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Introduction

In May 2024, Steward Health Care—the largest private healthcare system in the country—declared bankruptcy. Steward served 2 million patients annually, owned 36 hospitals in ten states, and employed 33,000 workers prior to its financial decline. The news stunned communities, practitioners, policy experts, and politicians nationwide. Media outlets across the country followed the saga, including *The Wall Street Journal, New York Times, Washington Post, Boston Globe, Philadelphia Inquirer, LA Times,* NBC News, ABC News, industry news, blogs, social media, and small-town papers. Wall Street insiders, investigative reporters, and a few politicians had cautioned that this was coming, but no one took action to prevent Steward's demise.

The fall of Steward Health Care was the largest scandal in healthcare history since the $2 billion Medicare fraud settlements by the Hospital Corporation of America (HCA) twenty-five years earlier. Steward collapsed under a debt load of $9.2 billion, with millions more owed to workers, vendors, future obligations in rent, and patients with medical malpractice claims. The private equity (PE) owner Cerberus Capital extracted an estimated $1.1 billion from the system, four times its equity investment; Medical Properties Trust (MPT), a real estate investment trust (REIT), pulled $2.5 billion in rent from Steward hospitals; and Ralph de la Torre took hundreds of millions in chief executive officer (CEO) pay and parked his $40 million yacht in the Galapagos Islands. But chronic understaffing left thousands of patients in hallways waiting for care, two dozen patients died of neglect, over 4,000 workers lost their jobs, hospitals were unsanitary

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and bat-infested, and communities lost access to care as hospital services and facilities closed.

Many view the Steward saga as a case of extreme greed. But it's not that, and it's not one bad apple. Almost everything that occurred was legal—or marginally legal in ways that make it extremely difficult to hold the owners accountable. As this book goes into production over two years later, the perpetrators have incurred no penalties, but states have spent billions buying or salvaging Steward hospitals while thousands of patients with malpractice lawsuits and unpaid vendors and workers have little chance of recouping their losses.

This book is about systemic change, not a collection of sensational stories about greed. Steward is emblematic of what is increasingly referred to as "financialization." The term is cumbersome and too academic, but it captures real world changes—the heightened role of financial actors, strategies, and calculations in Main Street companies. It is defined along two dimensions: the rising proportion of the U.S. economy that is owned and controlled by the financial sector, allowing it to accrue a greater share of profits overall; and the growing proportion of earnings in productive enterprises derived from financial rather than operational activities. Together, this means that industry practitioners increasingly make decisions driven by financial calculations and goals that often undermine productive activities.

For healthcare, it means that a larger share of organizations are owned and controlled by outside investors and a growing share of provider organizations shift their focus from a healthcare mission to financial calculations: from patients to profits. That is: *Financial actors and industry leaders increasingly view healthcare organizations as financial assets to be bought, sold, or managed for value extraction, regardless of the effects on patient care.*

Healthcare services become a by-product of meeting financial goals. While organizations have always had to balance budgets or make a profit, the question for debate is at what point financial goals eclipse the healthcare mission, undermine financial stability, or jeopardize patient care.

In this book, we explore this process across many healthcare segments. The degree to which financial actors and calculations overshadow the healthcare mission depends importantly on differences in institutional legacies, types of funding, reimbursement rules, and regulatory oversight. Some segments were early targets for financialization, like publicly traded drug corporations, insurance companies, and investor-owned nursing home chains; others less so, like mental health and disability services provided through public school systems.

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A major challenge in understanding this process is to unpack the institutional legacies and regulatory rules at play in distinct healthcare segments and how wealth extraction occurs differently as a result. A historical and institutional analysis helps identify the point at which financial calculations overtake the healthcare mission in a given segment.

