care will be.

Subsequent reforms to health policy, lax enforcement of healthcare standards, and the liberalization of tax, antitrust, and labor laws laid the foundation for the financialization of healthcare in the U.S. Medicare threw nonprofit and for-profit hospitals on the financial markets to raise funds for infrastructure investments. The rise of large investor-owned health corporations changed the competitive landscape. Nonprofit hospitals shifted attention from their healthcare mission and charity care to financial decisions to boost the bottom line and qualify for loans for construction and modernization. Hospitals gobbled up each other to form large consolidated systems and expand market power, driving up prices. They incorporated physicians' groups into vertically integrated systems to increase patient referrals and control costs. New corporate hierarchies of administrators undermined physician autonomy and shifted the distribution of earnings from healthcare professionals and workers to highly paid CEOs and CFOs. Investor-owned corporations also laid the foundations for private equity (PE) leveraged buyouts in nursing homes, hospitals, and by the 2010s, across all healthcare segments. In parallel with the rise of health system monopolies, pharmaceutical conglomerates emerged under the protection of patent laws that encouraged monopoly pricing of needed medications.

From the healthcare mission to profits to profiteering – federal health policies coupled with financial deregulation have facilitated and encouraged the financialization of healthcare with serious negative consequences. It's time to reclaim healthcare for all.

Financial actors are chameleons: If one form of profiteering is outlawed, they will move their extractive strategies into a new type of organization. The task is to change existing incentives that lead financial actors to raise costs, reduce quality, limit access to care, and undermine the ability of healthcare workers to provide care that is consistent with their ethical commitments and licensing requirements.

In this policy paper, we identify seven major areas in which financial actors and industry practitioners have exploited federal laws and regulations for private gain at the expense of patients, taxpayers, workers, and communities. We analyze practices that facilitate profiteering and the game changing policies needed to restore the healthcare mission.

1. **Public Financing of Healthcare Infrastructure**. End healthcare organizations' dependence on financial markets for funding new construction and modernization. Replace it with public financing of health infrastructure that benefits all healthcare organizations -- regardless of their creditworthiness -- and enables them to prioritize the quality of patient care for all.

2. **Hold Tax-exempt Hospitals Responsible for Indigent Care and Prohibit Self-enrichment.** Make nonprofit hospitals' tax-exempt status conditional on a mandated percent of total operating expenses spent on poor patients. Enforce the prohibition against self-enrichment.

3. **Hold Financiers Responsible for Bankruptcy Debts.** Change bankruptcy rules so that every entity with a financial interest in a company – including private equity firms and Real Estate Investment Trusts (REITs) – is jointly responsible for repaying any debt the company acquires. This would mitigate excessive use of debt.

4. **Take Labor Out of Competition.** Set specific minimum staffing levels for all hospitals and nursing homes. To support these standards, increase funding for Medicare and Medicaid and federally funded education and training programs. Minimum staffing standards will limit the ability of

employers to compete on the basis of low-cost labor. Publicly funded education will build a new generation of skilled workers needed to fill the current and future shortages across all nursing occupations.

5. **Break up Large Consolidated Hospital Chains in Concentrated Markets.** Horizontal concentration undermines competition in local health markets, leads to monopoly rents and higher prices, and reduces consumer choice. Antitrust regulators should break up companies with excessive market share to relieve upward pressure on prices and give patients greater choice.

6. **Break up Vertically Integrated Conglomerates.** Break up large, vertically integrated health conglomerates that own companies that provide services to the patients they serve or provide services to each other. These structures facilitate self-dealing and monopoly pricing.

7. **End Patent Monopolies for Medical Products**. Patent protections for prescription drugs, medical devices, and other medical products create exorbitant prices of these patient care essentials. Monopoly pricing incentivizes secrecy and illegal activity. Replace patents with government funding of research via competitive bidding and prize funds, then price medicines/devices as generics.

Public Financing of Healthcare Infrastructure: End Hospitals' Dependence on Financial Markets

In 1946, Congress passed the Hospital Survey and Construction Act, known as the Hill-Burton Act, to provide loans and grants for construction of nonprofit hospital and health facilities. Facilities that received the funds were required to care for patients unable to pay and to provide services to those who lived in its area. In the following decades, hospitals were built in small towns and rural areas across the U.S., many in the South. Direct federal funding of construction of hospitals and facilities declined rapidly after Medicare was implemented, nearly vanishing by 1974 and finally ending in 1997. By that time, the Hill-Burton Act had partly financed about 6,800 facilities in 4,000 communities, including hospitals, clinics, rehabilitation centers, and long-term care facilities.[2] A major problem with Hill-Burton is that it reinforced the structural racism of the period by paying for hospital constructions for segregated Black and White hospitals.

Medicare changed the funding of construction and modernization of hospitals and health facilities. In the early decades, the Centers for Medicare and Medicaid Services (CMS) reimbursed both nonprofit and, for the first time, for-profit hospitals for the operating costs of caring for patients. It subsidized investment in plant and equipment by paying for interest and depreciation costs (what economists call capital costs) related to hospitals past infrastructure investments and by an add-on equal to 2 percent of operating expenses for capital improvements. But CMS did not pay for the actual costs of construction or modernization of plant and equipment. Under Medicare, hospitals had to borrow in financial markets to finance these investments – a major change for nonprofit hospitals' costs.

Bigger and better resourced hospitals were able to benefit from this subsidy, which allowed them to obtain financing for construction and modernization in financial markets; and as they had higher capital

[2] Lawrence J. Clark et al., "The Impact of Hill-Burton: An Analysis of Hospital Bed and Physician Distribution in the United States, 1950-1970," *Medical Care* 18, no. 5 (1980): 532–50, http://www.jstor.org/stable/3763902; Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (New York: Basic Books, 1989), https://hdl.handle.net/2027/heb05752.0001.001, Downloaded on behalf of Cornell University.

costs and operating expenses, they received a bigger subsidy. Subsidies for mid-sized hospitals proved adequate. But smaller or poorer hospitals in inner cities and rural areas were especially hard hit by this change. They had low capital costs and low operating expenses, which meant they received a subsidy from CMS too small to facilitate their access to financial markets and to debt financing.

Debt financing became a major source of funds for investment in hospital infrastructure, and it increased rapidly; public funding and private philanthropy decreased dramatically. Less than 10 years after the introduction of Medicare, in 1974, tax-exempt bonds issued by nonprofit hospitals – a major source of borrowing – accounted for a quarter of spending on hospital construction.[3] Raising funds in financial markets reinforced disparities among nonprofit hospitals in the quality of their physical assets.[4] An inclusive healthcare system, in which all hospitals have access to funds to improve their physical plant and upgrade their technology, is not possible if the funds must be obtained in private financial markets.

The need for a high credit score to finance construction introduced the calculus of profit maximization into nonprofit hospital decision making. Decisions about patient care now had to be made with an eye on their effects on the hospital's bottom line, its ability to generate a surplus, and the implications for its ability to borrow.

This marked the end of mission-driven nonprofit hospitals whose only consideration when treating a patient was what was best for the patient. Now, the hospital's survival as a facility able to keep up with advances in medical knowledge and provide first class care for patients required it to generate a profit, euphemistically called a surplus.

Rural and poor community hospitals do have limited access to government grants and loan programs for capital projects from the US Department of Agriculture (USDA), Department of Housing and Urban Development (HUD), and the Small Business Administration (SBA). But the funding is generally insufficient to cover full capital costs, requiring these hospitals to cobble together financing, a process that may be daunting for understaffed rural or poor community hospitals.

High inflation in the late 1970s and increases in hospital charges threatened Medicare's solvency. This led Congress in 1983, with bipartisan support and backed by the Reagan Administration, to alter the way that CMS reimbursed hospitals. The change effectively reduced reimbursements for operating costs. It replaced the cost-plus payment model with a pre-determined payment (Prospective Payment System, PPS) for treating Medicare patients based on their particular diagnosis. Diagnoses were categorized in buckets according to their medical severity (the Medical Severity of the Diagnostically Related Group, MS-DRG). The new system set a clear, capitated payment rate based on the MS-DRG of the patient's diagnosis. It was accomplished via government price setting, one of the few times in the U.S. that this method was used to control costs. It was also intended to apply to the subsidies for hospital capital expenditures, but this reform was delayed until 1991 when it was slowly phased in.

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[3] W. J. Laffey and S. Lappen, "Tax-Exempt Hospital Financing: Revenue Bonds," *Health Care Management Review* 1, no. 4 (1976): 19–30, https://doi.org/10.1097/00004010-197600140-00006.

[4] Colleen M. Grogan, *Grow and Hide: The History of America's Health Care State* (Oxford, New York: Oxford University Press, 2023), 448; Rick Mayes and Robert A. Berenson, *Medicare Prospective Payment and the Shaping of U.S. Health Care* (Johns Hopkins University press, 2006), p. 274; Bradford H. Gray and Mark Schlesinger, "Health Care," in *The State of Nonprofit America*, ed. Lester M. Salamon (Brookings Institution Press, 2012), 89–136, http://www.jstor.org/stable/10.7864/j.ctt1xx6fn.5.

By 2015, it was virtually impossible for a stand-alone local community hospital to qualify in private financial markets for funds to invest in physical plant and new technology.

Game Changer Policy: Public Financing of Healthcare Infrastructure

A return to a system of public provision of loans and grants to finance infrastructure investment in hospitals and health facilities is essential for two reasons. First, it will not be possible to eliminate America's two-tier health system and create one that is inclusive and equitable without public financing of capital investments. And second, hospitals will not be able to put patients over profits as long as they need to consider the effects of patient care on their bottom line and their eligibility for loans in private financial markets. Not unlike the period following World War II, the U.S. has health deserts that lack clinics and hospitals within a reasonable radius of communities. People in those communities often need to make long trips for essential care, including in cases like heart attack or stroke where time is of the essence.

It's time for Congress to pass a 21at century Hill-Burton Act, without the racist baggage that sullied the original act, to provide public financing for hospital and health infrastructure investment, as many peer countries in the OECD currently do.[5]

Hold Tax-Exempt Hospitals Responsible for Indigent Care and Prohibit Self-enrichment

Historically, nonprofit organizations in the U.S. were exempt from taxation if they engaged in charitable activities broadly defined to include educational, religious, or scientific activities. Hospitals were held to a narrower standard of providing care for the poor and indigent. Nonprofit hospitals were exempt from paying taxes in exchange for promoting health and providing free or below-cost care to those unable to pay. Free care for indigent patients has been a basic tenet of charitable hospitals going back to colonial times and has long been the basis for the tax exemption enjoyed by today's nonprofit hospitals. This standard was upheld in IRS rulings in 1923, 1939, and as recently as 1956. The 1956 IRS Revenue Ruling (C.B. 202 Revenue Ruling 56-185) required hospitals to be "operated to the extent of [their] financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay." Essentially, charity care for the uninsured or underinsured was required for hospitals to receive an exemption from paying taxes. This changed in 1969.

In 1969, the IRS issued a revenue ruling (C.B. 117, Revenue Ruling 69-545) that argued that the requirement to provide relief to the poor was 'narrow and outmoded' and allowed the broader definition of a charitable organization to apply to hospitals. Public health researchers Fox and Schaffer (1991), in their analysis of the 1969 revenue ruling, noted: "In 1969, the Internal Revenue Service ruled that hospitals need not provide free or below-cost care to those unable to pay in order to qualify for federal tax exemption …. The practical significance of the ruling for health policy was that it removed an important obstacle to nonprofit hospitals' refusal to treat uninsured persons".[6] Revenue Ruling 69-545

[5] Rechel B, Duran A, Saltman R, authors; Richardson E, Sagan A, editors, "What is the experience of decentralized hospital governance in Europe? 10 case studies from Western Europe on institutional and accountability arrangements [Internet]," Copenhagen (Denmark): European Observatory on Health Systems and Policies, (Policy Brief, No. 28), 2018. https://www.ncbi.nlm.nih.gov/books/NBK525900/

[6] Daniel M. Fox and D. C. Schaffer, "Tax Administration as Health Policy: Hospitals, the Internal Revenue Service, and the Courts," *Journal of Health Politics, Policy and Law* 16, no. 2 (1991): 351-2. https://doi.org/10.1215/03616878-16-2-251

redefined hospitals' responsibility from the 'charity standard' of indigent care to an ill-defined 'community benefit' standard. Notably, however, the ruling also reiterated the prohibition against self-enrichment in tax-exempt nonprofits. “A nonprofit hospital … may not be operated, directly or indirectly, for the benefit of private interests” (C.B. 117. Revenue Ruling 69-545, page 2).[7] While no longer enforced by the IRS, this tenet has long been an underpinning of a charitable organization and a basis for its tax exemption.

The 1969 revenue ruling was based on research by a junior staffer of the IRS, who adopted the position of the hospital industry that hospitals benefit entire communities and should use their surplus revenue to advance modern medicine and purchase new technologies, not subsidize indigent care.[8] The IRS left as ambiguous whether hospitals had to accept Medicare and Medicaid patients in order to qualify for the tax exemption. Not until 1986 did Congress clarify the rule. Under the Emergency Medical Treatment and Active Labor Act (EMTALA), Congress required tax exempt hospitals to provide emergency medical services, including delivering babies, regardless of the patient’s ability to pay. The IRS ruled that providing emergency services plus the acceptance of Medicaid patients were necessary to demonstrate charity care.[9]

In 2010, the Patient Protection and Affordable Care Act (ACA) added new requirements for nonprofit hospitals to retain their tax-exempt status. These include assessing the health needs of the community they serve and identifying the charity care benefits they provide to this community, developing a financial assistance policy and informing all patients about it, setting limits on what hospitals can charge and standards for billing and collections. Despite these provisions, the ACA is weak on charity care: It includes no minimum required expenditure on charity care and no agreement on what charity care includes. And the IRS is not well-equipped to enforce these requirements.

The further requirements established under the ACA in 2010 do not seem to have had a substantial impact on the level of charity care provided by nonprofit hospitals. Nonprofit, tax-exempt hospitals have retained the flexibility to determine what counts as charity care and even how much they undertake to contribute to the community.[10] In a recent report, the Government Accountability Office (GAO) analyzed 2020 IRS data and found that 30 nonprofit hospitals received tax breaks in 2016 despite reporting no spending on community benefits.[11] The Lown Institute, a healthcare think tank, reviewed nonprofit hospitals’ reports to the IRS and found 50 hospitals that reported no spending on financial aid to patients in 2021.[12]

As a result of the 1969 IRS ruling, hospitals can satisfy the community benefit requirement by paying for health promotion activities. Some nonprofit hospitals have interpreted this to include absorbing payment-cost differentials from Medicaid and other public programs and paying for research and for

[7] Internal Revenue Service (IRS), “C.B. 117. Revenue Ruling 69-545,” 1969, https://www.irs.gov/pub/irs-tege/rr69-545.pdf.
[8] U.S. House of Representatives 109th Congress, *The Tax-Exempt Hospital Sector: Hearing before the Committee on Ways and Means*, (2005), https://www.govinfo.gov/content/pkg/CHRG-109hhrg26414/html/CHRG-109hhrg26414.htm; Daniel G. Bird and Eric Maier, “Wayward Samaritans: ‘Non-Profit’ Hospitals and Their Tax Exempt Status,” *University Of Pittsburgh Law Review* 85 (March 31, 2023): 84–144. https://doi.org/10.5195/lawreview.2023.981.
[9] Fox and Schaffer, “Tax Administration as Health Policy,” 253-274.
[10] U.S. Government Accountability Office (GAO), 2023, “Testimony Before the Subcommittee.”
[11] U.S. Government Accountability Office (GAO), 2023, “Testimony Before the Subcommittee.”
[12] Imari Daniels, “IRS Audits Spotlight Hospital Community Benefit Spending,” (Lown Institute, September 16, 2024), https://lowninstitute.org/irs-audits-spotlight-hospital-community-benefit-spending/.

health professionals' education (IRS Schedule H 990 2023). The majority of community benefit spending still goes to uncompensated care,[13] but this share is declining.

