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# Health Care Corporatization as a Catalyst for Wellness Legal Partnerships

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## Abstract/Summary:

The increasing presence of private equity investment in physician practices reveals that current health law practice sites such as in-house, corporate law firms, and Medical Legal Partnerships (MLPs) are ill equipped to address patient harm from health care corporatization. A new type of health law practice is needed to address the adverse impact health care corporatization is having on health care purchasers (primarily employers and patients) and physicians. I label this new health law practice the Wellness Legal Partnership (WLP), modeled after the Medical Legal Partnership (MLP). WLP lawyers can look to systems leadership theory, lawyer fiduciary duties, and health justice frameworks as guides to combat the adverse impacts of health care corporatization. WLPs would work best rooted in corporate health and wellness benefit settings and they would improve patient wellbeing using a three-fold approach of individual advocacy, organizational change, and systemic change.


## Introduction

The initial proposal for creating Wellness-Legal Partnerships (WLPs) was in response to implicit racial and ableist bias in workplace wellness programs.[1] The earlier argument suggested that WLPs, modeled after Medical-Legal Partnerships (MLPs), could help wellness programs steer away from focusing only on individual lifestyle and behavior choice to also addressing social and structural determinants of wellbeing.[2] But WLPs could also address the damage that corporatization of health care is causing to employer health benefits, of which wellness is a part, as well as to physicians and patients. This article explores the concept of WLPs more deeply, applying frameworks of systems leadership, lawyer fiduciary duty, and health justice to flesh out how and why WLPs may operate, particularly considering health care corporatization.

Every day there seems to be a news story detailing the increasing challenge patients face in accessing valuable health care – even if they have insurance.[3] When patients do finally access health care, it's often not the care that they want, need, or can afford. A U.S. survey by the Harris Poll found that 19 percent of respondents complained about the medical

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[1] Barbara J. Zabawa, *Countering Wellness Bias through Wellness-Legal Partnerships*, __ J. LAW & HEALTH (Forthcoming Fall 2024) (hereinafter *Wellness Bias*).

[2] *Id.*

[3] For example, a recent article by Axios highlights "long wait times for doctor appointments, crowded emergency departments, complicated insurance requirements and a dearth of local providers" that make health care access tough on patients. Caitlin Owens, *U.S. Health Care Is Increasingly Like a Casino*, Axios (May 12, 2024), https://www.axios.com/2024/05/10/health-insurance-quality-care.

system's lack of focus on "preventive care and wellness."[4] The Harris Poll found that the most common ways the U.S. healthcare system is falling short for consumers relate to getting appointments, costs, and focus on treating acute problems rather than providing preventative care and wellness.[5]

Moreover, both patients and employers feel powerless when it comes to health care costs. According to a Kaiser Family Foundation poll, about half of U.S. adults say it is difficult to afford health care costs and about 41 percent of American adults report having debt because of medical or dental bills.[6] A recent *New York Times* article pointed out that most employers select health care plans without knowing what they or their workers will pay.[7] This is especially concerning to patients with high deductible health plans, a growing segment of the insurance landscape.[8] Price transparency efforts have not proven helpful in addressing this powerlessness. For example, a 2021 study found the majority of surveyed hospitals are noncompliant with price transparency regulations, which were created to promote competition and advance patient informed decision making.[9] Furthermore, the pricing data collected from the No Surprises Act requirements show "numerous examples of major health insurers – some of the world's largest companies, with billions in annual profits – negotiating surprisingly unfavorable rates for their customers."[10] Thus, both patients and group purchasers of health care seem to have little say in the current health care market.

Physicians are not happy with the status quo either. Frontline health workers like physicians and nurses are burning out at an alarming rate, further exacerbating access and value problems. In 2022, the U.S. Surgeon General issued an Advisory on addressing health worker burnout, stating that even before the COVID-19 pandemic, "35 to 54 percent of nurses and physicians and 45 to 60 percent of medical students and residents reported symptoms of burnout."[11] The pandemic amplified the already-existing burnout being felt by

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[4] JOHN GERZEMA, HARRIS POLL, THE PATIENT EXPERIENCE: PERSPECTIVES ON TODAY'S HEALTHCARE 7 (2023) https://www.aapa.org/download/113513/?tmstv=1684243672 [https://perma.cc/VGD4-558S]. This poll was conducted in English and Spanish online in the United States and surveyed 2,519 adults age 18+ between February 23 and March 9, 2023.

[5] *Id.* at 7.

[6] Lunna Lopes et al., *Issue Brief: Americans' Challenges with Health Care Costs*, KAISER FAMILY FOUNDATION (Mar. 1, 2024), https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/.