The role of the state is a central theme in this book. Nonprofit institutions have dominated most healthcare services until recently; and healthcare is viewed as one of the most highly regulated industries in the country. The sector hardly seems attractive for private profit-making, especially in light of ongoing government pressure to reduce costs and prices. But most healthcare organizations receive at least 60 percent of their financing from government sources, according to Colleen Grogan's history of the industry between the 1930s and the 1960s. She shows how government funding grew dramatically via public financing of infrastructure, tax exemptions for hospital bonds, and funding of the U.S. Department of Veterans Affairs, with Medicare and Medicaid funding layered on in 1965. Growing public spending on health care did attract financial actors who, over time, learned to exploit quirks in funding mechanisms, loopholes in laws, and fragmented enforcement systems to extract public funds for private gain.

The legislation establishing Medicare and Medicaid and subsequent reforms to these programs regulate actors' behavior by tweaking the incentives embedded in reimbursement formulas. But this is not sufficient to explain the evolution of the health system that has culminated with the financialization of healthcare. That is the result of a much a broader array of laws and regulations that shape the behavior of firms in healthcare. The focus on enforcing Medicare rules in discussions of the failings of the health system has obscured the importance of this larger deregulatory arena. A singular focus on the evolution of the healthcare industry from the perspective of Medicare and health policy misses the many avenues for regulatory arbitrage afforded via the loosening of tax rules, antitrust enforcement, securities and labor law enforcement, and economy-wide financial deregulation.

"Regulatory arbitrage" refers to financial and business practices that capitalize on loopholes in regulations or variations in rules and their enforcement across state or local jurisdictions. While technically legal, they are often viewed as unethical or violating the legislative intent of laws as they may jeopardize patient care or the financial stability of provider organizations. The healthcare sector affords industry actors an abundance of public resources, coupled with a lax and fragmented regulatory framework—crowding in

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financial actors to exploit public funds for private gain with few downside risks.

Our analysis, then, examines the role of the state through the lens of health policy as well as tax policy and Internal Revenue Service (IRS) rules, securities and antitrust law, labor and employment law, and financial-sector regulation. Each legal arena provides a separate set of resources and constraints, as well as opportunities for exploiting legal loopholes and for regulatory arbitrage. Enforcement of these laws is fragmented and occurs through separate federal agencies operating in silos. Financial actors have learned to operate in the crevices between the silos. Enforcement is also undermined when states pass laws designed to circumvent federal authority, as in antitrust or labor laws, or when overlapping authority exists across federal, state, and local jurisdictions.

The result is a fragmented regulatory framework with little coordination across government actors. Industry players and financial actors, who view healthcare as a financial enterprise, develop strategies that respond to laws and regulations taken together as an incentive package. Steward and MPT didn't only exploit loopholes in Medicare, but also IRS rules for REITs, state requirements for hospital conversions from nonprofit to for-profit status, healthcare reporting requirements, and the complete lack of transparency afforded to private investment funds by securities laws. There were many opportunities to game the system—and do it legally.

Locating healthcare in a broader legal framework helps identify the various ways that public funds are used for private gain. Figure I.1 provides a simple framework for this approach.

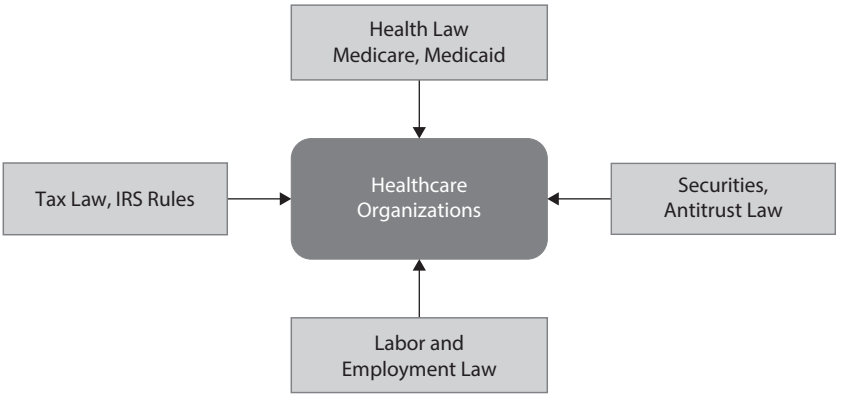


FIGURE I.1. Legal framework for healthcare

Source: Authors' illustration

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We contextualize the healthcare sector in the broader U.S. political economy. When the Medicare amendments to the Social Security Act (SSA) were passed in 1965, the U.S. economy was booming from the post–World War II era of rising demand for American goods. Firms made money by producing goods and services, and finance capital greased the wheels of productive capital. In healthcare as in other industries, executives with deep industry expertise managed the organization and directed investments into new technologies and innovations designed to enhance patient care, competitive advantage, and profitability. Executive compensation was tied to long-term growth and expansion of the organization.