This vagueness in specifying what hospitals can count as 'community benefits' has led to wide disparities in how much hospitals spend and whether the benefits to the community they serve outweigh the lost revenues in property and other taxes. The Lown Institute developed the concept of meaningful community benefits to identify hospital spending that benefits the local community. Categories of community benefits that improve community health and social conditions account for less than 8 percent of the total claimed in IRS reports. About 20 percent goes to cover the difference between what Medicaid pays hospitals and hospitals' costs of care. More than 70 percent goes to training people in the health professions and to medical research. Even if this research is fully funded by the government, hospitals can still claim it as a community benefit.[14]

The health policy research organization (KFF) estimated the total tax exemption for all nonprofit hospitals (including federal, state, and local taxation) was $28 billion in 2020.[15] Federal tax exemption accounts for about half of this ($14.4 billion) while state and local tax exemption was $13.7 billion.[16] A recent study of the tax benefit to nonprofit hospitals found much higher tax savings.[17] The researchers found a total of $37.4 billion in tax benefits accrued to 2,927 nonprofit hospitals in 2021. More than half (55 percent) of the benefit came from not having to pay state and local taxes. This is much larger than the KFF estimates, likely because this study estimates the savings from a broader range of tax breaks.[18] The researchers found that larger, wealthier hospitals received most of the tax breaks, with 7 percent of nonprofit hospitals receiving half the total tax savings.

The Lown Institute examined IRS filings for 2,425 nonprofit hospitals for 2021. It found that hospitals spent on average 3.87 percent of their budget on *meaningful* community benefits. Comparing spending on meaningful community health benefits to the tax breaks, as estimated by KFF, it found that tax savings often exceeded community benefits – what Lown termed a 'fair share deficit.' They found that 80 percent of hospitals have a fair share deficit and that the fair share deficit for all hospitals totaled $26 billion. Twenty-one hospitals had a fair share deficit that exceeded $100 million. The ten hospital *systems* with the largest fair share deficits included well-known, financially successful hospital chains: Kaiser Permanente, Providence, CommonSpirit Health, Ascension Health Care and UPMC.[19]

The prohibition on self-enrichment from charitable activities, retained in the 1969 revenue ruling, is simply not enforced. CEO pay at the 25 largest nonprofit hospital systems by number of beds ranged from $1.5 million to $16.2 million in 2024. CEO pay at some nonprofits, while not quite as high as the

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[13] Gary J. Young et al., "Provision of Community Benefits by Tax-Exempt U.S. Hospitals," *New England Journal of Medicine* 368, no. 16 (April 18, 2013): 1519–27, https://doi.org/10.1056/NEJMsa1210239.

[14] Judith Garber, "5 Things You Need to Know about Hospital Community Benefit Spending," *Lown Institute*, April 28, 2023, https://lowninstitute.org/5-things-you-need-to-know-about-hospital-community-benefit-spending/.

[15] Jamie Godwin, Zachery Levinson, and Scott Hulver, "The Estimated Value of Tax Exemption for Nonprofit Hospitals Was About $28 Billion in 2020," (Kaiser Family Foundation, March 14, 2023), https://www.kff.org/health-costs/issue-brief/the-estimated-value-of-tax-exemption-for-nonprofit-hospitals-was-about-28-billion-in-2020/.

[16] Godwin, Levinson, and Hulver, 2023, "The Estimated Value of Tax Exemption."

[17] Elizabeth Plummer et al., "Estimation of Tax Benefit of US Nonprofit Hospitals," *JAMA* 332, no. 20 (November 26, 2024): 1732–40, https://doi.org/10.1001/jama.2024.13413.

[18] Nonprofit hospitals' total tax benefit in this study equals the sum of federal and state income tax, sales tax, property tax, the fair market value of charitable contributions from donors, savings from tax exemptions on issued bonds, and federal unemployment tax.

[19] Lown Institute Hospitals Index, *2024 Results: Fair Share Spending* (2024), https://lownhospitalsindex.org/hospital-fair-share-spending-2024/.

highest paid CEOs at for-profit hospitals, compares favorably with those hospitals. The CEOs at for-profit Tenet and HCA earned $24.7 million and $23.8 million respectively in 2024. CEOs at Community Health Systems and Universal Health Systems earned $7.65 and $15.02 million respectively.[20]

Game Changer Policy: Hold Tax-Exempt Hospitals Responsible

Our proposal is for the IRS to hold tax-exempt hospitals responsible for providing indigent care and to enforce the historic prohibition against self-enrichment that is still required with penalties up to and including loss of tax-exempt status.

In light of the lost tax revenue at the state level and the increase in medical debt for state residents as financial assistance fails to keep up with the high cost of hospital care, states have begun to act. More than half the tax breaks for nonprofit hospitals come from exemptions from state and local taxes while many hospital systems fail to provide commensurate benefits to the communities they serve. This has led some states to take action to capture more benefits for their residents. They have set financial assistance standards intended to reduce medical debt that hospital systems have to meet to qualify for state and local tax exemptions. Oregon, for example, sets minimum levels of spending on community benefits. Florida and California require nonprofit hospitals to provide financial assistance to households that fall under 100 percent and 400 percent of the federal poverty level respectively. Illinois requires hospitals to screen patients for financial assistance as soon as possible, and before they are billed. Maryland and Colorado developed plain language, uniform applications for financial assistance that all hospitals in those states are required to use, making it easier for patients to apply for this help. North Carolina provides hospitals with incentives to increase the amount of financial assistance and to forgive unpaid medical debt for individuals enrolled in Medicaid.[21]

The ultimate solution, however, is a return to the 1956 standard of charity care as provided in revenue ruling 56-185. As specified in the key points in the ruling:

In order for a hospital to establish that it is exempt as a public charitable organization within the contemplation of section 501(c)(3), it must, among other things, show that it meets the following general requirements:

- It must be organized as a charitable nonprofit organization for the purpose of operating a hospital for the care of the sick.
- It must be operated to the extent of its financial ability for those not able to pay for the services rendered … It may provide services at reduced rates which are below cost and thereby render charity in that manner.
- It must not restrict the use of its facilities to a particular group of physicians and surgeons, such as a medical partnership or association, to the exclusion of all other qualified doctors.
- Its net earnings must not inure directly or indirectly to the benefit of any private shareholder or individual. This includes the use by or benefit to its members of its earnings by way of a distribution of profits, the payment of excessive rents or excessive salaries.

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[20] Caroline Hudson, "What For-Profit Systems' Top Execs Earned in 2024," *Modern Healthcare*, April 14, 2025, https://www.modernhealthcare.com/finance/hospital-ceo-pay-tenet-hca-ardent.

[21] Consumer Financial Protection Bureau, "Medical Debt and Non-Profit Hospital Billing Practices," October 1, 2024. https://www.consumerfinance.gov/about-us/blog/medical-debt-and-non-profit-hospital-billing-practices/.

It's important to re-establish that a hospital must provide charitable care to the extent of its financial ability in order to receive a tax exemption. The meaning of a hospital's financial ability to provide charity care will need to be specified. It's also important that the requirement that no one involved in the hospital's operations can benefit personally is upheld, and that this includes the payment of excessive rents to landlords or excessive salaries.

Hold Financiers Responsible for Bankruptcy Debts

The incursion of financial actors and investors into healthcare has led to heightened financial distress and higher bankruptcy rates, notably among healthcare entities acquired in private equity leveraged buyouts (LBOs). This tactic allows PE funds to reduce their equity exposure and boosts the returns to the PE firm and its investors when the company is successfully sold to a strategic buyer or to the public via an IPO. The debt used to acquire the company is placed on the company, which it is obligated to repay. This increases the probability the company will face financial distress or even bankruptcy as debt service eats into its net revenues and profit margins.

In addition, the General Partner of the PE fund (a committee drawn from principals at the PE firm that manages the fund), typically appoint themselves or their proxies to the company's Board of Directors and take control of strategic decisions. They often load the company with new debt and use the proceeds to pay dividends to the PE firm and the investors in the fund (referred to as a dividend recapitalization). The healthcare company's resources are used to enrich its PE owners rather than to improve patient care.

If the acquired healthcare company owns the facilities that house its operations, the PE firm often enters into a sale-leaseback agreement with a real estate investment trust (REIT) and sells the real estate to the REIT. The General Partners use the sale proceeds to pay dividends to themselves and their investors and to pay off some of the accumulated debt. The acquired company must now pay rent on property it used to own. The real estate also had provided a buffer for the healthcare company: In case of a downturn in revenue, it could use the real estate as collateral for loans to see it through hard times. Without this buffer, the healthcare company is vulnerable to economic headwinds and bankruptcy.

It's not surprising then that private equity owners have been responsible for a disproportionate share of bankruptcies in the healthcare industry. In 2024 and 2025 alone, companies acquired in a leveraged buyout accounted for 21 healthcare bankruptcies, including nine of the largest involving billions in assets, hundreds of ongoing patient malpractice lawsuits, and almost 10,000 layoffs.[22] But neither the PE firms nor the REITs are held accountable for repaying the debt or for other negative outcomes for patients, workers, or communities.

Private equity deal-making in healthcare grew exponentially from the mid-2000s with Bain's acquisition of the largest U.S. hospital chain, HCA, for $33 billion in 2006 and Carlyle Group's buyout of nursing home chain HCR ManorCare for $6 billion. The cumulative value of PE buyouts in healthcare between 2000 and 2025 is estimated at $1.46 trillion, and the number of deals at 14,500 (PitchBook data, authors' calculations). Healthcare REITs also grew markedly during this period. As of March 2026, 23

[22] Private Equity Stakeholder Project. "Private Equity Bankruptcy Tracker," February 20, 2026.

publicly traded healthcare REITs had a combined market value of $274.2 billion,[23] with each of the major firms owning thousands of properties.

PE firms load the companies they purchase with debt because they are playing with other people's money and are not concerned about the risk of bankruptcy. The firm contributes 2 cents for every dollar its investors contribute to the PE fund and may use 70 percent debt/30 percent equity to finance the acquisition. The PE firm's own money at risk amounts to less than 1 percent of the purchase price (.02 x .30 = .006 = .6%). It takes 20 percent of the winnings when the fund subsequently sells the company. It has no liability for the debt if the purchase ends in bankruptcy.[24]

Healthcare REITs also are frequent contributors to the bankruptcy of healthcare entities. They are tax-exempt investment vehicles that allow individuals to invest in a kind of mutual fund for commercial real estate, with the REIT acting as a 'pass through' entity for their investments. The REIT business model undermines the financial stability of healthcare organizations. Their lease agreements are particularly onerous for tenants. REITs also are allowed to take up to a 10 percent equity position in their tenants, which in effect allows them to influence healthcare operations even though their tax-exempt status requires that they hold an 'arm's length' relationship with the tenant.[25]

The thin operating margins of healthcare organizations means that the high costs of debt service and high and escalating rents in lease agreements lead them to disinvest in infrastructure and maintenance and to cut costs, especially staffing levels, which undermines patient care and leads to higher injury rates in hospitals and excess mortality rates in nursing homes.

Despite the active role that private equity and REIT owners play in directing the finances and operations of the companies they own, U.S. bankruptcy courts treat them as passive investors and exempt them from legal liability for the bankruptcies resulting from their financial strategies. But private equity owners take full ownership of companies, hold control over the board of directors, and make strategic and operational decisions that affect the financial condition of the companies they own. Bankruptcy laws that shield them from responsibility are outdated. In bankruptcy court, the distinction between secured and unsecured creditors is critical to claims on the bankrupt company's assets. Secured creditors receive priority in the settlement. Unsecured creditors – including workers owed wages and pension liabilities, patients' suing for malpractice or wrongful death, and unpaid vendors – are the last to be repaid, if at all.

Three recent cases, widely covered in the media, have brought attention to how the financial strategies of private equity firms and REITs can drive healthcare organizations into bankruptcy without accountability: Steward Healthcare, Prospect Medical Holdings, and Genesis.

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[23] ChartMill, "Health Care REITs Industry Stocks & Companies | USA," March 16, 2026. https://www.chartmill.com/stock/markets/usa/industry/254-health-care-reits

[24] Eileen Appelbaum and Rosemary Batt, *Private Equity at Work: When Wall Street Manages Main Street* (Russell Sage Foundation, 2014); Eileen Appelbaum and Rosemary Batt. 2020. "Private Equity Buyouts in Healthcare: Who Wins, Who Loses?" Working Paper No. 118 (Institute for New Economic Thinking, March 15). https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3593887

[25] Rosemary Batt and Eileen Appelbaum, with Tamar Katz. "The Role of Public REITs in Financialization and Industry Restructuring," (Institute for New Economic Thinking and Center for Economic and Policy Research, July, 2022). https://www.ineteconomics.org/research/research-papers/the-role-of-public-reits-in-financialization-and-industry-restructuring?emci=6791b7b8-bc11-ed11-b47a-281878b82c0f&emdi=ee79b9c2-bd11-ed11-b47a-281878b82c0f&ceid=9355399.

Game Changer Policy: Hold Investment Funds and Real Estate Investment Trusts Jointly Responsible for Bankruptcies of Companies in Which They Have a Financial Interest

Our policy proposal is that Congress should rewrite bankruptcy rules so that investment funds including private equity funds and Real Estate Investment Trusts (REITs) with a financial interest in a company are jointly responsible for repaying any debt the company acquires. This policy would limit the reckless use of debt by financial actors playing with other people's money and would hold financial actors responsible for their actions if they drive health systems into bankruptcy or result in the deaths of patients. Several bills have been introduced in Congress that would reduce investors' incentives to engage in the strategies described earlier that enrich investors while increasing the debt and rent liabilities of the healthcare enterprises they control – strategies that undermine financial stability and can lead to bankruptcy.

In 2019, Senator Warren introduced the Stop Wall Street Looting Act (SWSLA). The bill was reintroduced in 2021 and 2024. Importantly, the Act makes the general partner of private investment funds (effectively the PE firm behind the fund) that acquire portfolio companies jointly liable for repayment of all debt incurred by the companies acquired by the fund. This is a real game changer: A PE firm or other sponsor of a private investment fund would think twice before overburdening an acquired company with debt if it would be held jointly responsible for repaying that debt. Use of excessive debt in a leveraged buyout would be a risky proposition, as about 20 percent of LBOs end in bankruptcy – roughly 10 times the bankruptcy rate of companies – publicly traded or privately owned – with more modest debt levels.[26] SWSLA also prohibits portfolio companies from issuing dividends during the four years following a LBO and prohibits dividend distributions greater than 10 percent of the portfolio company's debt in a given year. It also reduces the interest deduction from corporate income taxes on excessive debt placed on the portfolio company.

In addition, SWSLA prohibits federal payments to healthcare enterprises that engage in loan or sale-leaseback activities with a REIT, essentially eliminating REITs from engaging with healthcare organizations. In bankruptcy proceedings, it moves obligations to employees to the front of the line. Employee obligations include severance pay, back wages, contributions to employee health, pension and 401(k) plans as well as back pay or damages arising from violations of federal or state labor and employment law, including the WARN Act. It closes the carried interest loophole and taxes carried interest as ordinary income. It increases transparency by requiring the Securities and Exchange Commission (SEC) to issue rules that will require each private investment fund to make disclosures about ownership interest in the fund, debt held by the fund and its portfolio companies, and fees and payments collected by the PE firm.

While SWSLA most explicitly holds private equity firms and REITs jointly responsible for repaying the debts of companies in which they have a financial interest, other proposed legislative initiatives reduce incentives and opportunities for the extreme profiteering that puts companies acquired by PE firms at greater risk of bankruptcy. Representative Pramila Jayapal introduced two bills in 2020 that would rein in the financial bad behavior of private investment funds. One required greater transparency into the financial activities of both the PE owners of a company and the portfolio companies it acquired. The second was designed to limit PE involvement in medical practices and to limit consolidation of health

[26] Brian Ayash, and Mahdi Rastad. "Leveraged Buyouts and Financial Distress." *Finance Research Letters* 38, (January 2021). https://doi.org/10.1016/j.frl.2020.101452

systems. In 2024, she joined with Senator Ed Markey to introduce the Health over Wealth legislation which retained many of these provisions.

The Health Over Wealth bill requires PE-owned or affiliated healthcare providers to report detailed information about the company's owners and use of debt. The information would be publicly available. The bill would increase the ability of the Department of Health and Human Services (HHS) to address PE abuses. PE firms would have to be licensed by HHS to directly or indirectly invest in healthcare entities. HHS would have the authority to deny or revoke a license, for example, for charging excessively high prices or for understaffing.

HHS would be authorized to establish a mechanism for risk mitigation – for example, by requiring PE owners to fund an escrow account to cover operating and capital expenditures for a period of years. The account would support a healthcare company that has been financially weakened by the PE firm's use of excessive debt, dividend recapitalizations, and sale-lease back agreements. HHS could also prohibit healthcare companies or their affiliated PE firms from engaging in sale-leaseback agreements with REITS.