[7] Sarah Kliff & Josh Katz, *Hospitals and Insurers Didn't Want You to See These Prices. Here's Why*, N.Y. TIMES (Aug. 22, 2021), https://www.nytimes.com/interactive/2021/08/22/upshot/hospital-prices.html (last visited July 2, 2024).

[8] *Id.*

[9] *See* Amitai S. Miller, Stephen A. Stearns & Donald M. Berwick, *Hospital Noncompliance with U.S. Price Transparency Regulations*, 12 LANCET at 1 (Aug. 2022) (referencing 45 CFR § 180.50).

[10] *Id.* (pointing out that in many cases patients are getting prices that are higher than they would if they were uninsured).

[11] Vivek A. Murthy, *U.S. Surgeon General Advisory on Addressing Health Worker Burnout*, at 7 (2022), https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf . According to the Advisory, "burnout" is defined as "an occupational syndrome characterized by a high degree of emotional exhaustion and depersonalization (i.e., cynicism), and a low sense of personal accomplishment at work." *Id.*

health care workers.[12] Physicians would welcome more time to address patient wellbeing and understand the social drivers that impact their patients' health, but the current health system does not permit it.[13] Effectively addressing health worker burnout requires systems-oriented, organizational-level solutions, not just individual practitioner support.[14] Systemic changes should address burdensome regulations, administrative paperwork, lack of time with patients, the need for greater physician autonomy, and an alignment of values and key health care decisions.[15]

In sum, as expensive as U.S. health care is, gobbling up almost 20 percent of America's national Gross Domestic Product,[16] it is far from satisfactory for end users and practitioners in terms of equity, accessibility, affordability, efficiency and effectiveness.

Some commentators blame this disconnect between U.S. health spending and perceived value on physician shortages, particularly in primary care, as well as administrative burdens, physician burnout and large medical school debt that forces students to lean heavily into financial considerations when choosing how to practice medicine.[17] The physician challenges are mere symptoms of a larger problem, however. The larger problem is the corporatization and consolidation of health care, driven most recently by a frenzy of private equity investment in physician practices.

To reverse this corporatization trend, the health care field needs lawyers who practice law through an approach that blends thinking from systems leadership, lawyer fiduciary duty, and health justice. The primary objective of such lawyers is to champion efforts to improve patient wellbeing and make health care more holistic, affordable, and valuable for all purchasers and physicians. This article proposes to have these lawyers practice in Wellness-Legal Partnerships (WLPs) that work collaboratively with health care purchasers and physicians, since the interests of purchasers and physicians align when it comes to the corporatization of health care.

The first part of this article argues that health care corporatization has caused dire consequences for purchasers and physicians, highlighting the most recent efforts by

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[12] *Id.* at 11.
[13] *Id.* (citing a 2022 survey of over 1,500 U.S. physicians that found that 61% feel they have little to no time and ability to effectively address their patients' social determinants of health, and 83% believe that addressing patients' social determinants of health contributes to physician burnout rates; and 87% want greater time and ability to do so in the future).
[14] *Id.* at 7.
[15] *Id.,* Figure 2, at 12.
[16] *See, e.g.*, NATIONAL HEALTH EXPENDITURES FACT SHEET, CENTERS FOR MEDICARE AND MEDICAID SERVICES (2022) (stating that over 2022-2031 average growth in National Health Expenditures (5.4 percent) is projected to outpace that of average GDP growth (4.6 percent) resulting in an increase in the health spending share of GDP from 18.3 percent in 2021 to 199.6 percent in 2031), https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet#:~:text=Projected%20NHE%2C%202022%2D2031%3A,to%2019.6%20percent%20in%202031.
[17] Owens, *supra* note 3,; *see also* Murthy, *supra* note 11, at 10 (noting the alarming gaps in primary care).

private equity to buy up physician practices. This part will examine the impact of corporatization on health care purchasers, which includes both employers and patients, as well as physicians, and how the shared interests of these stakeholders make them good partners for systemic change.

Part II explores the impact of health care corporatization on traditional health law practice sites of in-house counsel departments, corporate law firms, and Medical-Legal Partnerships and describes a new type of legal practice to take on health care corporatization. This new legal practice draws elements from legal practice frameworks of systems leadership, lawyer fiduciary duty and health justice to form a Wellness-Legal Partnership practice model.