Most health services provider organizations, regardless of their ownership structure, focused on providing care for people with medical needs, which was their primary source of revenue. The overwhelming majority of providers were public or nonprofit, while for-profit entities were small proprietary hospitals owned by doctors who followed the ethical precepts of the Hippocratic oath, or small nursing homes.

That changed in the decades after Congress passed the 1965 Medicare and Medicaid amendments to the SSA. While the Act provided government-funded healthcare insurance for millions of elderly (under Medicare) and low-income or disabled people (under Medicaid), it had a critical flaw: it adopted the view that quality, efficiency and innovation would improve if the role of market forces in healthcare were expanded.

After 1965, healthcare grew rapidly, due in large measure to very large taxpayer subsidies embodied in Medicare's reimbursement formulas. Moreover, healthcare markets do not meet economists' standard definition of a market. Patients are especially vulnerable to asymmetric information about treatment options and their efficacy. The quality of care that they will receive or how much it will ultimately cost is unknown, which means that they can't make well-informed choices. Moreover, healthcare is paid for by the government or third-party payers, who also don't know what the ultimate cost of care will be, as it is often contested and negotiated post hoc. As a result, policies intended to introduce healthy market competition into healthcare have failed; consolidation and monopolistic pricing by dominant firms are the norm in much of healthcare today.

The deregulation of financial markets by Democratic and Republican administrations, beginning with the Carter administration and continuing during Reagan's presidency, freed up pools of capital for investment during the same period that rules governing health, tax, antitrust, securities, and labor and employment law were relaxed. Changes in health policy interacted

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with these broader deregulatory changes which, taken together, provided openings for financial actors to capture public funds.

Taking a view of these changes from 30,000 feet, we briefly sketch some of the main developments that have affected healthcare. Medicare reimbursed both for-profit and nonprofit enterprises, the first time that for-profit firms received public funds. But the for-profits had access to government reimbursement rates higher than those for nonprofits, as well as to generous bank financing and stock market equity. Changes to the Employment Retirement Income Security Act (ERISA) in 1974 allowed pension funds to invest in the stock market for the first time—increasing by billions the pool of capital available for equity investments. This facilitated the explosive growth of investor-owned nursing home and hospital chains.

In addition, Medicare reimbursement rules subsidized new construction by hospitals by reimbursing them for the cost of capital, mainly interest and depreciation expenses. But they did not provide funds for construction itself. This was a change from the first two decades after World War II, when the government provided public funds for new construction to nonprofits, including those serving poor urban and rural communities. Under Medicare, these hospitals had to borrow in financial markets to fund infrastructure development. They found it necessary to focus on increasing their bottom lines and to adopt business strategies to demonstrate their creditworthiness. Those hospitals not considered creditworthy fell behind and their physical facilities deteriorated, widening the gap between poorly resourced and other hospitals and increasing inequitable patient care and outcomes in America's two-tier health system.

Reagan era laws and regulations provide another example of the complex interaction between health laws and the changing broader legal, institutional, and regulatory environment. The governance of U.S. corporations evolved from managerial capitalism based on industry expertise to a shareholder value model that shifted the distribution of profits from retained earnings the corporation could use for investments in people, equipment and R&D to payouts to shareholders. Shareholders demanded higher returns and the Reagan administration responded by relaxing the rules regarding the use of stock buybacks that corporations could use to boost stock prices and reward shareholders. Reagan-era changes in antitrust rules facilitated the growth of mergers and acquisitions among both investor-owned and nonprofit healthcare systems, allowing them to expand revenues and market share. Legislation passed in 1982 paved the way for the expansion of privatized Medicare, now known as Medicare Advantage, in which Medicare contracts with insurance companies to manage the care of Medicare beneficiaries.