The bill also has a provision that overcomes the Supreme Court's overturning of the Chevron decision that gave primacy to expert agency interpretations of government regulations. It specifically gives the SEC the authority to determine the meaning of key components of the bill, removing partisan politics from the implementation of the law.

Finally, Warren introduced the Corporate Crimes Against Health Care Act in 2024 in the wake of Steward's bankruptcy and revelations that patients died as a result of Steward's reckless behavior. The health system's former private equity owner, Cerberus, in conjunction with the REIT, Medical Property Trust, extracted hundreds of millions of dollars from the health system, leaving it financially unstable and unable to pay vendors for life saving equipment or maintain safe staffing levels. The Act would create stiff penalties for investors that reap personal profits while allowing the healthcare business to fail. It would impose prison sentences on executives whose unjust enrichment led to a patient's death in a hospital or nursing home. It would impose harsh civil penalties on executives that profited while the healthcare company was unable to meet its debt obligations or to meet payroll. The financial penalties and prison time in the extreme case of a patient's death are likely to limit investors' willingness to ignore the requirements of patient care and safety while enriching themselves by extracting huge amounts of money from the health system and putting it at risk of bankruptcy.

Take Labor Out of Competition

The most urgent problem facing healthcare workers and patients is understaffing, which causes hazardous and unsafe working conditions, higher patient falls, and in extreme cases, higher patient mortality. Owners and executives of healthcare organizations routinely balance their budgets and extract wealth by cutting labor costs, even though the quality of care depends substantially on the quality of jobs and staffing levels. Labor costs are the easiest target: They represent the largest category of expenses in healthcare organizations – at 60 percent of operating expenses in hospitals in 2023.[27]

[27] American Hospital Association (AHA), "America's Hospitals and Health Systems Continue to Face Escalating Operational Costs and Economic Pressures as They Care for Patients and Communities," AHA. May 2024. https://www.aha.org/guidesreports/2025-04-28-2024-costs-caring

Healthcare staffing decisions are driven by employers' financial calculations, not the healthcare mission. They can drive down costs and increase their share of net revenue while labor's share falls. In highly concentrated local markets, they have monopoly pricing power as well as monopsony power over labor markets to drive down wages and debase working conditions.

Employers prey on the goodwill of healthcare workers, who self-select into healthcare occupations with an ethical commitment to patient care above all else. They absorb the costs of low wages and understaffing, without compensating pay, when patient crises require extra work, as in the COVID pandemic.

The staffing shortage is not a supply side issue. Employers' financial calculations have driven the national crisis in nurse staffing. In 2020, prior to the COVID pandemic, 26 percent of licensed registered nurses (RNs) were not working in their profession.[28] Forty percent say they will exit their profession by 2029, half retiring and the other half leaving due to intolerable workloads, understaffing, workplace violence, and inadequate pay. The federal government projects hundreds of thousands of shortages in all nursing occupations over the next two decades.[29]

Even the U.S. Chamber of Commerce, a major lobbying group on behalf of employers, has reported that employment conditions drive excessive turnover among nurses, with half of them quitting within two years of hiring due to emotional exhaustion and burnout – even after the pandemic years.[30] Nursing staff face onerous conditions, leading to excessive turnover rates: In 2025, average annual turnover was 27.1 percent for RNs, 25 percent for LPNs, and 31.2 percent for certified nursing assistants.[31]

Healthcare is the largest private employment sector in the U.S. It is the only one that added jobs over the last two decades, even during the 2008 recession and the 2020 pandemic. Yet, despite their essential role, healthcare workers have faced stagnant wages, chronic understaffing, and onerous working conditions. Healthcare support workers, including nurse aides and assistants, have faced particularly harsh challenges as low skilled caregivers with an historic stigma reflecting their status during slavery as unpaid labor. They typically lack the time and financial resources to earn at least an associate degree, locking them into dead-end jobs.[32] Both professional and non-professional healthcare staff are disproportionately women and people of color.

Healthcare financialization has exacerbated these wages and working conditions, as the shareholder value revolution has led publicly traded healthcare corporations to maximize stock price and shift a greater portion of earnings gains to stockholders and executive pay. Nonprofit hospitals have increasingly mimicked the financial strategies of their for-profit competitors. Between 2005 and 2015, healthcare jobs in the entire sector grew by 20 percent on average, and education levels rose in every occupational group; but real median wages for full-time, full-year healthcare professionals were

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[28] U.S. Bureau of Labor Statistics, "Occupational Employment and Wage Statistics, 29-1141 Registered Nurses," May 2020. https://www.bls.gov/oes/2020/may/oes291141.htm; For RNs with active licenses see, Richard A. Smiley et al., "The 2022 National Nursing Workforce Survey," *Journal of Nursing Regulation*, 14, no. 1, Supplement 2 (April 2023): S1-S90, Table 17 https://www.journalofnursingregulation.com/article/S2155-8256(23)00047-9/fulltext.

[29] HRSA, "Nurse Workforce Projections, 2023-2038." HRSA. National Center for Health Workforce Analysis. December 2025. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/nursing-projections-factsheet.pdf

[30] Makinizi Hoover, Isabella Lucy, and Katie Mahoney, "Data Deep Dive: A National Nursing Crisis," (U.S. Chamber of Commerce, January 29, 2024). https://www.uschamber.com/workforce/nursing-workforce-data-center-a-national-nursing-crisis

[31] Lisa Wright, "Average Turnover Rate in Healthcare: 2025 Data," *The Resource,* Nov. 19, 2025. https://www.theresource.com/2025/11/19/healthcare-turnover-rate/

[32] Eileen Appelbaum and Rosemary Batt, "The Potential for Good Jobs in Hospitals and Outpatient Care," In Paul Osterman, ed., *Creating Good Jobs: An Industry-Based Strategy* (Cambridge: MIT Press, 2020, 145-186(.

stagnant, while they fell for nurse support staff, medical technicians, and food service workers by between 2.5 and 5 percent.[33] Low pay as well as poor working conditions drive high quit rates and exacerbate labor shortages; and employers have lobbied against raising the minimum wage.

In the meantime, CEO pay has risen dramatically. A study of CEO pay in a broad set of 1,000 nonprofit hospitals found a 34 percent increase -- from $1.0 to $1.3 million (2012-2019) -- far more than CEOs of other nonprofit organizations. Over a quarter of pay increases were linked to rising profits and organizational size, while the link to quality measures declined. In the same period, average wages for all healthcare workers in the U.S. grew by only 5.4 percent but fell for some.[34] Moreover, the gap between CEOs and highly skilled physician specialists also has grown.[35]

Corporate financial strategies to expand market share and dominate local markets have contributed to these patterns. Both for-profit and non-profit hospitals have engaged in massive consolidation of hospitals in local markets to garner concentrated or monopoly market power. This has led to *higher prices* for patients[36] but stagnant or *lower wages* for healthcare workers, due to the monopsony power of healthcare employers. In healthcare markets that are highly concentrated, medically skilled workers in nursing and pharmacy experience a 6.8 wage penalty, and administrative staff, 4 percent, according to one study[37]. In another, nurse wages were $.70 per hour lower in concentrated markets.[38]

But employers understand that wages and salaries are relatively fixed costs: They can be minimized but rarely cut -- especially in tight labor markets. Employment headcount, however, is viewed as a variable cost. Moreover, financial accounting rules treat physical assets as 'investments' that they own and can be paid for and depreciated over time, which is not true of employees and their human capital. Despite the fact that physical assets *erode in value* over time while the value of training and employees' work experience *increases their value over time* to the organization, the costs of human capital development are not treated as investments and cannot be depreciated.[39] Cutting staff is consistent with financial accounting rules and less visible to the external market.

Financial calculations that minimize staffing undermine the health of workers, who already face hazardous conditions at work. Hospital and nursing home staff have rates of nonfatal occupational injuries and illnesses that are over twice the rate experienced by all U.S. workers (2025).[40] RNs and LPNs

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[33] Eileen Appelbaum and Rosemary Batt, *Organizational Restructuring in U.S. Health Care Systems: Implications for Jobs, Wages, and Inequality,* Table 7a, 7b, 8; Appendix C and D (Center for Economic and Policy Research, 2017), https://cepr.net/images/stories/reports/organizational-restructuring-healthcare-2017-09.pdf,

[34] Derek Jenkins, Marah Short, and Vivian Ho. 2025, "Nonprofit Hospital CEO Compensation: Does Quality Matter? *Medical Care* 63(10):787-793, October DOI: 10.1097/MLR.0000000000002198

[35] JY Du, AS Rascoe, and RE Marcus, "The Growing Executive-Physician Wage Gap in Major US Nonprofit Hospitals and Burden of Nonclinical Workers on the US Healthcare System," *Clin Orthop Relat Res*. 476(10) (October, 2018): 1910-1919. doi: 10.1097/CORR.0000000000000394;

[36] Zack Cooper, Stuart V. Craig, Martin Gaynor, and John Van Reenen, "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," *The Quarterly Journal of Economics* 134, no. 1 (2019): 51–107. https://doi.org/10.1093/qje/qjy020; Martin Gaynor, Farzad Mostashari, and Paul B. Ginsburg, "Making Health Care Markets Work: Competition Policy for Health Care," *JAMA* 317, no. 13 (2017): 1313–14. https://doi.org/10.1001/jama.2017.1173.

[37] Elena Prager and Matt Schmitt, "Employer Consolidation and Wages: Evidence from Hospitals," *American Economic Review* 111, no. 2 (n.d.): 397–427.

[38] Sylvia A. Allegretto and David Graham, "Monopsony in Professional Labor Markets: Hospital System Concentration and Nurse Wages," Working Paper, 2022, available from the authors

[39] Peter Cappelli. *Our Least Important Asset: Why the Relentless Focus on Finance and Accounting Is Bad for Business and Employees* (Oxford University Press, 2023).

[40] U.S. Bureau of Labor Statistics. "Injuries, Illnesses, and Fatalities." January 22, 2026. https://www.bls.gov/iif/oshwc/osh/case/cd_r100_r200.htm.

report higher than average rates of musculoskeletal injuries, infectious diseases, workplace violence, exposure to sexual harassment by patients, work intensification, and mental exhaustion.[41] In 2025, over 50 percent of nurses reported seeking mental healthcare due to work-related stress – years after the pandemic. And younger nurses — the next generation workforce — reported even higher levels. Understaffing was the major reason why. Second were financial worries, which also contribute to poor mental health and exhaustion.[42]

Poor mental health and exhaustion undermine the ability of healthcare workers to care for patients, as well documented in the research literature. A cumulative body of evidence shows understaffing leads to higher rates of patient falls, pressure ulcers, infections, medication errors, re-admissions, and mortality, according to a cumulative body of academic evidence.[43]

More extreme forms of financialization have been found in nursing homes, which lead to more excessive understaffing, harsh working conditions, and injury to patients, according to the growing body of research on private equity ownership of healthcare entities. For example, a 2015 longitudinal study of Florida nursing homes found that, compared to for-profit nursing homes, equivalent private equity-owned homes had 29 percent lower RN staffing levels by substituting lower skilled LPNs and nurse assistants. Lower staffing levels led to significantly higher patient care deficiencies, and these negative effects increased over time.[44] A 2017 econometric study of PE buyouts of nursing homes (2000-2012) found that post-PE buyout, staffing per patient per day dropped significantly while total deficiencies rose by 18 percent.[45] Another longitudinal study of nursing homes analyzed for-profits and comparable homes bought out by private equity. The latter had significantly lower nurse staffing ratios: To compensate, they made 50 percent higher use of antipsychotic drugs, leading to 10 percent higher mortality rates, while billing Medicare 11 percent higher.[46] And among hospitals, a matched comparison of for-profit hospitals and those acquired by private equity showed that post-acquisition, the latter had a 25.4 percent increase in hospital-acquired conditions, driven by a 27.3 percent increase in falls and a 37.7 percent increase in associated bloodstream infections. These types of patient injuries are highly correlated with staffing levels.

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[41] National Nurses United, *Protecting Our Front Line: Ending the Shortage of Good Nursing Jobs and Industry-Created Unsafe Staffing Crisis*. (National Nurses United, 2021). https://www.nationalnursesunited.org/sites/default/files/nnu/documents/1121_StaffingCrisis_ProtectingOurFrontLine_Report_FINAL.pdf.

[42] WellSky, "National Workforce Study from WellSky® Finds 51% of Nurses Have Sought Mental Health Care," WellSky, Sept. 30, 2025.. https://www.businesswire.com/news/home/20250930329821/en/National-Workforce-Study-From-WellSky-Finds-51-of-Nurses-Have-Sought-Mental-Health-Care

[43] PG. Shekelle, "Nurse-Patient Ratios as a Patient Safety Strategy: A Systematic Review," *Annals of Internal Medicine* 158, no. 5 Part 2 (2013): 404–9. https://doi.org/10.7326/0003-4819-158-5-201303051-00007; Chiara Dall'Ora et al., "Nurse Staffing Levels and Patient Outcomes: A Systematic Review of Longitudinal Studies," *International Journal of Nursing Studies* 134, no. 104311 (2022); Izabelle Uchmanowicz et. al., "The Impact of Rationing Nursing Care on Patient Safety: A Systematic Review," *Med Sci Monit*. (January 10, 2024); doi: 10.12659/MSM.942031.

[44] Rohit Pradhan et al., "Private Equity Ownership of Nursing Homes: Implications for Quality," *Journal of Health Care Finance* 42, no. 2 (Oct 2015), https://www.researchgate.net/publication/317744034_Private_equity_ownership_of_nursing_homes_Implications_for_quality.

[45] Aline Bos and Charlene Harrington, "What Happens to a Nursing Home Chain When Private Equity Takes Over? A Longitudinal Case Study," *Inquiry: A Journal of Medical Care Organization, Provision and Financing* 54 (January 2017), 1-10. https://doi.org/10.1177/0046958017742761.

[46] Atul Gupta, Sabrina T Howell, Constantine Yannelis, and Abhinav Gupta, "Owner Incentives and Performance in Healthcare: Private Equity Investment in Nursing Homes," *The Review of Financial Studies*, 37, no. 4, (April 2024): 1029–1077. https://doi.org/10.1093/rfs/hhad082.

Game Changer Policy: Minimum Staffing Laws and National Funding for Workforce Training

Mandated minimum staffing laws are needed to take labor out of competition as a business strategy. Growing evidence shows the effectiveness of state minimum standards in raising nurse staffing ratios across the board. The most comprehensive law, passed by the state of California in 1999, set minimum RN-to-patient ratios for hospitals by specialty and acuity level of patients. Since then, Oregon set minimums for each type of unit, and Massachusetts and New York set minimums for intensive care units. Four other states have mandated reporting of staffing levels, several require hospitals to create staffing committees that involve nurses, and several have pending legislation as of 2026.[47] Unions have been at the forefront of this movement, including National Nurses United, the RN division of the Service Employees International Union (SEIU), and the National Nurses Association and State affiliates (which include nurse managers). These unions have supported employers by fighting for higher reimbursement rates to cover the costs of additional staff.

The evidence shows that minimum staffing laws matter. In a longitudinal study of the impact of California's law, researchers found that the average RN hours per patient day (HPPD) increased over time: By 30 minutes prior to the 2008 recession to 1.3 hours in 2009-2016.[48] Higher staffing levels, in turn, are significantly associated with better patient outcomes, as noted above.

At the national level, the CMS under the Biden Administration introduced new rules for minimum staffing in nursing homes in April 2024. They required 3.48 hours per resident day (HPRD), with 0.55 HPRD for RNs and 2.45 HPRD for nurse aides. These requirements were based on almost 50,000 comments from industry actors, who viewed them as too high, and researchers and family advocates and, who viewed them as too low. Given that only 20 percent of U.S. nursing homes met the new standards at the time, the rules would have led to substantial improvements in nursing staff levels.[49] But in December 2025, the Department of Health and Human Services repealed the provisions of the rule.[50]

Nurse staffing mandates must be accompanied by increases in federal reimbursement rates to cover the added costs, with special attention to the needs of smaller and rural providers, as well as a substantial increase in public funding to train the healthcare workforce of the future. This proposal builds on the existing federal government health education and training program administered by the Health Resources and Services Administration (HRSA). It primarily offers grants to healthcare organizations and scholarships and loan repayments to health professionals. Its budget for fiscal year 2026 is $1.4 billion.

