# California's Targeting of Private Equity Looks More Like Misplaced Anger Than Good Policy

*California's newest statutes assume that private equity firms and management services organizations are at the root of runaway healthcare costs. Is that really justified?*

**Brooke Hannon**

America's healthcare policymakers are repeating the first mistake every medical student is taught to avoid: prescribing a treatment before making the right diagnosis. With healthcare costs increasing and quality of care decreasing, conversations surround private equity investment and the belief that special restrictions are necessary. But before prescribing these solutions, lawmakers should identify the true root of the problem.

Here is the main symptom: in just a decade, the prices at California's largest multi-hospital systems grew 113% compared to 70% at all other hospitals.[1] A decade ago choosing a hospital based on price was not difficult; prices were similar and reasonably competitive across facilities. Today, however, you could pay thousands more at one hospital versus another, not because of quality or amenities, but because of who owns and runs the hospital behind the scenes.[1]

Arbitrary variation in prices is understandably frustrating for patients. But instead of looking at the structural factors causing care to become more expensive, California has passed AB-1415 and SB-351, both of which target Private Equity (PE) firms and Management Services Organizations (MSOs). Are PE firms and MSOs really the cause of California's rising healthcare prices, or are they just an easy target to blame?

PE firms acquire and manage hospitals and physician practices to increase their financial value by consolidating operations, cutting administrative costs, and expanding market share, with the ultimate goal of selling the entity for a profit. MSOs exist to provide the behind-the-scenes business support while physicians remain in control of patient care.[2] Their existence gives physicians the ability to keep their independent practices open and not have to immediately sell out to massive hospital giants, which can be enticing, especially in an expensive state like California. Getting involved with a PE firm and an MSO is not imposed on anyone. These are voluntary partnerships between doctor owners who choose to solve capital problems and investors choosing to back a practice they believe in.

Most doctors went to medical school because they wanted to practice medicine and not become accountants, insurance adjusters, or contract negotiators. But independent physicians are sucked into doing it all, arguing with insurance companies, balancing payroll, and doing

regulatory compliance. Some doctors enjoy the business side of running their practice. Others don't. For the ones who don't, it is a second job they didn't ask for, might not be good at, and don't want to be doing.

California's bill AB1415 makes that partnership harder to reach. In bringing private equity groups and MSOs under the Office of Health Care Affordability (OHCA), it requires written notice before closure of any material transaction.[3] These reviews can last months, especially if a "Cost and Market Impact Review" (CMIR) is ordered and findings are referred to the California Attorney General.[4] A regulatory delay of this length can destroy a deal due to financing terms expiring or parties back out. At the end of the day, time is money.

In hampering how PE firms and MSOs make deals, California is suppressing one source of competition that could serve as a check against hospital systems being able to raise their prices. As physicians consolidate into large systems, the hospitals gain the leverage to negotiate prices as a single entity. Get rid of the option for MSO partnerships and private investment and the physician's next call is going to be to join one of the systems. Not because they want to or because it is better for their patients, because it allows them to keep practicing medicine.

SB-351 takes this even farther, eliminating standard business agreements such as non-competes and continuity agreements.[5] These are easy to vilify, but they serve the purpose of providing security for the investment that MSOs are making. Why would an MSO invest in training a doctor who is free to leave and join a competing practice down the road? Provider shortages can increase due to this as entities will be hesitant to expand their clinics and put money into a risky asset. Even organizations like the California Medical Association warranted policymakers that rigid barriers for standard business structures are likely to disrupt existing, stable provider alignments.[6]

Perhaps some PE firms and MSOs deserve criticism. As businesses they often make hard or unpopular management choices as they seek to optimize the practices and facilities that they buy and work with. They are bound to make mistakes, such as cutting too many resources or pushing their staff too hard to increase efficiency. But, to use a cliche, those decisions are literally *their* business, i.e., they have purchased these practices and facilities with their capital from willing buyers.

Likewise, perhaps not every aspect of SB-351 deserves criticism. The bill prohibits private equity investment groups from impacting the professional judgment of physicians. Given the way licensing and liability work, maybe this is reasonable. It is the physicians who are the ones who spent years going to school to learn treatment plans and who are in many ways responsible for patient outcomes. It also makes sure that patients feel protected in a very vulnerable space.

California's AB1415 and SB351, which went into effect on January 1, 2026, represent significant government intervention that stifles capital investment, creates administrative hurdles, and distorts the private healthcare marketplace. They are predicated on a belief that PE firms and MSOs are irredeemably bad for healthcare, but the evidence saying that their involvement leads to increases in prices is thin, at high risk of bias, and still emerging. States should be careful

about passing aggressive regulations, especially when the "solution" might make the problem worse. In California, lawmakers looked right past other possible explanations, such as how past policy decisions have led to hospital consolidation, and pushed for these two laws anyways. Policymakers in other states should take heed and come up with a better treatment plan that attacks the real root of the problem.

**About the Author**

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The author has declared no potential conflicts of interest with respect to the research, authorship, or publication of this article.

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