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An IRS revenue ruling in 1998 allowed nonprofit hospitals to establish for-profit subsidiaries which, by virtue of their affiliation with a nonprofit hospital, were exempt from paying taxes on their profits. In 1999, Congress passed the Graham-Leach-Bliley Act to repeal the Depression-era Glass-Steagall Act which provided financial actors with enlarged pools of capital searching for investment opportunities. In 2000, Congress passed the Commodities Futures Modernization Act, which ensured that private-market funds were virtually unregulated. In addition, fiduciary rules for pension funds were tightened to require a focus on maximizing fund returns.

The volume of capital committed and the number of PE deals in healthcare increased in the 2000s and accelerated markedly after 2010. PE firms then partnered with Real Estate Investment Trusts to monetize the property assets of nursing homes and hospitals through sale-leaseback agreements, abetted by Congress, which passed laws that facilitated this alliance.

These examples make the point, elaborated in detail throughout this book, that it is the interaction of health laws with the deregulation of financial markets, changes in tax and anti-trust rules, and relaxing of security laws among other changes in the legal environment that shaped the evolution of the American health system.

Taken together, these changes have advanced three processes in the evolution of the health system. The first is privatization—the growth of private for-profit healthcare as opposed to public or nonprofit. The second, corporatization, refers to the rise of corporate hierarchies in which professional administrators increasingly control decisions that affect healthcare. Financialization is the third process, in which organizations increasingly make money not through providing healthcare services but through financial strategies or calculations, which have increasingly dominated healthcare decision-making.

While doctors' practices have always been private sector enterprises, private sector nursing homes surged after funds for the elderly became available under Social Security in 1935. But Medicare financing expanded the market share of those nursing homes to over 70 percent while also expanding the for-profit hospital segment, as the number of government hospitals declined.

Medicare also launched two decades of corporatization and corporate consolidation as it financed the growth of investor-owned nursing home and hospital chains and required nonprofit hospitals to depend on financial markets to fund hospital construction. Nonprofit hospitals, like their for-profit competitors, had to adopt the profit motive and develop a corporate

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structure similar to the investor-owned chains to establish their creditworthiness and manage their relationships with creditors.

By the 1980s, the corporate form in hospitals and nursing homes had spread across the healthcare industry. But the 1980s and 1990s saw a different form of corporatization emerge, with much greater attention to financial strategies and calculations. Some publicly traded healthcare corporations embraced the shareholder value model of governance, which emphasizes the pursuit of profit to the exclusion of other values and shifts a greater share of profits to investors. In the 1990s, the parallel movement in nonprofit hospital corporations occurred when IRS rules allowed them to establish tax-exempt for-profit subsidiaries, initially to subsidize their healthcare operations which were under pressure from the ratcheting down of Medicare spending as Congress sought to get the federal budget deficit under control. Well-resourced for-profits and nonprofits took advantage of relaxed anti-trust rules to expand their footprint in local health markets and raise prices. While the revenue and profits of healthcare organizations still came from providing healthcare services, profits made from financial strategies grew and played a much larger role in decision-making.

By the late 1990s and early 2000s, a qualitative shift occurred with the penetration of private market actors in healthcare, including, prominently, private equity firms. They lacked transparency, engaged in leveraged buyouts of healthcare organizations, and prioritized wealth extraction over healthcare service delivery. PE firms were buying out healthcare organizations—primarily investor-owned nursing homes and hospitals, but also government and nonprofit healthcare enterprises. While they built on the financial strategies of investor-owned chains, PE firms also expanded their repertoire by doubling down on more extreme forms of extracting wealth—siphoning off public funds intended for the care of patients and degrading healthcare facilities and patient care. These included greater debt used in buyouts and loaded on healthcare providers; disinvestment in facilities; sale-leasebacks in which the proceeds went to the PE firm and its investors, while healthcare providers were saddled with the rent payments; dividend recapitalizations in which the healthcare company took on more debt and used the funds to pay out dividends to its owners; and excessive cost cutting and understaffing. PE's lack of transparency and public accountability made PE owners more willing to take risks with other people's money, not to mention the lives of patients. Their penetration into healthcare expanded from the 2000s on because by then financial deregulation made available larger pools of lightly regulated capital for leveraged buyouts.