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[47] John Kasprak, *California RN Staffing Ratio Law*. (OLR Research Report Nos. 2004-R-0212, 2004). https://www.cga.ct.gov/2004/rpt/2004-r-0212.htm; Laila Ighani, "RN Nurse-to-Patient Ratios by State [2024]," NURSA, March 11, 2024. https://nursa.com/blog/rn-to-patient-staffing-ratios; Ayla Roberts, "Nurse-Patient Ratios: These States Have These Controversial Policies in Place," *NurseJournal*, October 3, 2023. https://nursejournal.org/articles/nurse-patient-ratios/%20; Laila Ighani, "Find Your State's Current RN-to-Patient Ratios by State [2026]," NURSA (blog), March 4, 2026, https://nursa.com/blog/rn-to-patient-staffing-ratios.

[48] Andrew Dierkes et al., "The Impact of California's Staffing Mandate and the Economic Recession on Registered Nurse Staffing Levels: A Longitudinal Analysis," *Nursing Outlook* 70, no. 2 (2022): 219–27. https://doi.org/10.1016/j.outlook.2021.09.007. See also Linda H. Aiken et al., "Implications of the California Nurse Staffing Mandate for Other States," *Health Services Research* 45, no. 4 (2010): 904–21.

[49] Priya Chidambaram, Alice Burns, Tricia Neuman, and Robin Rudowitz, "A Closer Look at the Final Nursing Facility Rule and Which Facilities Might Meet New Staffing Requirements," (KFF. May 21, 2024). https://www.kff.org/medicaid/a-closer-look-at-the-final-nursing-facility-rule-and-which-facilities-might-meet-new-staffing-requirements/.

[50] U.S. Department of Health and Human Services, "HHS' Cleanup of Federal Nursing Home Minimum Staffing Standards Rule Expands Access to Rural and Tribal Health Care," December 2, 2025. https://www.hhs.gov/press-room/hhs-cleanup-federal-nursing-home-minimum-staffing-standards-rule-expands-access-rural-tribal-health-care.html.

Funding needs to be substantially increased and expanded to include the education and training needs of the non-professional workforce.

The training and upgrading fund, established by the Service Employees International Union over fifty years ago, provides a well-established model for a federally funded program. The jointly governed union-management funds have served several hundred thousand workers in thirteen states and the District of Columbia. A similar fund by AFSCME (American Federation of State, County, and Municipal Employees) serves the Philadelphia metropolitan area. These multiemployer training funds offer instructional and clinical training for employed workers. But only a minority of healthcare support workers are union members (8.7 percent) or are covered by union contracts (10.2 percent).[51] National funding to serve all healthcare workers is needed.

In sum, this Game Changer calls for Congress to pass legislation that establishes

- National minimum nursing staff standards that include both professional and non-professional workers.
- The substantial expansion of federally funded education and training programs to address current and future healthcare workforce needs.

These policies will take labor out of competition, preventing financially driven owners and executives from balancing budgets and profiteering off the backs of healthcare workers. It will reduce the high costs of staff turnover, improve healthcare operations and patient care, and expand the skilled healthcare workforce in the coming decades. It is an agenda that can garner widespread support.

Break Up Large Consolidated Hospital Chains in Concentrated Markets

The horizontal consolidation of hospitals into large healthcare systems has allowed them to gain concentrated power in local healthcare markets. This power undermines competition, leads to monopoly rents and higher prices, drives down healthcare workers' wages, and reduces consumer choice. Antitrust regulators should break up companies with excessive market share to relieve upward pressure on prices, downward pressure on wages, and give patients greater choice.

For several decades, hospitals have been consolidating into large multi-hospital systems. The percentage of U.S. community hospitals in multihospital systems rose from 41 percent in 1995 to 65 percent in 2016 and 70 percent in 2026.[52] Hospital consolidation was extensive in the decade of the 2010s, with an estimated 1,537 system changes between 2010 and 2019, including 422 mergers of equals.[53] Post COVID, mergers & acquisitions (M&As) rebounded.

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[51] U.S. Bureau of Labor Statistics (BLS), "Table 3. Union Affiliation of Employed Wage and Salary Workers by Occupation and Industry, 2024-2025 Annual Averages," U.S. BLS, 2025. https://www.bls.gov/news.release/union2.t03.htm

52 Statista, "Percentage of Hospitals in Hospital Systems in the U.S. from 1995 to 2016," https://www.statista.com/statistics/800899/percentage-of-hospitals-in-community-hospital-systems-us/. American Hospital Association (AHA), "Fast Facts on U.S. Hospitals Infographics," (AHA, 2026). https://www.aha.org/infographics/2026-02-05-fast-facts-us-hospitals-infographics

53 H. Oh, V. Mor, D. Kim, A Foster, and M Rahman, "Hospital Mergers and Acquisitions From 2010 to 2019: Creating a Valid Public Use Database," Health Serv Res. 60, no. 5 (Oct. 2025):e14642. doi: 10.1111/1475-6773.14642.

As organizational consolidation tends to occur among hospitals in the same local or regional market, consolidation has led to local market concentration.[54] As a result, the percent of the country's Metropolitan Statistical Areas (MSAs) defined as 'highly concentrated' in hospital services has grown markedly over time – from 65 percent in 1990 to an estimated 80-90 percent in 2016.[55] By 2022, 97 percent of metropolitan areas were defined as highly concentrated, with 47 percent having only one or two hospitals or healthcare systems offering inpatient care. In over 80 percent of metro areas, one or two health systems controlled 75 percent of the market.[56]

These estimates are based on the measure of market concentration used by the Department of Justice (DOJ) and the Federal Trade Commission (FTC), known as the Herfindahl-Hirschman Index (HHI). It is based on the number of participants in a market and their respective shares.[57] A growing body of empirical evidence consistently shows that hospital market concentration has led to significantly higher prices for payers and patients and may reduce access in rural areas and for disadvantaged populations, according to a major review by the RAND Corporation in 2022.[58] The magnitude of price increases varies, but for markets with four systems or fewer, the estimated price increase is at least 15 percent.[59] This rise in prices is particularly important because hospitals constitute 31 percent of total healthcare expenditures -- $1.5 trillion in 2023.[60]

Horizontal M&As enable major hospitals to acquire smaller ones as feeder hospitals in a health system designed to keep the patient census high in the system's flagship medical centers. They allow more powerful health systems to demand higher reimbursements from insurance companies and self-insured employers. This increases the operating revenues of these hospital systems. But patients and taxpayers pay the costs: Higher prices for medical procedures, higher insurance premiums and co-pays, and higher healthcare costs overall that go mainly to higher prices, rather than to improvements in care.[61] In addition to higher costs, a dozen studies have examined the impact of horizontal consolidation on the quality of care, using a range of measures. The majority showed worse quality or no change after a consolidation event. Cross-market mergers of hospitals that serve different healthcare markets have

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[54] While consolidation leads to a fewer number of large firms overall, concentration refers to the extent to which a small number of firms control a given market. Zack Cooper and Martin Gaynor, "Addressing Hospital Concentration and Rising Consolidation in the United States," 1% Steps for Health Care Reform, N.D., https://onepercentsteps.com/policy-briefs/addressing-hospital-concentration-and-rising-consolidation-in-the-united-states/ (accessed May 25, 2025); B. Fulton, "Health Care Market Concentration Trends in the United States: Evidence and Policy Responses," *Health Affairs*. 36(9) (2017):1530–38. https://doi.org/10.1377/hlthaff.2017.0556.

[56] Jamie Godwin, Zachary Levinson, and Tricia Neuman, "Nearly Half of Metro Areas Have Only One or Two Hospitals or Health Systems Providing Inpatient Care," *KFF News,* October 1, 2024.. https://www.kff.org/health-costs/nearly-half-of-metro-areas-have-only-one-or-two-hospitals-or-health-systems-providing-inpatient-care/

[57] U.S. Department of Justice, Antitrust Division, "Herfindahl-Hirschman Index." https://www.justice.gov/atr/herfindahl-hirschman-index

[58] Jodi L. Liu et al, "Environmental Scan on Consolidation Trends and Impacts in Health Care Markets," RAND, Sep 30, 2022. https://www.rand.org/pubs/research_reports/RRA1820-1.html; See also M. V. Pauly, L. R. Burns, A. Benitez, and M. Sielski, "Hospital Consolidation and Quality: Opening the Behavioral Black Box," *Social Science & Medicine,* 386 (December 2025). https://www.sciencedirect.com/science/article/abs/pii/S0277953625009244?via%3Dihub.

[59] Zack Cooper et al. "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," *National Bureau of Economic Research (NBER), Working Paper No. 21815,* 2015. https://healthcarepricingproject.org/.

[60] Zachary Levinson, Scott Hulver, Jamie Godwin, and Tricia Neuman, "Key Facts About Hospitals," KFF, 2025. https://www.kff.org/health-costs/key-facts-about-hospitals/?entry=national-hospital-spending-national-spending-on-hospital-care.

[61] Zack Cooper et al. "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured;"Leemore Dafny et al. The Price Effects of Cross-Market Mergers: Theory and Evidence from the Hospital Industry," *The RAND Journal of Economics* 50 (2): 286–325, 2019. https://doi.org/10.1111/1756-2171.12270.

received less attention, but evidence is emerging that they also have negative effects on prices within and across state boundaries.[62] Taxpayers cover 60 percent of hospital operating costs.[63]

A small number of studies have focused on access to care following hospital consolidations in rural areas, identifying the closure of core services as problematic.[64] This lack of access was a major theme in a report released by HHS in January 2025. The agency's review of the empirical research was consistent with the findings of the RAND scan of research cited earlier.[65]

Other empirical research shows that hospital prices have risen far faster than physician prices: For the period 2007-2014, inpatient hospital prices rose 42 percent compared to 18 percent for physicians, with an even greater difference for outpatient services (25 percent vs. 6 percent).[66] Hospital consolidation also has led to monopsony power in local markets, depressing wages of nurses.[67] In the meantime, CEO pay has skyrocketed in both for-profit and nonprofit hospitals, with higher pay tied to profits and organizational size, not improvements in care quality.[68] Pay inequality has grown not only between executives and nurses and workers, but between CEOs and highly skilled physician specialists.[69]

Private equity leveraged buyouts have played a major role in healthcare M&As since 2000. PE activity in the sector grew substantially between 2000 and 2021 – from a low base of about $6 billion annually in 2000 to a high of $210 billion in 2021 during the COVID-19 pandemic – a 35-fold increase.[70] It fell after due to macroeconomic factors (the overvaluation of PE-owned assets when the stock market underwent a correction and high interest rates). Cumulative dealmaking by PE in healthcare between 2000-2025 is estimated at $1.46 trillion, and the number of deals at 14,500.

The PE business model is to establish a 'platform,' buy up and add on additional hospitals, and aggregate them into large chains before selling them at a higher price within a five-year window. The platform

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[62] Leemore Dafny, Kate Ho, and Robin S. Lee, "The Price Effects of Cross-Market Mergers: Theory and Evidence from the Hospital Industry," *The RAND Journal of Economics* 50, 2 (2019): 286–325, https://doi.org/10.1111/1756-2171.12270; Arnold DR et al., "New Evidence on the Impacts of Cross-Market Hospital Mergers on Commercial Prices and Measures of Quality." *Health Services Research*, 60,1(Feb 2025):e14291. doi: 10.1111/1475-6773.14291.

[63] American Hospital Association (AHA), "America's Hospitals and Health Systems Continue to Face Escalating Operational Costs and Economic Pressures as They Care for Patients and Communities," AHA, May, 2024. https://www.aha.org/guidesreports/2025-04-28-2024-costs-caring.

[64] Jodi L. Liu et. al., "Environmental Scan on Consolidation Trends and Impacts in Health Care Markets," 2022.

[65] U.S. Department of Health and Human Services (HHS), "Consolidation in Health Care Markets RFI Response," *Report prepared by the HHS Office of the Secretary (OS), in consultation with the U.S. Department of Justice and the U.S. Federal Trade Commission,* January 15, 2025. https://www.hhs.gov/sites/default/files/hhs-consolidation-health-care-markets-rfi-response-report.pdf.

[66] Z Cooper et. al., "Hospital Prices Grew Substantially Faster Than Physician Prices for Hospital-Based Care in 2007-14," *Health Aff,* 38(2) (Feb 2019.):184-189. doi: 10.1377/hlthaff.2018.05424.

[67] Sylvia A. Allegretto and Dave Graham-Squire, "Monopsony in Professional Labor Markets: Hospital System Concentration and Nurse Wages," Working Paper No. 197 (*Institute for New Economic Thinking,* January 5, 2023) https://doi.org/10.36687/inetwp197.

[68] Derek Jenkins, Marah Short, and Vivian Ho, "Nonprofit Hospital CEO Compensation: Does Quality Matter?. *Medical Care* 63(10)(October 2025): 787-793, DOI: 10.1097/MLR.0000000000002198.

[69] JY Du, AS Rascoe, and RE Marcus, "The Growing Executive-Physician Wage Gap in Major US Nonprofit Hospitals and Burden of Nonclinical Workers on the US Healthcare System," *Clin Orthop Relat Res*. 476(10), Oct 2018):1910-1919. doi: 10.1097/CORR.0000000000000394; Majd Marrache et al., "Hospital Payments Increase as Payments to Surgeons Decrease for Common Inpatient Orthopedic Procedures," *Journal of the American Academy of Orthopaedic Surgeons. Global Research & Reviews* 4 (4) (2020). e20.00026, https://doi.org/10.5435/JAAOSGlobal-D-20-00026.

[70] The numbers in this section are estimates based on the best available data by PitchBook, an industry data aggregator that compiles publicly available data. Values are in 2024 dollars. The estimates of deal value are based on PitchBook's extrapolation formula because PE firms increasingly do not report deal values. On average, capital values are based on about 50 percent of the deals actually completed.

carries all the debt; and the 'blended' total cost of the platform company is lower than it otherwise would be. This enlarges the size of returns as the profits from the sale of this company are higher than if the PE firm had initially purchased one large entity. This strategy also allows PE firms to escape regulatory oversight by the FTC because any one acquisition of a hospital or other healthcare provider typically falls below the size threshold set by the law (the Hart-Scott-Rodino standard), which triggers an antitrust review.[71]

While PE ownership represents a relatively small share of all owners in healthcare, they account for a disproportionately large share of consolidations. The percent of all M&As in healthcare due to private equity grew exponentially over time. By 2011, eleven of the 12 largest hospital chains were PE-owned, and a twelfth was formerly owned by private equity.[72] In 2025, they owned roughly 30 percent of all proprietary hospitals but were responsible for most of the bankruptcies, including the recent bankruptcies of health systems Steward Healthcare and Prospect Medical Holdings. In the 2025 report by HHS that reviewed 2,000 commentaries from stakeholders, over 40% of the comments mentioned PE, and 95% of those comments were negative.[73]

Federal Health Policy and Lax Antitrust Regulation Drive Hospital Consolidation

Federal health policy coupled with lax antitrust rules have driven hospital consolidation, which expanded rapidly after passage of the 1965 Medicare and Medicaid Act. The Act funded for-profit hospitals for the first time without regulatory safeguards. With the subsidy for capital costs and access to capital markets, investor-owned chains aggressively acquired small proprietary hospitals and combined them into large chains. Higher revenue made hospitals more creditworthy, driving consolidation of nonprofit hospitals as well.

The relaxation of antitrust regulations in 1982 opened the doors for extensive M&A activity. Antitrust regulation had been designed to prevent monopolies or other anti-competitive corporate practices. Prior to 1982, guidelines for whether a proposed M&A would trigger antitrust enforcement relied on concentration ratios – or the share of the market held by one or a small number of companies. That measure identified whether the merger would give the newly formed company undue power to stifle innovation, reduce quality, raise prices for consumers, or reduce prices paid to suppliers and wages for workers. [74]

The Reagan administration changed the standard for measuring whether a merger violated antitrust law, replacing concentration ratios with a standard to safeguard "consumer welfare," narrowly conceived of as lower consumer prices. Since 1982, regulators have approved mergers based on a promise of improved efficiency, usually ascribed to larger economies of scale that trickle down to

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[71] Benjamin R. Dryden et al., "Hart-Scott-Rodino Reporting Thresholds Adjust Downward for Just Second Time Ever," *Foley & Lardner LLP*, n.d., https://www.foley.com/insights/publications/2021/02/hart-scott-rodino-reporting-thresholds-downward/.
[72] Rosemary Batt and Eileen Appelbaum, *Healthcare in the Age of Finance Capital: Public Funds for Private Gain.* (Princeton University Press, 2026), Chapter 6.
[73] U.S. Department of Health and Human Services (HHS), "Consolidation in Health Care Markets RFI Response," *Report prepared by the HHS Office of the Secretary (OS), in consultation with the U.S. Department of Justice and the U.S. Federal Trade Commission,* January 15, 2025. https://www.hhs.gov/sites/default/files/hhs-consolidation-health-care-markets-rfi-response-report.pdf.
[74] Eileen Appelbaum and Rosemary Batt, "Financialization in Health Care: The Transformation of US Hospital Systems," (Center for Economic and Policy Research, September 9, 2021), https://cepr.net/wp-content/uploads/2021/10/AB-Financialization-In-Healthcare-Spitzer-Rept-09-09-21.pdf.

consumers in the form of lower prices, an outcome that in most instances did not materialize. Hospital consolidation accelerated almost without constraint and hospital prices rose.