Part III introduces the WLP model that like its counterpart, the Medical-Legal Partnership (MLP), uses a three-fold approach to advocacy: 1) individual representation; 2) organizational change; and 3) systemic change. Yet, unlike the MLP, which partners with exclusively with medical providers, the WLP would form partnerships in the employee benefits arena, such as operating as part of a corporate wellness initiative. Potential WLP partners include existing Employee Assistance Programs (EAPs), business coalitions, wellness vendors and Direct Primary Care (DPC) arrangements. With these potential partners, WLP lawyers could build collaborative networks of stakeholders harmed by health care corporatization to effect system change, while also addressing social and structural determinants of wellbeing through individual and organizational advocacy. Overarching this three-pronged approach is a goal for the WLP lawyer to improve patient wellbeing by making employee health and wellness benefits more holistic, affordable, and valuable. By working independently through solo practice or other private practice law firms, lawyers can manage some of the major ethical considerations WLP work may encounter, such as confidentiality and conflict of interest concerns, while finding a sustainable and satisfying career.

## I. The Corporatization of Health Care

Health care corporatization is a phenomenon in which corporate investors such as publicly traded organizations, large health systems, health insurers, and private equity firms, seek to maximize revenues over what is best for patients, clinicians, and purchasers of health care overall.[18] Private equity is the most recent entrant into the corporate health care space.

### A. Private Equity Investment in Health Care

[18] Erin C. Fuse Brown, & Mark A. Hall, *Private Equity and the Corporatization of Health Care*, 76 STAN. L. REV. at 6-11 (forthcoming 2024).

"Private equity investors spent more than $200 billion on health care acquisitions in 2021 alone, and $1 trillion in the past decade."[19] Investing in health care is not new. What is different and troubling about the recent surge in private equity investing is twofold: first, private equity investors are typically lay people with little knowledge of health care;[20] and second, the investment tactics are aggressive and solely about turning a quick profit, often to the detriment of patients.[21] The typical private equity investor in health care is a lay person or entity that lacks "professional and institutional obligations to promote the higher ethical goals of medical care."[22]

Unlike venture capitalists (another type of private equity investor), the typical private equity health care investor seeks mature businesses whose profits can be substantially improved through the lay investor's "active management."[23] This focus on mature business allows the investors to liquidate valuable assets like real estate. In contrast, venture capitalists focus on early-stage investing in exchange for equity in the emerging company.[24] Some argue that private equity investment in health care is a welcome disruption given health care's poor performance on access, quality, and cost. However, such praise may more rightfully be reserved for venture capital and early stage investing and not the typical investment in mature health provider organizations.[25]

Private equity's active management of a mature health care entity often consists of first liquidating the health care business's most valuable assets (usually real estate) to secure a loan or sell those assets to other investors to generate immediate returns for the new owners of the practice.[26] The investors then lease back the real estate to the practice, which doesn't save the practice any money in the long run. In fact, often the health care provider must pay back the loan taken out by the investors as well as pay rent to use the facility that they once owned, often leading to bankruptcy.[27] This private equity financial

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[19] David Blumenthal, *Private Equity's Role in Health Care*, Commonwealth Fund, at 2 (Nov. 17, 2023).
[20] Id. at 3.
[21] Id. *But see* American Hospital Association Fact Sheet, *Setting the Record Straight: Private Equity and Health Insurers Acquire More Physicians than Hospitals* (June 2023) (contending that private equity and insurer acquisitions of physician practices far exceed those by hospitals).
[22] Fuse Brown, & Hall, *supra* note 18, at 4.
[23] *Id*. at 11-13.
[24] *Id*. at 13.
[25] Blumenthal, *supra* note 19, at 4-5 (reasoning that private equity is investing in health care in part to bring fresh energy, perspective and capital, offering hope for change in a system that is failing in terms of access, quality and costs).
[26] Blumenthal, *supra* note 19, at 3. It is worth noting that private equity firms rely more heavily on debt to finance operations than publicly traded healthcare companies. According to the Private Equity Stakeholder Project, private equity debt levels on leveraged buyouts reached a 15-year high in 2022 of 7.1x earnings (EBITDA), while average debt-to-EBITDA rations for publicly traded healthcare companies are around 3x. *See* Fact Sheet, *Private Equity Healthcare Bankruptcies are on the Rise*, Private Equity Stakeholder Project, at 3 (2024), https://pestakeholder.org/private-equity-healthcare-bankruptcies-are-on-the-rise/ (last visited May 22, 2024).
[27] Blumenthal, *supra* note 19, at 4; Rebecca Pifer, *Private Equity Investing in Healthcare Continues to Slow*, Healthcare Dive (May 8, 2024), https://www.healthcaredive.com/news/private-equity-healthcare-investing-

playbook disproportionately affects poor and rural communities.[28] Other tactics private equity investors use to boost medical practice profits are aggressive payment collection, cutting staffing costs, consolidating market power, increasing prices and focusing on high-volume services.[29] The consolidation of market power starts with acquiring a large, established practice and then adding on smaller practices to build a larger organization that has more market power.[30] Once the private equity firm has maximized the profit-making ability of its health care company, the investors sell the company or take it public, usually within three to seven years of the initial purchase.[31]