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The early 2000s were also a critical period of change for nonprofit hospitals. Many academic medical centers (AMCs) and other well-endowed nonprofit health systems partnered with venture capital (VC) firms and/or developed their own venture capital arms to invest in start-ups. The nonoperating side of these health systems no longer existed simply to subsidize healthcare services but went on to develop assets under management that rivaled the hospital and other physical assets of the health system. Operating surpluses were swept into the trading portfolios of these nonprofit hospitals, and the financial side of the health system made spending decisions that affected medical operations and expansion plans. Shortfalls on the operating side were covered by the nonoperating profits (referred to as surpluses) of the trading portfolio.

Financialization processes played out differently in Medicare insurance for the elderly and Medicaid for people with low incomes or disabilities. In the 1980s, in line with the view that introducing market forces into health care would make the industry more efficient and innovative, the Reagan administration sought an option in Medicare that would enable the Centers for Medicare and Medicaid Services (CMS) to contract with private insurance plans. Legislation passed in 1982 did just that. A new Part C was added to Medicare for health insurer managed care plans. CMS contracted with insurance companies to manage the care of Medicare beneficiaries. The goal of this privatized version of Medicare was to save taxpayers money by reducing Medicare's costs while increasing beneficiaries' choices, but it failed to do so.

Nonetheless, the Bush administration looked to expand the number of private insurer-sponsored plans and beneficiaries served by them. Privatized Medicare got a makeover: it was renamed Medicare Advantage (MA) and payments to these plans were increased. This enabled MA plans to lower premiums and/or provide added benefits. With these enticements, enrollment in MA plans began to soar, reaching a peak of 54 percent of Medicare beneficiaries in 2024. Meanwhile, the major health insurers morphed into vertically integrated health conglomerates that own companies that provide health services to MA beneficiaries. The health insurance company became one subsidiary among many, managed by the conglomerate to maximize its profits.

As for Medicaid, from its inception, states were allowed to contract with HMOs for services. But Medicaid HMOs were slow to develop. In 1980, less than 2 percent of the approximately 2.1 million Medicaid beneficiaries were in HMOs. But in the 1990s, states faced cost increases just as Congress was

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pressuring Medicare and Medicaid to constrain costs. Seeking lower and more stable spending, states found HMO-managed Medicaid plans attractive. States began contracting with insurance companies to run their Medicaid programs. By 2020, 72 percent of Medicaid beneficiaries were in managed care plans; today it's more than three-quarters in privatized Medicaid.

Under the influence of changes in health policy, tax and antitrust rules, and the legal environment, the healthcare system has evolved from delivery of health services mainly by nonprofit and public entities to successive waves of change resulting first in privatization, then in corporatization, and finally in financialization. The healthcare mission of large for-profit and nonprofit providers is dominated by a laser focus on the pursuit of profit and the extraction of wealth from healthcare entities that are largely financed by public funds intended for the care of patients.

Threaded throughout this book are stories of how financialization has disproportionately hurt people who already suffer from structural inequalities and disadvantage based on race, ethnicity, gender, income, and age. When the federal government passed the Hill-Burton Act in 1946 to provide massive funding for public hospital construction, it did so with the caveat that hospitals could remain segregated. The passage of Medicare and Medicaid ended the practice of funding segregated health facilities. But it exacerbated this two-tiered hospital system by requiring hospitals to raise funds for the construction and modernization of facilities in financial markets, where hospitals that disproportionately served Black patients were not considered creditworthy and were denied necessary funds for investment in physical infrastructure.