Other dimensions of antitrust enforcement also allow ongoing hospital consolidation. First, the FTC tends to focus on mergers of entities that compete head-to-head. But mergers between two hospitals in different cities or regions are unlikely to attract FTC attention. Second, antitrust enforcement of nonprofit hospital mergers is especially problematic. The FTC's authority to prosecute firms that engage in unfair competition or deceptive acts excludes nonprofit organizations. The FTC can turn over such cases to the DOJ to pursue at its discretion.[75] The FTC can review hospital mergers and issue opinions but lacks enforcement authority to prevent mergers that limit competition.[76]

Third, the Scott-Hart-Rodino threshold that requires parties in a merger to file a pre-merger notification is set too high to apply to small hospitals and healthcare organizations. Private equity firms have evaded this reporting requirement by using multiple investment vehicles to buy out and add-on healthcare entities. Recent research shows that antitrust enforcement drops by 90 percent when deals are exempt from reporting.[77] Finally, states can pass Certificate of Public Advantage (COPA) laws that allow them to take control of hospital mergers without oversight by the FTC.

Game Changer Policy: Break Up Large Consolidated Hospital Chains in Concentrated Markets

Horizontal concentration has reduced competition in local health markets. Antitrust regulators at the Federal Trade Commission and Department of Justice should have the authority not only to prevent anticompetitive mergers but also to break up companies with excessive market share to relieve upward pressure on prices and give patients greater choice.

Under the Biden administration, the FTC and DOJ began serious antitrust enforcement against private equity serial roll-ups. Through a joint Request for Information (RFI) in May 2024, they sought information on serial roll-ups that harm competition.[78] And in January 2025, the FTC reached a settlement against a private equity firm in an antitrust roll-up case, which would prevent future anticompetitive conduct, although the PE firm paid no penalties.[79] In December 2023, the FTC also adopted tougher merger guidelines for hospitals that weigh the effects of a merger on competition before approving it and require more information from parties in pre-merger filings. The rules were finalized in October 2024 and went into effect in February 2025.[80] But in February 2026, a federal judge

[75] E. John Steren and Patricia M. Wagner, "Not-for-Profit Hospitals and Enforcement of Section 5 of the FTC Act," *EBG Law*, May 23, 2019. https://www.ebglaw.com/insights/publications/not-for-profit-hospitals-and-enforcement-of-section-5-of-the-ftc-act.
[76] See Scott Hulver and Zachary Levinson, "Understanding the Role of the FTC, DOJ, and States in Challenging Anticompetitive Practices Of Hospitals and Other Health Care Providers," KFF, August 7, 2023, https://www.kff.org/health-costs/issue-brief/understanding-the-role-of-the-ftc-doj-and-states-in-challenging-anticompetitive-practices-of-hospitals-and-other-health-care-providers/.
[77] Asil, Aslihan, John Barrios, and Thomas Wollmann, "Misaligned Measures of Control: Private Equity's Antitrust Loophole." *Virginia Law & Business Review* 18.1 (Fall, 2023). https://static1.squarespace.com/static/5e2a02e0f00f9944398e756a/t/65aac2ff5a2020646c9c763d/1705689856588/6_Asil_Misaligned+Measures+of+Control.pdf.
[78] U.S. Department of Justice, "Justice Department and Federal Trade Commission Seek Information on Serial Acquisitions, Roll-Up Strategies Across U.S. Economy," May 23, 2024. https://www.justice.gov/archives/opa/pr/justice-department-and-federal-trade-commission-seek-information-serial-acquisitions-roll.
[79] Federal Trade Commission, "FTC Secures Settlement with Private Equity Firm in Antitrust Roll-Up Scheme Case," January 17, 2025. https://www.ftc.gov/news-events/news/press-releases/2025/01/ftc-secures-settlement-private-equity-firm-antitrust-roll-scheme-case.
[80] E. John Steren and Patricia M. Wagner, "Not-for-Profit Hospitals and Enforcement of Section 5 of the FTC Act," *EBG Law*, May 23, 2019, https://www.ebglaw.com/insights/publications/not-for-profit-hospitals-and-enforcement-of-section-5-of-the-ftc-act.

threw out the FTC's new information requirements on grounds they were unnecessary and onerous. Whether the FTC will revise the rules in the future is uncertain.[81] But the steps taken to date are insufficient to curb monopoly behavior in hospital markets.

The evidence clearly shows that hospital consolidation has led to concentrated markets for healthcare services that have led to substantial increases in hospital prices, decreases in care quality and patients' choices, and stagnant wages for healthcare professionals and workers.

We recommend that Congress pass explicit antitrust legislation that will:

- Return to the antitrust merger guidelines to pre-1982 standards that use concentration ratios to determine anti-competitive mergers.
- Lower the Scott-Hart Rodino threshold for mergers to include smaller entities and smaller mergers.
- Amend the Federal Trade Commission Act to allow the FTC to take enforcement action against anti- competitive actions by non-profit firms and to supersede state COPA laws.
- Substantially Increase the budgets of the FTC and DOJ for antitrust enforcement.
- Allow the DOJ to break up monopolies in concentrated markets that have stifled competition in health markets and driven up health costs.

Break up Large Vertically Integrated Conglomerates

Large, vertically integrated health conglomerates, especially those in health insurance and nursing homes, have built empires by buying up companies that provide services to the company's other subsidiaries and to the patients they serve. In exchanges between subsidiaries of a vertically integrated healthcare conglomerate, one part of the organization is transferring goods and services to other parts of the conglomerate. Conglomerates that own both a Medicare Advantage plan and the companies that provide health services to beneficiaries are on both sides of the table in negotiations over the prices (called transfer prices) of these goods and services. Similarly, nursing home chains are structured as holding companies with separate subsidiaries for nursing home operations, services (such as supplies), and property ownership. The nursing home subsidiaries, referred to as related party businesses, pay for services from the company's service subsidiaries as well as paying rent to the real estate subsidiary, thereby boosting overall profits of the holding company. Again, prices and rents are not set in a market but are negotiated between the nursing home and the related party businesses. The parent company that owns these entities sits on both sides of the table as prices are negotiated.

Both the health conglomerates that own MA plans and the nursing home holding companies favor high prices in these transactions. As vertically integrated organizations, they are able to direct their subsidiaries/related party businesses to give preference to their other subsidiaries/related party businesses and to pay them above market prices/rents for the purchased goods and services. The health conglomerate or nursing home holding company books the overpayment as profit. Their structures allow them to undertake anticompetitive practices. The vertically integrated organization is denying

[81] Dave Muoio, "Federal Judge Vacates FTC's Expanded Premerger Notification Requirements," *Fierce Health*. Feb 13, 2026. https://www.fiercehealthcare.com/regulatory/federal-judge-vacates-ftcs-expanded-premerger-notification-requirements.

companies that compete with its subsidiaries or related party businesses access to patients, limiting their opportunities to compete in these markets.

Medicare Advantage

Many health insurers have evolved into healthcare conglomerates that are not only insurance companies that pay for patient care but are major providers of this care. This new organizational form is characteristic of the largest insurers – United Health Group (UHG), Humana, CVS-Aetna, Cigna, but even some smaller providers like Centene and Molina. It's part of a long-term shift that began when insurers worried that new regulations in the Affordable Care Act (ACA) would impinge on insurance company profits. They sought to own provider organizations that play key roles in healthcare delivery and drug distribution. Now they own physician practices, including pediatricians and primary health providers, as well as pharmacy benefit managers (PBMs) and pharmacies, surgical centers, and even home health and hospice agencies.[82]

Vertical integration is especially advantageous for healthcare companies with Medicare Advantage plans. The largest of these companies accounted for 58 percent of Medicare Advantage enrollment in 2025: UHG (29 percent), Humana (17 percent) and CVS-Aetna (12 percent).[83] These vertically integrated insurers are more easily able to meet standards for Medicare Advantage set by the ACA. Beginning in 2012, the ACA implemented the 'Medical Loss Ratio' (MLR), which requires MA plans to spend 80 to 85 percent of premiums on enrollees' healthcare (depending on the size of the MA plans) and limits administration, marketing, and profits to 15 to 20 percent of premiums. MA plans that do not meet the MLR standard must rebate part of the premium.

Vertical integration means that MA plans can direct their members to utilize service providers owned by their parent company and pay above market prices for these services.84 Plan costs for patient care are, in part, profits to the health service provider; and these profits pad the bottom line of the conglomerate that owns them both. The overpayments for patient care count toward meeting the plan's MLR requirement while the profits to the parent company are outside the MA plan and not subject to the MLR cap. For example, the three largest PBMs, which control 80 percent of the pharmacy market, are OptumRx (UnitedHealth Group), CVS Caremark (owned by Aetna/CVS), and Express Scripts (Cigna). Both the MA plan and the supplier are happy with a high price. Transfer pricing lets the vertically integrated company that owns both the MA insurance plan, and the for-profit suppliers evade the MLR constraint on insurer's profits. As one industry observer put it, "The insurance side has a cap on profitability. Providers don't have that. So [the big insurers are] passing money from the insurance side to the provider side."[85]

UHG, via its Optum subsidiary, is the largest of the health insurance conglomerates. In 2024, UHG acquired or created 250 subsidiaries, with little public notice, as these acquisitions were relatively small and flew under the antitrust radar. It focused on surgery centers that provide highly profitable services

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[82] Rooke-Ley, Hayden, "Medicare Advantage and Vertical Consolidation in Health Care." American Economic Liberties Project. April, 2024. https://www.economicliberties.us/wp-content/uploads/2024/04/Medicare-Advantage-AELP.pdf

[83] Ochieng, Nancy, Meredith Freed, Jeannie Fuglesten Biniek, Anthony Damico, and Tricia Neuman, "Medicare Advantage in 2025: Enrollment Actions Update and Key Trends," *KFF,* July 28, 2025. https://www.kff.org/medicare/medicare-advantage-enrollment-update-and-key-trends/

[84] Arnold, Daniel R. and Brent D. Fulton, "UnitedHealthcare Pays Optum Providers More Than Non-Optum Providers," *Health Affairs* 44(11), November2025. https://doi.org/10.1377/hlthaff.2025.00155

[85] Bob Herman, "The Health Insurer Will See You Now: How UnitedHealth Is Keeping More Profits, as Your Doctor," *STAT News*, December 5, 2022. https://www.statnews.com/2022/12/05/unitedhealth-keeping-profits-as-your-doctor-insurer/.

such as heart catheter labs, orthopedics, ophthalmology, and gastroenterology, and acquired full or partial ownership of more than 100 of them.[86] At the end of 2024, UHG owned a profit-driven empire that employed 400,000 people, controlled 20 percent of the pharmacy market, and dominated Medicare Advantage plans. It owned or contracted with a physician network of over 90,000 doctors, a major pharmacy benefits manager, and a total of 2,694 businesses. UHG paid itself $150.9 million in 2024 for services its subsidiaries provided to its own MA members.[87] In March 2026, UHG walked back its commitment to transparency and reported on just 10 of its subsidiaries. The SEC requires companies to report a subsidiary that represents at least 10 percent of the parent company's income or assets. UHG's size – its annual revenue is $440 billion, its assets total $310 billion, and it earns $12 billion a year in profits – means it is required to report on very few of its subsidiaries.[88]

Numerous harms to patients, doctors, taxpayers, and Medicare result from inclusion of MA plans in these vertically integrated conglomerates. Some harms are related to upcoding, which occurs when MA plans exaggerate the seriousness of a diagnosis or code beneficiaries as having conditions for which the plans provide no treatment. Others are related to favorable selection of beneficiaries. CMS uses a capitated payment system to fund MA plans: Plans are paid a fixed fee per enrollee per month adjusted for how sick the beneficiary is. CMS provides higher payments for enrollees who are coded as sicker than the average Medicare beneficiary. The MA plan is supposed to monitor healthcare utilization and deny medically unnecessary procedures. It keeps as its profit whatever is not spent on patient care, providing strong incentives for MA plans to game the system by upcoding enrollees and denying necessary care. Overpayments to individual MA plans will cost Medicare $76 billion in 2026, threatening Medicare's financial future.[89]

The clinical workforce and, especially, doctors whose practices are owned by or affiliated with health conglomerates that own MA plans also suffer. They experience a loss of autonomy as the number of patients they see, the length of patient visits, and the technology they have access to are dictated by the health companies that own their practices. They face ethical dilemmas as they are often unable to provide patients with the level of care they believe is needed -- especially if the best care requires expensive medications or procedures not available in the MA plan's networks. The doctors are pushed to maximize profits for the MA plan. They are no longer independent medical professionals but are at-will employees of a company that is focused on making money.[90]

This focus on profits at the expense of patient care leads to demoralization, burnout, and high turnover rates of clinical staff. It results in 'moral injury' – the inability of doctors to meet their ethical obligations to patients. A nationally representative survey of 1,000 physicians whose practices had been acquired by

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[86] Bob Herman, "UnitedHealth Continues Making Stealthy Deals, Pushing Deeper into Medical Care as Scrutiny Mounts," *STAT News*, March 7, 2025. https://www.statnews.com/2025/03/07/unitedhealth-surgery-centers-physicians-endoscopy-pharmacies-acquisitions/?_hsmi=395363589

[87] Wendell Potter, "The Sunlight Report on UnitedHealth Group." Substack newsletter. *Health Care Un-Covered*, July 16, 2025. https://healthcareuncovered.substack.com/p/the-sunlight-report-on-unitedhealth?utm_source=post-email-title&publication_id=255152&post_id=168349733&utm_campaign=email-post-title&isFreemail=false&r=18kjm&triedRedirect=true&utm_medium=email; Jarod Facundo and Patrick Rucker..

[88] Bob Herman, "Unitedhealth Promised Transparency. Instead, It's Cutting Back Key Disclosures," *STAT+*. March 5, 2026. https://www.statnews.com/2026/03/04/unitedhealth-limits-subsidiary-disclosure-sec-reporting-shift/

[89] Batt and Appelbaum. *Healthcare in the Age of Finance Capital,* Chapter 13. (Princeton University Press, 2026); Rebecca Pifer Parduhn, "Medicare Advantage Over payments will total $76B this Year: MedPac, Healthcare Dive, January 16, 2026. https://www.healthcaredive.com/news/medicare-advantage-overpayments-76b-2026-medpac/809859/

[90] Bob Herman, "The Health Insurer Will See You Now: How UnitedHealth Is Keeping More Profits, as Your Doctor," *STAT News*, December 5, 2022, https://www.statnews.com/2022/12/05/unitedhealth-keeping-profits-as-your-doctor-insurer/.

hospital subsidiaries or corporations, including health insurance conglomerates, found that almost 60 percent of physicians reported reduced autonomy and a negative effect on their ability to deliver quality care, while 45 percent said that the ownership changes undermined their relationships with patients, including reduced communication time. Seventy percent of respondents said employers used incentives to push them to see more patients, and 61 percent said they had low to moderate autonomy to refer patients outside of their ownership structure.[91]

In all these ways, vertical integration enhances the monopolistic control of markets and prices and enables profiteering by integrated health insurance conglomerates that diverts resources meant for patient care to the bottom lines of these organizations.