After first investing in nursing homes and hospitals, private equity firms are now swallowing up physician practices, particularly in the specialties of dermatology, gastroenterology, ophthalmology, obstetrics/gynecology, orthopedics, and primary care.[32]

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pace-pitchbook/715280/ (last visited July 2, 2024) (stating "[p]hysician practices owned by [private equity] firms have also suffered some of the largest healthcare bankruptcies in 2023, including KKR's Envision Healthcare and American Physician Partners, which is owned by Brown Brothers Harriman Capital Partners.").

[28] Blumenthal, *supra* note 19, at 4.

[29] Fuse Brown and Hall, *supra* note 18, at 11-13.

[30] *Id*.

[31] *Id*.; *see also* Joseph D. Broch, et al., *Workforce Composition in Private-Equity Acquired Versus Non-Private Equity-Acquired Physician Practices*, Health Aff., Vol. 32, No. 1, at 122 (Jan. 2023) (stating that private equity firms sell companies for sizable profits over three-to-seven-year time frames); Fred Schulte, *Sick Profit: Investigating Private Equity's Stealthy Takeover of Health Care Across Cities and Specialties*, Kaiser Family Foundation news, at 4 (Nov. 14, 2022) (stating that private equity firms pool money from investors and use that money to buy into businesses they hope to flip at a sizable profit, usually within three to seven years, by making them more efficient and lucrative).

[32] Carol K. Kane, *Recent Changes in Physician Practice Arrangements: Shifts Away from Private Practice and Towards Larger Practice Size Continue Through 2022*, American Medical Association Policy Research Perspectives, at 6 (July 2023); see also American Medical Association Report of the Council on Medical Service, CMS Report 02-1-22 (2022). There has been a recent decline in private equity investments in health care, primarily due to boosted enforcement efforts by certain states and the federal government. *See e.g.,* Kara Hartnett, *M&A, Private Equity Deals Likely to Keep Law Firms Busy: Survey*, Modern Healthcare, Vol. 54, at 36 (April 8, 2024); Pifer, *supra* note 26 (mentioning recent federal and state actions tamping down on anticompetitive activity). For example, several states are enacting laws to curb private equity investment in health care. In 2024, the Minnesota legislature has introduced a bill that prohibits private equity firms and real estate investment trusts from acquiring operational or financial control over health care providers. Minn. H.F. No. 4206 (Feb. 19, 2024), https://www.revisor.mn.gov/bills/text.php?number=HF4206&version=0&session=ls93&session_year=2024&session_number=0&format=pdf (last visited May 27, 2024). Also in 2024, the Oregon legislature introduced a bill that prohibit companies from controlling medical work. Oregon House Bill 4130 (March 1, 2024), https://olis.oregonlegislature.gov/liz/2024R1/Downloads/MeasureDocument/HB4130 (last visited May 28, 2024). New Mexico passed a law requiring advance notice and approval from the New Mexico Office of Superintendent of Insurance of any transaction involving a hospital merger, acquisition or change of control. 2024 SB 15, https://www.nmlegis.gov/Sessions/24%20Regular/final/SB0015.pdf (last visited May 28, 2024). Finally, California has introduced a bill to require private equity groups or hedge funds to notify and obtain consent from the Attorney General before any change of control or acquisition of a health care facility or provider group occurs. AB 3129 (April 24, 2024), https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB3129 (last visited May 28, 2024).

### B. Other Health Care Corporatization Efforts

Private equity investment in health care is only one aspect of health care corporatization. The health insurance industry is vertically integrating at a disturbing rate. According to the American Hospital Association (AHA), health insurance plans have spent billions in the last five years to acquire physician practices.[33] For example, UnitedHealth and its subsidiary Optum is the largest employer of physicians in the United States, with over 70,000 employed physicians.[34] Indeed, the U.S. Department of Justice recently launched an antitrust investigation into UnitedHealth.[35] But that investigation is not necessarily slowing down UnitedHealth's desire for growth. Recently, Optum was seeking to acquire a Massachusetts-based physician group that had recently filed for bankruptcy.[36] U.S. health insurers may have reached "too big to fail" status: six health insurance companies make up 30 percent of total U.S. healthcare spending in 2023, and three of the largest insurers processed 80 percent of all prescription drug claims in 2023.[37]