When investor-owned chains like Hospital Corporation of America (HCA) expanded rapidly after passage of Medicare, they targeted southern and western rural communities with low-income populations, where they gained concentrated market power in the context of lax state regulations. Based in Nashville, investor-owned chains provided platforms for private equity leveraged buyouts, and the city became the epicenter of a megabillion dollar healthcare ecosystem. But the city's deep legacy of racism still leaves Black and Hispanic families impoverished and with low access to decent health care.

Large nonprofit hospital systems began to discard their charity care obligations as they took advantage of the 1969 IRS ruling that allows then to keep their tax-exempt status without caring for the uninsured or underinsured. Charity care has been on a downward trajectory since, and access to healthcare has declined for Black communities. Healthcare workers,

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disproportionately women and people of color, have found their wages squeezed and working conditions degraded as hospitals and nursing homes compete on the basis of low-cost labor—cutting staff and outsourcing jobs as a key financial strategy. The low wages and onerous working conditions of support staff—nurse aides and housekeeping workers who are disproportionately Black or people of color—are a legacy of the unpaid labor provided in the past by enslaved people. They, and the elderly and disabled persons that depend on them, disproportionately absorb the costs of financially driven home-based care and hospice operators.

Healthcare in the age of finance capital is a system in which dominant firms prioritize profits extracted from entities that receive much of their funding from public programs intended to provide care for patients. Indeed, public funds are the enticement that, over more than 60 years and through Democratic and Republican administrations, has drawn Wall Street firms to healthcare. We describe in detail the interplay of the forces that have gotten the American health care system to this point and the incentives and opportunities provided for exploiting the system for private gain. We explain how financial actors extract resources and enrich themselves and their organizations at the expense of patients and taxpayers, revealing the methods they employ in various segments of the industry.

This book makes clear that finance capital is deeply entrenched in the American health system, and it demonstrates that the state has been central to the financialization of healthcare although its role has largely been hidden from view. Dislodging finance capital from the health system will require fundamental changes in the incentives and opportunities available to organizations. Without opportunities to extract excessive profits from providing care, healthcare will attract only those who embrace its mission of caring for the ill, the frail, the elderly, and the disabled; and those who will target resources to neglected Black, rural and poor urban communities that have been disenfranchised by a system that prioritizes profits.

The debates over financialization today echo those of the 1980s, when scholars and policymakers scrambled to make sense of the exceptional rise in investor-owned chains and worried that healthcare was becoming excessively commercialized.[1] In 1983, the National Academy of Sciences published the first volume of a multiyear study, *The New Health Care for Profit*, edited by Bradford Gray. It began, "With little initial public notice . . . health services are now being provided by thousands of for-profit organizations that range from large investor-owned hospital and nursing home chains, whose stock has rapidly appreciated on the New York Stock Exchange, to

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various types of independent medical facilities—such as ambulatory surgery centers, cardiopulmonary testing centers, etc.—owned by local investors who often are also physicians."[2] A year earlier, Paul Starr published *The Social Transformation of American Medicine,* analyzing the rise of the medical profession and the struggle between doctors and corporations over the control of healthcare decision-making.

Moreover, the contradictions between Medicare's Great Society goals of the 1960s and its subsequent evolution under both Republican and Democratic administrations, which privileged market solutions, soon became clear. In 1989, Rosemary Stevens succinctly captured them: "Far from making hospitals more 'socialized,' Medicare encouraged them to be more 'capitalistic' in the most fundamental sense of this word."[3]

The language of healthcare also has changed. In 1983, Gray wrote, "Even the language used today in hospital journals—such as 'lines of business,' 'market shares,' and 'profit centers'—would have seemed foreign in the health policy world of only a few years ago."[4] Today, financial metaphors have replaced business ones: Hot markets, deal multiples, LBOs, monetizing healthcare assets, private credit markets, and bankruptcy for profit characterize financial actors' takeover of mental health, home health, and hospice, where the most vulnerable in society seek help.

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