Vertical integration of healthcare companies is not only bad for patients and providers, but it also stifles competition. As in the case of physicians, Medicare Advantage plans can leverage their size and reach to overpay affiliated providers and squeeze other providers with below market payments. With over half of Medicare beneficiaries enrolled in MA plans, unaffiliated health service providers need access to these patients to remain financially viable. The anticompetitive practices of the healthcare conglomerates often leave competitors to their subsidiaries and affiliated providers with no option but to sell themselves to a healthcare conglomerate or face financial distress. Home health and hospice agencies provide a vivid example of this pattern. Even the largest agencies have found it difficult to survive as independent businesses.[92]

In 2023, LHC Group, a home health and hospice provider with 527 locations and 500,000 clients, sold itself to UHG's Optum subsidiary. In 2024, Amedisys, with 500 locations in 32 states, and a highly developed home health partner for hospital-at-home operations agreed to be acquired by Optum. [93] The Department of Justice opposed the deal, arguing it would end competition in hundreds of markets. But a new settlement, proposed under the Trump Administration, was approved, allowing Optum to acquire Amedisys in 2025 for $3.3 billion.[94] The DOJ approved the merger despite an ongoing DOJ criminal investigation of UHG's potential fraud related to overbilling the government.[95]

Nursing Home Chains

Vertically integrated nursing home holding companies also have engaged in profiteering at the expense of patients and taxpayer funded Medicaid, their largest source of funding. They accomplish this by

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[91] Fuse-Brown and Rooke- Ley, "Healthcare Financialization," Physicians Advocacy Institute (PAI) and NORC at the University of Chicago, *The Impact of Practice Acquisitions and Employment on Physician Experience and Care Delivery* (2023), https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/NORC-Employed-Physician-Survey-Report-Final.pdf?ver=yInykkKFPb3EZ6JMfQCelA%3d%3d

[92] UnitedHealth Group's acquisition of ambulatory surgery centers provides another example where subsidiaries of a vertically integrated organizations put competitors at a severe disadvantage. See Derek T. Lake et al. "Selection and Pricing Power: Optum's Strategic Acquisition of Ambulatory Surgery Centers and Physician Practices," *Health Affairs,* February 2026, https://doi.org/10.1377/hlthaff.2025.01062

[93] Rebecca Pifer, "UnitedHealth, Amedisys Merger Appears Set to Close Post-DOJ Settlement," *Healthcare Dive*, August 8, 2025, https://www.healthcaredive.com/news/unitedhealth-amedisys-deal-set-close-doj-settlement/757118/.

[94] Rebecca Pifer. "UnitedHealth, Amedisys Merger Appears Set to Close Post-DOJ Settlement | Healthcare Dive." *Healthcare Dive*, August 8, 2025, https://www.healthcaredive.com/news/unitedhealth-amedisys-deal-set-close-doj-settlement/757118/.

[95] Sydney Halleman, "UnitedHealth Confirms It's under Investigation by DOJ," *Healthcare Dive*, July 24, 2025. https://www.healthcaredive.com/news/unitedhealth-under-investigation-department-of-justice-medicare/753913/; Christopher Weaver and Anna Wilde Mathews,"DOJ Investigates Medicare Billing Practices at UnitedHealth," Business. *Wall Street Journal*, February 21, 2025. https://www.wsj.com/health/healthcare/unitedhealth-medicare-doj-diagnosis-investigation-66b9f1db

creating a complex legal structure in which the holding company owns multiple subsidiaries: a management services company to manage nursing home operations, a property company that owns the real estate, various healthcare services suppliers, and various nursing home operators. In this legal structure, the holding company owns no assets and is shielded from lawsuits against other entities in the organization, and each of these entities is legally separate from the others and also is shielded from legal liability arising from actions of the others. The nursing home pays high fees to the management services company, which benefits the holding company at the expense of the operating subsidiary and its residents. The real estate subsidiary, which acquires the nursing home's real estate at below market prices, then leases it back to the nursing home operating companies at inflated rents. The sale price and rental rates are negotiated between the two parties -- they are not set in a market. They are related party payments between two entities, both of which are owned by the same holding company.

This kind of self-dealing and internal transfer payments improve the bottom line of the parent company that owns these entities. Medicaid payments in many states are linked to a nursing home's reported costs. These related party payments inflate nursing home costs and may result in higher payments from Medicaid for care of low-income patients. Nursing homes can plead poverty when legislators try to set minimum staffing levels for their facilities and claim that the staffing levels will drive them out of business. And they can shelter assets from malpractice liability if a patient is harmed by transferring them to companies not involved in patient care. In the nursing home industry, these practices are referred to as the 'tunneling of profit.' The extensive tunneling by nursing home holding companies led about half of the nursing home companies to report operating losses in 2023.[96]

Case studies illustrate the conflicts of interest embedded in these complex legal structures.[97] A classic example is the largest regional chain in California (Country Villa Service Corporation, CVSC), which was owned by a group of privately held family trusts. They set up a management services company through which they established contracts and charged fees to their 46 nursing home operating companies and property companies. They set the rents and interest rates charged by their property companies to their nursing home operations. They made hidden profits through ownership of related party businesses that supply goods and services to their nursing homes. Their facilities had substantially higher deficiency rates and lower staffing than the average for all California homes.[98] A similar trajectory is documented in a 22-year analysis of Plum Healthcare Group. In 2018, the parent company consisted of 14 holding companies that managed operations, property, finance, and development of 63 nursing homes and related companies. This arrangement allowed the owners to avoid litigation, taxes, and government oversight. Staffing levels were substantially lower than the state average while staff turnover and patient care deficiencies were substantially higher.[99]

A recent quantitative study of detailed financial transactions of nursing homes in one state showed that payments to related parties more than doubled between 2000 and 2021 – rising from 5.5 percent to 12 percent of operating expenses. By 2021, over 70 percent of companies engaged in these related party payments. The parent company extracts excessive profits by inflating the payments made from one

[96] Erin C. Fuse Brown, Andrew R. Olenski, and Ashvin D. Gandhi, "Pleading Poverty — Related-Party Payments and Health Care Entities' Financial Health," *NEJM*, January 2026. DOI: 10.1056/NEJMp2512845

[97] The case examples are excepted from *Healthcare in the Age of Finance Capital*, 2026.

[98] Charlene Harrington, Leslie Ross, and Taewoon Kang, "Hidden Owners, Hidden Profits, and Poor Nursing Home Care: A Case Study," *International Journal of Health Services: Planning, Administration, Evaluation* 45, no. 4 (2015): 779–800, https://doi.org/10.1177/0020731415594772.

[99] Charlene Harrington, "Wealth Extraction from a Nursing Home Chain with Individual, Private Equity, and Real Estate Owners," *Int J Soc Determinants Health Health Serv*. (May 11, 2025). doi: 10.1177/27551938251335565.

company to another, both of which they own - thereby masking profits as costs. This allows nursing homes to under-report their true profitability to CMS and justify their lobbying efforts to boost Medicare and Medicaid reimbursements. The researchers estimated that in 2019, 63 percent of nursing home profits were hidden through inflated internal transfer prices.[100]

Congress attempted to improve transparency and oversight under the 2010 ACA by requiring nursing facilities to disclose detailed ownership information. The regulations to implement the requirements were not implemented until a decade later when the Biden Administration finally issued them,[101] and also proposed minimum staffing levels for nursing homes; but the improved staffing level requirements were quashed by the Republican Congress in 2025.

Game Changer Policy: Congress Should Pass the Break Up Big Medicine Act and End Vertically Integrated Health Conglomerates

Self-dealing and monopoly pricing via vertically integrated conglomerates can be curtailed by breaking them up. Vertical integration was long ignored by antitrust regulators as unlikely to affect market competition. But that changed with the expansion of vertically integrated holding companies and conglomerates that are able to direct the purchase of goods and services to their own subsidiaries or related party businesses. That challenged the view of vertical integration as benign. New guidelines governing merger activity, developed by U.S. antitrust regulators and adopted in 2023, specify the circumstances under which mergers that increase vertical integration will be considered anticompetitive and will be opposed by the agencies that regulate merger activity, the Federal Trade Commission (FTC) and the Department of Justice (DOJ).

Merger Guidelines 2023

In December 2023, the DOJ and FTC released new guidelines detailing what the antitrust agencies use to investigate whether mergers violate antitrust laws. The antitrust agencies have been charged by Congress with "upholding policies that promote open and fair competition, including by preventing mergers and acquisitions that would violate these laws." Guideline 5 is most salient for vertical integration. [102] It recognizes that a merger that creates or expands a vertically integrated firm can also act to foreclose competition from a rival firm by denying it access to customers. In determining whether a vertical merger will limit competition, Guideline 5 instructs the antitrust agencies to consider evidence about the "degree of integration between firms in the relevant and related markets" and whether a trend toward further vertical integration may affect competition and whether the merger was motivated by a desire to "dissuade rivals from entering the market or expanding their operations."[103] Guideline 7 also touches on the anticompetitive potential of mergers that increase vertical integration in the context of consolidation in the relevant markets. The antitrust agencies are instructed to consider

[100] Ashvin Gandhi and Andrew Olenski, "Tunneling and Hidden Profits in Health Care," National Bureau of Economic Research (NBER) Working Paper No. w32258, Mar 2024. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4762965
101 "The Patient Protections and Affordable Care Act," Pub. L. No. 111–148, § 6101, H.R. 3590 42 USC 18001 (2010), https://www.congress.gov/111/plaws/publ148/PLAW-111publ148.pdf; Taylor Lincoln, "Is It Private Equity? We Can't See: Federal Database on Owners of Nursing Homes Is Incomplete and Out-of-Compliance with the Law," (Washington, D.C.: Public Citizen, September 1, 2022), https://www.citizen.org/article/nursing-home-transparency/.
102 Department of Justice and Federal Trade Commission, Merger Guidelines 2023, December 2023. https://www.ftc.gov.
[103] Department of Justice and Federal Trade Commission, *Merger Guidelines 2023*, Guideline 5: Mergers Can Violate the Law When They Create a Firm that May Limit Access to Products or Services That Its Rivals Use to Compete.

the competitive dynamics of the industry which may prevent "the emergence of new competitive threats over time."

These guidelines require the DOL and the FTC to oversee vertical as well as horizontal mergers and to oppose vertical mergers that limit rivals' ability to compete with subsidiaries or related party businesses.

Break Up Big Medicine Act of 2026

On February 10, 2026, Republican Senator Josh Hawley and Democratic Senator Elizabeth Warren introduced the Break Up Big Medicine Act.[104] The purpose of the bill is to remedy a situation in which "large vertically integrated healthcare platforms dominate the American healthcare system" and "own or control every part of the healthcare supply chain." They documented the extent of vertical integration and the numerous conflicts of interest that result. These include:

- One vertically integrated conglomerate owns or controls approximately 10 percent of all physicians in the U.S.
- The three largest drug wholesalers control 98 percent of the drug distribution market and have themselves engaged in substantial vertical integration.
- Since January 2024 the three largest drug wholesalers (McKesson Corporation, Cencora, Inc., and Cardinal Health, Inc.) have proposed or completed acquisitions of four downstream companies with more than 1,000 locations across 35 states.
- Conflicts of interest are endemic when vertically integrated conglomerates own both upstream and downstream providers
    - Drug conglomerates can steer customers to their own pharmacies, which reduces competition and raises costs
    - Health conglomerates that own an insurance company can steer enrollees to doctors' practices owned by the parent company; steering enrollees this way may allow the health conglomerate to evade limits on profits in the Medical Loss Ratio and hide profits
    - Private insurance companies that sponsor Medicare Advantage (MA) plans enable physicians they employ to code enrollees as sicker than they are, driving up government payments to the MA plan without improvements in patient care
    - Vertically integrated drug wholesalers can steer specialty doctors' practices they own to prescribe the most lucrative drugs and devices rather than what is best for patients

To eliminate these conflicts of interest, the bill requires parent companies that own an insurer or pharmacy benefit manager to divest any medical providers they own. The bill also requires parent companies that own a prescription drug or medical device wholesaler to divest any medical provider or management service organization they own. It also empowers a range of regulators to bring civil actions to enforce these separations. And it enables private citizens to bring actions over a violation of the act.

Divestment is to occur within one year of the passage of the Act. For firms that violate provisions of this bill, 10.4 percent of the firm's profits are to be placed in an escrow account on a monthly basis.

[104] Josh Hawley, "Hawley Warren Introduce Bill to Break Up Big Medicine," February 11, 2026. https://www.hawley.senate.gov/hawley-warren-introduce-bill-to-break-up-big-medicine/ Read the bill text here.

It will take the breakup of vertically integrated conglomerates that control the healthcare supply chain to bring down health costs and end profiteering.

Replace the Patent System for Medical Innovation

The United States spends more on prescription drugs than any other country. In 2022, Americans spent nearly three times as much as other OECD countries, and we paid over four times as much for brand-name drugs specifically.[105]

Prices are higher for the same medications in the United States compared to other wealthy nations primarily because other governments use their leverage to negotiate lower prices. In comparison, the U.S. has a complicated insurance system of both private and public payers that lacks a similar negotiation program. As a result, various private and public plans individually or through a third party negotiate deals with drug and device manufacturers. These smaller actors have less power and thus are less successful at lowering prices.

While the United States pays far more for prescription drugs, other countries also face rising costs that threaten public health budgets, because government negotiation merely mitigates the underlying patent system causing high prices.[106] To incentivize innovation, the U.S. government issues patents to the developers of new medical products with a length of 20 years.[107] For various types of products, the government also grants exclusivities to guard against competition and incentivize greater product development.

By blocking competition, patents award drugmakers with monopoly pricing power, allowing them to set extremely high prices to maximize profits. Consequently, generic drugs are often 80-85 percent cheaper than their brand name counterparts.[108] Brand name drugs prices are especially high before patent expiration and generic competition. In 2025, Lendmely – a one-time gene therapy for the rare genetic disease metachromatic leukodystrophy (MLD) – had the highest price drug, costing $4.25 million per dose.[109] The other 9 drugs among the top 10 highest priced medications cost between $2.32 and $3.95 million.

For the 224 cancer drug approvals that the FDA granted for 119 individual drugs between 2015-2020, the median cost was $196,000 annually.[110] These prices were not associated with novelty in how each drug works. Such high prices for cancer medications have likely led millions of Americans to forgo

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[105] Andrew W. Mulcahy, Daniel Schwam, and Susan L. Lovejoy, "International Prescription Drug Price Comparisons: Estimates Using 2022 Data" (RAND Corporation, February 1, 2024), https://doi.org/10.7249/RRA788-3.
[106] European Social Insurance Platform and Medicine Evaluation Committee, *Trends in Pharmaceutical Expenditure* (2024), https://www.politico.eu/wp-content/uploads/2024/10/11/Trends-in-Pharmaceutical-Expenditure_ESIP-MEDEV_2024.pdf.
[107] FDA, "Small Business Assistance: Frequently Asked Questions on the Patent Term Restoration Program," U.S. Food & Drug Administration, August 15, 2025, https://www.fda.gov/drugs/cder-small-business-industry-assistance-sbia/small-business-assistance-frequently-asked-questions-patent-term-restoration-program.
[108] FDA, "Generic Drugs: Questions & Answers," U.S. Food & Drug Administration, March 16, 2021, https://www.fda.gov/drugs/frequently-asked-questions-popular-topics/generic-drugs-questions-answers#:~:text=The%20reduction%20in%20upfront%20research,of%20the%20brand%2Dname%20medicine.
[109] Zoey Becker et al., "UPDATED: Most Expensive Drugs in the US in 2025," Fierce Pharma, August 11, 2025, https://www.fiercepharma.com/special-reports/most-expensive-drugs-us-2025.
[110] Miloš D. Miljković et al., "Cancer Drug Price and Novelty in Mechanism of Action," *JAMA Network Open* 6, no. 12 (December 2023): e2347006, https://doi.org/10.1001/jamanetworkopen.2023.47006.

treatment.[111] Many more experience immense financial strain with one survey finding nearly half of patients going into debt due to their treatment even though 98% had insurance.[112]

Patent Monopolies Are Financial Commodities

Patent monopolies create exorbitant prices not solely by blocking competition, but by turning medicines into financial commodities.[113] Since the 1980s, corporations have embraced a model of shareholder-first capitalism, where their purpose is to maximize shareholder value. Thus, patents don't solely exist to allow a drug company to research and develop a drug; rather, they turn medications into a financial commodity that enriches investors and shareholders.

The pharmaceutical justifies high prices as necessary to finance R&D; however, they actually use the profits to enrich their shareholders through dividends and stock buybacks. From 2013-2022, 14 of the largest publicly traded pharmaceutical companies spent more than 100 percent of their net income on enriching shareholders this way.[114] They spent $773 billion on shareholders compared to just $701 billion on R&D. By spending more and dipping into cash reserves to pay shareholders, the financialization of drug development actually restricts companies from reinvesting profits into R&D.

Corporate executives are incentivized funnel money away from R&D or patients in the form of lower prices and towards shareholders as most of their pay comes from stock options. From 2006-2022, the highest paid pharmaceutical company executives annually earned almost 82 percent of their total direct compensation from stock options and awards on average (median of 86 percent).[115]

Patented medicines as financial assets have also pushed large pharmaceutical companies to use acquisitions and mergers to own products rather than doing the necessary R&D themselves.[116] Most new medications come from smaller biotechnology firms that raise funds by the means necessary to eventually get acquired.[117] For example, the Hepatitis C curative treatment sofosbuvir was originally created by Pharmasset, a company explicitly named as an asset of "Pharma." While Pharmasset went into $330 million in deficits to finance its operations, its financial gambit played out when Gilead Sciences acquired them for $11.2 billion.[118]

Pharmaceutical companies justify high prices by arguing that the exorbitant prices are less than a health system would otherwise spend on worse treatments and the resulting costly care like hospitalizations.[119] Gilead Sciences used this justification for the launch price of sofosbuvir, which has the ability to

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[111] Liz Szabo, "Sticker Shock Forces Thousands Of Cancer Patients To Skip Drugs, Skimp On Treatment," KFF Health News, March 15, 2017, https://kffhealthnews.org/news/sticker-shock-forces-thousands-of-cancer-patients-to-skip-drugs-skimp-on-treatment/; Stacie B. Dusetzina et al., "Many Medicare Beneficiaries Do Not Fill High-Price Specialty Drug Prescriptions," *Health Affairs* 41, no. 4 (April 2022): 487–96, https://doi.org/10.1377/hlthaff.2021.01742.

[112] "Survivor Views: Majority of Cancer Patients & Survivors Have or Expect to Have Medical Debt," American Cancer Society Cancer Action Network, May 9, 2024, https://www.fightcancer.org/policy-resources/survivor-views-majority-cancer-patients-survivors-have-or-expect-have-medical-debt.

[113] Victor Roy, *Capitalizing a Cure: How Finance Controls the Price and Value of Medicines* (Oakland, CA: University of California Press, 2023).

[114] Öner Tulum and William Lazonick, *Innovation versus Financialization in the US Pharmaceutical Industry* (Cambridge, UK: Cambridge University Press, 2025), 20.

[115] Ibid, 23.

[116] Roy, *Capitalizing a Cure*, 110-11.

[117] "The US Ecosystem for Medicines. How New Drug Innovations Get to Patients.," *Vital Transformation*, December 5, 2022, https://vitaltransformation.com/2022/12/the-us-ecosystem-for-medicines-how-new-drug-innovations-get-to-patients/.

[118] Roy, Capitalizing a Cure, 60, 111.

[119] Ibid, Chapter 3.

eliminate Hepatitis C. The company priced its sofosbuvir-based combination therapy at $94,500 for a twelve-week regimen. "Value-based" pricing schemes cause a cascade of ever-increasing prices, as new and improved treatments are priced higher than previous standards for care for providing additional "value."

High costs from patent monopolies and financialization mean that many Americans cannot access critical, life-saving medications. While sofosbuvir treatment could have eliminated Hepatitis C following FDA approval in December 2013, only a third of adults diagnosed with the disease were cured from 2013-2022.[120] Even Gilead's generic sofosbuvir treatment costs over $20,000.[121] High prices forced Medicare and Medicaid – like other nations – to ration access to sofosbuvir to the sickest patients.[122]

Financialized profits encourage lack of access, as share prices come from expected growth. While an expensive curative treatment may generate immense profits, it hurts future growth as the patient population will inherently decrease as people are cured.[123] However, forcing rationed care prolongs growth and raises share prices. As a Wall Street analyst remarked about Gilead Sciences and sofosbuvir: "if anyone including Medicaid starts to limit to only sicker patients, this wouldn't dramatically worry us and could be better long-term."[124]

Patent Monopolies Distort Innovation and Encourage Dangerous Secrecy

Patent monopolies do not just reduce access for lifesaving, safe, and effective medications: They promote significant spending on less effective and even dangerous medicines as well.

Through patents, drug companies reap exorbitant profits by preventing competition, and they enrich shareholders with the expectations of growth and profit rather than the direct benefit to public health. Thus, if companies are to get doctors to prescribe and health systems to pay for their products – regardless of if they are better than existing standards of care – then they reap the financial rewards. Among the 150 drugs with the top U.S. sales in 2020, pharmaceutical companies spent more money marketing less clinically beneficial drugs compared to medications that provided greater benefit to patients.[125]

Drug companies have "innovated" new products to boost profits without greatly improving care. A central method of such innovation is evergreening: expanding patent and exclusivity protections through small adjustments to an existing product that don't meaningfully benefit public health. From 2005-2015, 78% of drugs tied to new patents were not genuinely novel.[126] The companies behind 72% of

[120] Carolyn Wester et al., "Hepatitis C Virus Clearance Cascade — United States, 2013–2022," MMWR Morbidity and Mortality Weekly Report 72, no. 26 (June 30, 2023): 716–720, http://dx.doi.org/10.15585/mmwr.mm7226a3.
[121] "Gilead Subsidiary to Launch Authorized Generics of Epclusa® (Sofosbuvir/Velpatasvir) and Harvoni® (Ledipasvir/Sofosbuvir) for the Treatment of Chronic Hepatitis C," Gilead, September 24, 2018, https://www.gilead.com/news/news-details/2018/gilead-subsidiary-to-launch-authorized-generics-of-epclusa-sofosbuvirvelpatasvir-and-harvoni-ledipasvirsofosbuvir-for-the-treatment-of-chronic-hepatitis-c.
[122] Roy, *Capitalizing a Cure*, 87-91.
[123] Ibid, 98-101.
[124] Ibid, 90.
[125] Michael J. DiStefano et al., "Association Between Drug Characteristics and Manufacturer Spending on Direct-to-Consumer Advertising," *JAMA* 329, no. 5 (February 7, 2023): 386–92, https://doi.org/10.1001/jama.2022.23968.
[126] Robin Feldman, "May Your Drug Price Be Evergreen," *Journal of Law and the Biosciences* 5, no. 3 (December 7, 2018): 590–647, https://doi.org/10.1093/jlb/lsy022.

the top 106 best-selling drugs extended their patents past the original 20-year protection period at least once; most (roughly 51%) did so multiple times.

Patents also promote secrecy by granting companies control over their research and clinical trial data. This control allows companies to frame and distort medical knowledge to their benefit while hiding the full truth of medications from independent actors. According to an internal Pfizer document: "Pfizer-sponsored studies belong to Pfizer, not to any individual ... Purpose of data is to support, directly or indirectly, marketing of our product ... Therefore, commercial marketing/medical need to be involved in all data dissemination efforts."[127]

Only the FDA can require companies to share the full, underlying clinical trial data meant to prove the safety and efficacy of their products. Yet, the FDA has weakened its preapproval evidentiary standards over the last several decades so that drugs require less high-quality evidence for approval.[128] Additionally, agency approval does not demonstrate whether treatments are significantly better than existing standards of care. Thus, outside observers do not have access to the essential data that would guide clinical practice to best benefit patients.

The weaknesses of FDA approval are compounded by the fact that industry funds and controls the studies meant to demonstrate safety and effectiveness. Numerous studies have repeatedly demonstrated that industry-sponsored research is significantly more likely to produce findings favorable to the respective company than independent studies.[129] Exorbitant patent monopoly profits greatly incentivize such biasing of research and the hiding of unfavorable results, and the FDA's inability to demand high-quality evidence fails to check such corporate power.

Furthermore, the premier sources of knowledge for practicing healthcare professionals are peer-reviewed medical journals. While drugmakers submit manuscripts from their clinical trials to journals for publishing, these submissions only include limited selections of the full trial data.[130] Thus, the journal editors and peer-reviewers do not properly vet the published trial results that influence clinical decision-making.

Data secrecy has caused both significant physical and financial harm to patients and society at large. In the early 2000s, Merck hid the significant cardiovascular side effects that its drug Vioxx – a nonsteroidal anti-inflammatory drug (NSAID) – caused from the *New England Journal of Medicine* (*NEJM*) and public at large. Consequently, Vioxx killed an estimated 30,000-60,000 Americans in the 5 years it was on the market before Merck pulled it.[131] In the earlier stages of the opioid epidemic that killed over 800,000

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[127] Glen I. Spielmans and Peter I. Parry, "From Evidence-Based Medicine to Marketing-Based Medicine: Evidence from Internal Industry Documents," *Journal of Bioethical Inquiry* 7 (January 21, 2010): 14, https://doi.org/10.1007/s11673-010-9208-8.
[128] Jonathan J. Darrow, Jerry Avorn, and Aaron S. Kesselheim, "FDA Approval and Regulation of Pharmaceuticals, 1983-2018," *JAMA* 323, no. 2 (January 14, 2020): 164–76, https://doi.org/10.1001/jama.2019.20288; Aaron P. Mitchell et al., "The Prescription Drug User Fee Act: Much More Than User Fees," *Medical Care* 60, no. 4 (2022): 287–93, https://doi.org/10.1097/MLR.0000000000001692.
[129] Justin E. Bekelman, Yan Li, and Cary P. Gross, "Scope and Impact of Financial Conflicts of Interest in Biomedical Research: A Systematic Review," JAMA 289, no. 4 (January 22, 2003): 454–65, https://doi.org/10.1001/jama.289.4.454; Andreas Lundh et al., "Industry Sponsorship and Research Outcome," ed. Cochrane Methodology Review Group, Cochrane Database of Systematic Reviews 2017, no. 2 (February 16, 2017): Article MR000033, https://doi.org/10.1002/14651858.MR000033.pub3.
[130] John Abramson, *Sickening: How Big Pharma Broke American Health Care and How We Can Repair It* (Boston, MA: Mariner Books, 2022).
[131] David J. Graham et al., "Risk of Acute Myocardial Infarction and Sudden Cardiac Death in Patients Treated with Cyclo-Oxygenase 2 Selective and Non-Selective Non-Steroidal Anti-Inflammatory Drugs: Nested Case-Control Study," *The Lancet* 365, no. 9458 (February 5, 2005): 475–81, https://doi.org/10.1016/S0140-6736(05)17864-7; David Graham, "Testimony of David J.

Americans from 1999-2023, the *Archives of Internal Medicine* in 2000 published results from one of the many Purdue-Pharma-sponsored trials.[132] The article reported less patients experiencing withdrawal symptoms than the number revealed in Purdue's 2007 legal settlement.[133] According to one of the article's authors, "we reported on the data which was provided to us [by Purdue]."

Roche hid the underlying data behind its trials for Tamiflu – an influenza treatment – from *JAMA Internal Medicine* and the Cochrane Collaboration, leading to the company earning $18 billion globally from 1999-2014.[134] Governments stockpiled the drug, believing it would greatly help prevent and treat influenza in a serious pandemic or pandemic. However, when Cochrane researchers got access to the underlying trial data, they saw a different picture.[135] Tamiflu had minimal impact on preventing and treating influenza and it had relatively common harms of nausea, vomiting, headaches, and psychiatric adverse events.

Exorbitant profits from patent monopolies also encourage illegal behavior because the cost of getting caught by federal enforcers is less than the money made from such illicit activities. A 2026 research letter in *JAMA Network Open* looked at the size of financial penalties the US government levied against pharmaceutical companies for making illegal kickbacks to physicians, pharmacies, and other healthcare entities between 2000 and 2025.[136] The median penalty was just 2.2 percent of US revenue from selling the implicated drugs during the years of alleged kickback behavior.

Patent Monopolies Promote Corruption of Medical Institutions

Patent monopolies incentivize industry to buy influence over medical institutions. Major medical journals have earned significant revenues from pharmaceutical company advertising and/or reprints.[137] Industry finances organizations who make clinical guidelines that clinicians follow when treating their

Graham, MD, MPH" (U.S. Senate Committee on Finance, November 18, 2004), https://www.govinfo.gov/content/pkg/CHRG-112hhrg72917/pdf/CHRG-112hhrg72917.pdf; Abramson, *Sickening*, Chapter 1.

[132] CDC, "Understanding the Opioid Overdose Epidemic," CDC: Overdose Prevention, June 9, 2025, https://www.cdc.gov/overdose-prevention/about/understanding-the-opioid-overdose-epidemic.html; Sanford H. Roth et al., "Around-the-Clock, Controlled-Release Oxycodone Therapy for Osteoarthritis-Related Pain: Placebo-Controlled Trial and Long-Term Evaluation," *Archives of Internal Medicine* 160, no. 6 (March 27, 2000): 853–60, https://doi.org/10.1001/archinte.160.6.853.

[133] Peter Whoriskey, "Rising Painkiller Addiction Shows Damage from Drugmakers' Role in Shaping Medical Opinion," *The Washington Post*, December 30, 2012, https://www.washingtonpost.com/business/economy/2012/12/30/014205a6-4bc3-11e2-b709-667035ff9029_story.html.

[134] Abramson, *Sickening*, 127-28; Andrew Jack, "Tamiflu: 'A Nice Little Earner,'" *BMJ* 348, no. 7953 (April 9, 2014): g2524, https://doi.org/10.1136/bmj.g2524.

[135] Tom Jefferson et al., "Neuraminidase Inhibitors for Preventing and Treating Influenza in Adults and Children," *Cochrane Database of Systematic Reviews* 2018, no. 1 (April 10, 2014): Article CD008965, https://doi.org/10.1002/14651858.CD008965.pub4.

[136] Tobias Liu et al., "Pharmaceutical Manufacturer Kickback Resolutions and Associated Financial Penalties, 2000-2025," *JAMA Network Open* 9, no. 3 (March 13, 2026): e261735, https://doi.org/10.1001/jamanetworkopen.2026.1735.

[137] Richard Smith, "Medical Journals Are an Extension of the Marketing Arm of Pharmaceutical Companies," *PLoS Medicine* 2, no. 5 (May 17, 2005): e138, https://doi.org/10.1371/journal.pmed.0020138; Michael S. Sinha, Aaron S. Kesselheim, and Jonathan J. Darrow, "Pharmaceutical Advertising in Medical Journals," *Chest* 153, no. 1 (2018): 9–11, https://doi.org/10.1016/j.chest.2017.09.048.

patients.[138] Many editors and authors for both journals and guidelines maintain significant financial conflicts of interest with the very companies whose products they are meant to analyze.[139]

Such significant entanglements are not secret. In 2004, editor-in-chief of *The Lancet* Richard Horton wrote about the "corrupt covenant" between medical societies and industry and how "journals have devolved into information laundering operations for the pharmaceutical industry."[140] Similarly, former editor-in-chief of NEJM Marcia Angell remarked that the drug industry is "a marketing machine to sell drugs of dubious benefit, this industry uses its wealth and power to co-opt every institution that might stand in its way, including the U.S. Congress, the Food and Drug Administration, academic medical centers, and the medical profession itself."[141]

Industry also uses its profits reaped from patent monopolies to invest in and thus influence medical schools. In 2010, Stanford University received $3 million from Pfizer to fund a continuing medical education (CME) program for its physicians and other healthcare professionals.[142] The Yale School of Medicine inked a $100 million research deal with Gilead Sciences for 2011-2021.[143] Harvard Medical School (HMS) signed a five-year $30 million research deal with drugmaker National Resilience in 2021.[144] The Executive Director of Therapeutics at HMS, Mark Namchuck, supported such industry funding as greater exposure to industry would help the many students' future careers working for biopharmaceutical companies.[145] These examples are not unique as medical schools increasingly seek industry financing.

Drugmakers have also devoted significant resources to influencing students directly. A 2011 systemic review of 32 peer-reviewed research articles found that 89-98% of medical students accepted food from the pharmaceutical industry during the clinical years of their medical education.[146] This influence carries over into professional practice, as most newly independent physicians from residency or fellowship

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[138] Paul Campsall et al., "Financial Relationships between Organizations That Produce Clinical Practice Guidelines and the Biomedical Industry: A Cross-Sectional Study," ed. Hilda Bastian, *PLoS Med* 13, no. 5 (May 31, 2016): e1002029, https://doi.org/10.1371/journal.pmed.1002029.

[139] Kristine Rasmussen et al., "Collaboration between Academics and Industry in Clinical Trials: Cross Sectional Study of Publications and Survey of Lead Academic Authors," *BMJ* 363, no. 8170 (October 3, 2018): k3654, https://doi.org/10.1136/bmj.k3654; Maryam Mooghali et al., "Financial Conflicts of Interest among US Physician Authors of 2020 Clinical Practice Guidelines: A Cross-Sectional Study," *BMJ Open* 13, no. 1 (January 23, 2023): e069115, https://doi.org/10.1136/bmjopen-2022-069115.

[140] Richard Horton, review of *The Dawn of McScience*, by Sheldon Krimsky, *The New York Review of Books*, March 11, 2004, https://www.nybooks.com/articles/2004/03/11/the-dawn-of-mcscience/.

[141] Marcia Angell, *The Truth about the Drug Companies: How They Deceive Us and What to Do About It* (Random House Trade Paperbacks, 2005).

[142] Dan Bowman, "Stanford: Pfizer Will Fund Our Med School Curriculum with 'No Strings Attached,'" Fierce Healthcare, January 12, 2010, https://www.fiercehealthcare.com/healthcare/stanford-pfizer-will-fund-our-med-school-curriculum-no-strings-attached.

[143] Kara Nyberg, "Pharma and Academia Partner for Better Health," Yale School of Medicine, Spring 2013.

[144] "Harvard University and Resilience Announce Five-Year R&D Alliance to Incubate New Technologies, Launch Companies to Advance the Manufacture of Complex Medicines," Harvard Office of Technology Development, President and Fellows of Harvard College, October 15, 2021, https://otd.harvard.edu/news/harvard-university-resilience-announce-five-year-rd-alliance/; Ariel H. Kim and Meimei Xu, "HMS Dean Outlines Financial, Institutional Goals in State of the School Address," *The Harvard Crimson*, October 6, 2021, https://www.thecrimson.com/article/2021/10/6/hms-state-of-the-school/.

[145] Veronica Paulus and Akshaya Ravi, "'Deal with the Devil': Harvard Medical School Faculty Grapple with Increased Industry Research Funding," *The Harvard Crimson*, April 23, 2024, https://www.thecrimson.com/article/2024/4/23/hms-biopharma-funding/.

[146] Kirsten E. Austad, Jerry Avorn, and Aaron S. Kesselheim, "Medical Students' Exposure to and Attitudes about the Pharmaceutical Industry: A Systematic Review," ed. Joel Lexchin, *PLoS Med* 8, no. 5 (May 24, 2011): e1001037, https://doi.org/10.1371/journal.pmed.1001037.

programs received payments from drugmakers.[147] This is part of an intentional marketing strategy, as an internal Parke-Davis document outlined its plan to "initiate a regional epilepsy residents program in order to influence physicians from the bottom up."[148]

Industry also uses its patent monopoly profits to influence highly respected doctors or key opinion leaders (KOLs).[149] Through funding these scientists and getting them to give presentations favorable to industry products, pharmaceutical companies use KOLs as salespeople that increase prescriptions, sales, and profits.

While control over medical institutions increases drugmakers' profits, the current patent system only exists insofar as government policy permits it. Thus, the pharmaceutical industry has invested billions of dollars to finance political campaigns and employ lobbyists to shape public policy. From 1990-2024, the pharmaceutical/health products industry (including both individuals and corporate PACs) spent $522.4 million on federal campaign contributions, and it spent $7.0 billion on lobbying the federal government from 1998-2025.[150]

Consequently, patent monopolies do not just grant industry significant economic power but political power as well. For example, PhRMA, the organization lobbying on behalf of the pharmaceutical industry, spent $72.6 million lobbying Congress in 2003, pushing the government to explicitly bar Medicare from negotiating and thus lowering drug prices in the Medicare Modernization Act.[151] One of the legislation's leaders, Rep. Billy Tauzin, left Congress to become the CEO and president of PhRMA.[152] In 2010, he was the highest-paid health-law lobbyist, earning $11.6 million.[153]

Ultimately, patents only partially address the fundamental free market failure for innovation: in a completely unregulated market, innovators bear the cost of developing new products while copycats can reap the benefits without having to innovate at all. However, patents fail to both direct innovation to benefit public health and allow patients to access critical, potentially life-saving treatments. And the vast majority of FDA-approved drugs on the market benefitted from publicly funded basic and translational research.[154] Drugmakers wouldn't have had the knowledge to make their products without such public investment; yet patents grant them the power to use monopoly prices thereby by socializing the costs and privatizing the profits.

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[147] Misop Han et al., "Trends in Industry Payments to Physicians in the First 6 Years After Graduate Medical Training," *JAMA Network Open* 5, no. 10 (October 19, 2022): e2237574, https://doi.org/10.1001/jamanetworkopen.2022.37574.
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[153] Alex Wayne and Drew Armstrong, "Tauzin's $11.6 Million Made Him Highest-Paid Health-Law Lobbyist," Bloomberg, November 29, 2011, https://www.bloomberg.com/news/articles/2011-11-29/tauzin-s-11-6-million-made-him-highest-paid-health-law-lobbyist.
[154] Ekaterina Galkina Cleary et al., "Comparison of Research Spending on New Drug Approvals by the National Institutes of Health vs the Pharmaceutical Industry, 2010-2019," *JAMA Health Forum* 4, no. 4 (April 28, 2023): e230511, https://doi.org/10.1001/jamahealthforum.2023.0511.

Game Changer Policy: Public Funding Through Direct Contracts and Prize Funds

Policymakers must move away from the patent system of innovation so that (A) innovators are rewarded (B) innovation is geared toward public health and (C) patients have access to the medical products they need. Congress should legislate the two alternative systems that can replace the patent system and co-exist with one another: federal contracts and prize funds.

Direct contracts already exist to a limited extent with the National Institutes of Health (NIH) and its budget of nearly $50 billion that primarily funds research.[155] In a new system like defense contracts, researchers could competitively bid for government contracts to research new medicines and disease cures. Upfront funding of research would have products face immediate competition upon FDA approval and be priced as generics. Additionally, the contracts can stipulate open sharing of clinical research to prevent secrecy. On its own, this system of federal contracts need not overly replace the patent system; rather it would serve as a public option.[156]

A few legislative proposals in the United States would implement similar programs. Most recently, Representative Rashida Tlaib introduced the Medicines for the People Act in March 2026.[157] The bill would create the National Institute for Biomedical Research and Development (NIBRD) which would fund the entire lifecycle of research and development for drugs, biologics, and medical devices. The NIBRD would exist with the NIH, and research would either take place internally or through awarding contracts to private actors.

The federal government would hold the patent for any medical product that it funded internally or through contracts. Similarly, the government would have the ability to acquire and right of first refusal of any other product "that is the result of research conducted or supported by the National Institutes of Health." Unlike corporations in the current patent-based system, the NIBRD's mission is to set low prices so that medicines are broadly accessible. Health technology assessments (HTAs) – which compare the new treatment to existing alternatives – would inform the prices behind each product. To varying degrees, similar HTA programs exist in peer nations like the United Kingdom, Canada, and Australia.

Research priorities for the NIBRD would come from a 15-voting-member board with six-year terms and restrictions meant to prevent members having corrupting financial ties to industry. The three guiding principles for research prioritization that the bill provides are (1) the potential public health impact, (2) unmet needs in current product development, and (3) the potential for scientific breakthrough. Along with research priorities, the bill directs the NIBRD to make publicly available the "preclinical and clinical trial data and data on costs" for its products "in an open and timely manner."

Before the Medicines for the People Act, Representative Dennis Kucinich introduced the Free Market Drug Act (FMDA) in 2004.[158] Creating an institute with the same name (NIBRD), this proposal would similarly fund research and development for drugs, biologics, and medical devices. The NIBRD would

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[155] "Budget," National Institutes of Health, June 13, 2025, https://www.nih.gov/about-nih/organization/budget.
[156] Dean Baker, *Rigged: How Globalization and the Rules of the Modern Economy Were Structured to Make the Rich Richer* (Washington, D.C.: Center for Economic and Policy Research, 2016): 81-82, https://deanbaker.net/images/stories/documents/Rigged.pdf.
[157] Rashida Tlaib, "Medicines for the People Act," H.R.7854 (2026), https://web.archive.org/web/20260309032049/https://d12t4t5x3vyizu.cloudfront.net/tlaib.house.gov/uploads/2026/03/TLAIB_083_xml_Final.pdf.
[158] Dennis J. Kucinich, "Free Market Drug Act," H.R.5155 (2004), https://www.congress.gov/bill/108th-congress/house-bill/5155/cosponsors.

post online "all raw data developed … in carrying out research and development activities." The NIBRD would issue nonexclusive licenses to private manufacturers, creating a competitive market to lower prices. The Medicines for the People Act similarly allowed for such nonexclusive licensing, while also prioritizing providing licenses to nonprofits over for-profit entities.

Importantly, these direct funding programs would create a public option rather than replace the current patent system. Highlighting this reality, industry spent $161.8 billion (66.0 percent) in 2020 on US medical and health R&D.[159] In comparison, the FMDA appropriated $19.9 billion to the NIBRD in 2004 (around $27.3 billion in 2020 dollars), and the Medicines for the People Act granted $90 billion to the NIBRD for FY 2027 (around $71.3 billion in 2020 dollars).[160] Thus, the United States would still face products with exorbitant prices that often are not better than existing treatments and which industry hides the underlying data.

Contrastingly, a prize-fund system would replace patents. Such a model has been proposed both domestically and globally. In 2017, Senator Bernie Sanders introduced the Medical Innovation Prize Fund Act (MIPFA).[161] This legislation would create a prize fund authority to appropriate funds to reward innovative drugs, biologics, and manufacturing processes for a drug or biologic. While the bill did not include medical devices, future proposals could do so.

The MIPFA would create a 13-member board to make decisions on allocating prize funds and six advisory committees to assist the board's decision-making. The key difference between the MIPFA and the direct contract proposals is that the former explicitly bars anyone from having "the right to exclusively manufacture, distribute, sell, or use a drug, a biological product, or a manufacturing process for a drug or biological product in interstate commerce."

The MIPF board would make decisions on how to allocate prize funds based on criteria that include how many patients would benefit from the innovation along with the added therapeutic benefit to existing standards of care. Additional categories would exist, such as specific funding for the open sharing of "knowledge, data, materials and technology." Other proposals can include a requirement that all clinical research – deidentifying patient data – is made available to the public following prize fund allocation. Similar to the contract model, medical products would face competition immediately following FDA approval.

Rather than appropriate a specific amount per year to fund medical research, the MIPFA would allocate a defined percentage of US gross domestic product (0.55 percent) from the previous fiscal year. In 2020, the bill would have provided $118.5 billion in prize funds.[162] This figure is roughly 73.2 percent of industry spending on medical and health R&D, which includes a broader scope of research, including but not limited to medical devices.

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[159] "U.S. Investments in Medical and Health Research and Development: 2016-2020" (Research!America, January 2022), https://www.researchamerica.org/wp-content/uploads/2022/09/ResearchAmerica-Investment-Report.Final_.January-2022-1.pdf.

[160] Maple Tech International, Inflation Calculator, accessed March 23, 2026, https://www.calculator.net/inflation-calculator.html.

[161] Bernard Sanders, "Medical Innovation Prize Fund Act," S.495 (2017), https://www.congress.gov/bill/115th-congress/senate-bill/495.

[162] U.S. Bureau of Economic Analysis, "National Data: National Income and Product Accounts (2019)," BEA, March 13, 2026, https://apps.bea.gov/iTable/?reqid=19&step=2&isuri=1&categories=survey#eyJhcHBpZCI6MTksInN0ZXBzIjpbMSwyLDMsM10sImRhdGEiOltbImNhdGVnb3JpZXMiLCJTdXJ2ZXkiXSxbIk5JUEFfVGFibGVfTGlzdCIsIjUiXSxbIkZpcnN0X1llYXIiLCIyMDE5Ll0sWyJMYXN0X1llYXIiLCIyMDE5Ll0sWyJTY2FsZSIsIi05Ll0sWyJTZXJpZXMiLCJBIl1dfQ==.

Together, the contract and prize fund models would replace the patent system and complement each other by addressing each other's limitations. Direct federal funding of research both in house and via contracts would not get rid of the patent system and its consequences while a prize fund would. Contracts incentivize the financing of long-term, risky research due to upfront financing. However, the government would directly decide what research to fund while a prize fund would allow researchers to decide what avenue is best to take.

Direct, upfront funding of medical research has already been crucial to drug development in the United States. NIH spending on basic and translational research has served as the necessary foundation that industry capitalizes on to develop medical products. The authors of a 2023 study in *JAMA Health Forum* examined the NIH's discounted investment in FDA-approved drugs from 2010 to 2019.[163] Among 356 approved products, NIH-funded research contributed to 354 (99.4 percent).

NIH research was crucial in the underlying technology behind the mRNA COVID-19 vaccines.[164] With Moderna, the NIH helped design and test the vaccine, and it even filed patents covering key components.[165] After years of dismissing government involvement, Moderna eventually made a $400 million catch-up payment to the US government in February 2023 along with agreeing to pay single-digit royalties.[166] NIH funding was additionally crucial in allowing for the development of the hepatitis C treatment sofosbuvir, and additional government funding served as a confidence boost that drew in key private investment into Pharmasset.[167]

Regarding transparency, a prize fund would not guarantee open sharing of data until after market approval while contracts could allow immediate sharing of data. Thus, rather than companies' hiding data to stave off competitors and maximize patent-monopoly profits, public funding would boost scientific advancement through ending siloes and sharing information. As many cases such as Vioxx show, the patent system's secrecy additionally encourages the hiding of data to suppress the dangers and/or ineffectiveness of medical products.

Public funding of medical research through contracts and prize funds would not only combat the consequences of the patent system's exorbitant profits discussed earlier, but policymakers have the power to set strict standards. On top of data transparency, contract and prize fund recipients could face design requirements for high-quality clinical trials to improve the validity of each study's findings. Policymakers can also prevent these entities from lobbying the federal government.

While government spending on medical research would need to significantly increase to replace the patent system, the country would likely save hundreds of billions of dollars. Generic drugs are often 80-85 percent cheaper than their brand-name counterparts.[168] By eliminating patent monopoly prices, allowing low-cost manufacturing of drugs, and assuming a 80 percent cost reduction via generics, the

[163] Ekaterina Galkina Cleary et al., "Comparison of Research Spending on New Drug Approvals by the National Institutes of Health vs the Pharmaceutical Industry, 2010-2019."
[164] "Analysis: Pfizer Vaccine Relies on U.S. Government-Developed Spike Protein Technology," Public Citizen, November 10, 2020, https://www.citizen.org/news/analysis-pfizer-vaccine-relies-on-u-s-government-developed-spike-protein-technology/.
[165] Zain Rizvi, "The NIH Vaccine" (Public Citizen, June 25, 2020), https://www.citizen.org/article/the-nih-vaccine/.
[166] Eric Sagonowsky, "Moderna Pays US Government $400M 'Catch-Up Payment' under New COVID-19 Vaccine License," Fierce Pharma, February 24, 2023, https://www.fiercepharma.com/pharma/moderna-pays-us-government-400m-catch-payment-under-new-covid-19-vaccine-license; Moderna, "Moderna Reports Fourth Quarter and Fiscal Year 2022 Financial Results and Provides Business Updates," Access Newswire, February 23, 2023, https://www.accesswire.com/740439/Moderna-Reports-Fourth-Quarter-and-Fiscal-Year-2022-Financial-Results-and-Provides-Business-Updates.
[167] Roy, *Capitalizing a Cure*, 23-50.
[168] FDA, "Generic Drugs: Questions & Answers."

United States would have saved $430 billion in 2022.[169] This is $179 billion more than the pharmaceutical industry spent globally on medical R&D in the same year.[170]

Ultimately, under a system of public contracts and prize funds, patients would not lack access to treatments due to exorbitant prices, and health systems would save hundreds of billions of dollars. Drugs and other medical products would not exist as financial assets to fuel the enrichment of shareholders rather than R&D into better treatments that improve public health. Profits from monopoly prices would not enable the purchasing of influence over medical institutions, doctors, elected officials, and regulators alike that distort the medical knowledge that healthcare workers rely upon. Rather than encourage secrecy that hides ineffective and dangerous products, open sharing of research would accelerate scientific and medical progress. As stated by Dr. John Abramson: "Healthcare has become yet another test of our democracy. Although success is in no way preordained, we, the citizens of that democracy, can rise to meet these immense challenges."[171]

*For more information on this topic, including the **Background Paper**,* please visit our policy page.

Contacts: Rosemary Batt: rb41@cornell.edu / Eileen Applebaum: appelbaum@cepr.net

[169] Andrew W. Mulcahy, Daniel Schwam, and Susan L. Lovejoy, "International Prescription Drug Price Comparisons: Estimates Using 2022 Data" (RAND Corporation, February 1, 2024), https://doi.org/10.7249/RRA788-3.
[170] "Pharma's Rx for R&D," McKinsey & Company, February 11, 2025, https://www.mckinsey.com/featured-insights/sustainable-inclusive-growth/charts/pharmas-rx-for-r-and-d.
[171] Abramson, *Sickening*, 230.