Vertical integration of physician practices with hospitals and health systems has also increased in the last several years.[38] For example, the percentage of primary care providers in hospital-owned practices increased 57 percent between 2010 to 2016, and the number of physicians who owned their practices fell from 60 to 47 percent between 2012 and 2022.[39] Some commentators argue that hospital acquisitions of physician practices creates a loyal referral source for the hospital and allows the hospital to bill for physician

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[33] Fact Sheet, *Setting the Record Straight: Private Equity and Health Insurers Acquire More Physicians than Hospitals*, American Hospital Association (June 2023), https://www.aha.org/system/files/media/file/2023/06/Private-Equity-and-Health-Insurers-Acquire-More-Physicians-than-Hospitals-Infographic.pdf (last visited July 2, 204).

[34] *Id*; *see also* Hayden Rooke-Ley, *Medicare Advantage and Vertical Consolidation in Health Care, American Economic Liberties Projec*t, at 19 (April 2024), https://www.economicliberties.us/wp-content/uploads/2024/04/Medicare-Advantage-AELP.pdf (last visited July 2, 2024) (stating that UnitedHealth now comprises both the nation's largest health insurance company and the largest employer of physicians).

[35] Anna Wilde Matthews and Dave Michaels, *U.S. Opens UnitedHealth Antitrust Probe*, Wall Street J. (Feb. 27, 2024), https://www.wsj.com/health/healthcare/u-s-launches-antitrust-investigation-of-healthcare-giant-unitedhealth-ff5a00d2 (last visited May 24, 2024).

[36] Pifer, *supra* note 27. Incidentally, this physician practice acquisition is the result of another private equity health system purchase gone bad. Specifically, on May 6, 2024, Steward Health Care filed for Chapter 11 bankruptcy after being acquired by private equity firm Cerberus Capital Management of New York in 2010, converting the nonprofit health system run for decades by the Boston Archdiocese to a for-profit network of institutions. See Robert Weisman and Jessica Bartlett, *Steward Files for Bankruptcy, leaving its Eight Massachusetts Hospitals in Limbo*, Boston Globe (May 6, 2024). "The company said it was forced into bankruptcy because of a delay in a plan to sell its nationwide physician group, called Stewardship Health, which would have brought additional capital to pay off its lenders." *Id*.

[37] Caitlin Owens, *Major Health Insurance Companies are Nearing Too Big to Fail Status*, Axios (April 19, 2024), https://www.axios.com/2024/04/19/health-insurance-companies-uhg-aetna-cigna (last visited May 24, 2024).

[38] Letter from Lovisa Gustafsson, Christina Ramsay and Sara Federman of the Commonwealth Fund to the DOJ, DHHS and FTC in response to ATR 102, at 3-4 (May 14, 2024) (on file with author).

[39] *Id*.

services at higher priced hospital outpatient departments compared to physician-owned clinics.[40] Consolidation of hospitals and acquisitions of physician practices has led to large health systems whose operating revenues rival or exceed that of large corporations like Netflix of Starbucks and leave patients in many U.S. markets without competitive options.[41] Finally, large corporations like Amazon and CVS have been purchasing primary care providers.[42]

The corporatization of health care is antithetical to the very nature of medical care. In 1963, economist Ken Arrow explained that medical care has a social value founded on a special trust relationship between physician and patient.[43] A large part of what medical care offers is a social obligation for best practice on behalf of the buyer, knowing that the buyer, such as a patient or group health plan, is not able to competently determine what constitutes best practice.[44] "The very word, 'profit,' is a signal that denies the trust relations."[45] Yet, private equity investment in health care is all about profit maximization.[46]Profit maximization contradicts the "social contract" premise of health care, which assumes health care is a public good that is safe, effective, and available equally to all people in the community.[47] Some legal scholars have even called for health care to be treated like a public utility by regulating prices and administrative costs.[48]

Although often touted as preferable over fee-for-service payment models,[49] value-based payment models encourage market consolidation. One legal researcher recently pointed out that capitation-based financing, which pays providers a flat fee for a population of

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[40] Letter from US Women's Health Alliance Response to DOJ, DHHS, and FTC in response to ATR 102, at 5-6 (citing Medicare Payment Differentials Across Outpatient Settings of Care, Avalere Health (Feb. 2016) and Anna Wilde Matthews and Melanie Evans, The Hidden System that Explains How Your Doctor Makes Referrals, Wall Street J. (Dec. 27, 2016)) (on file with author).

[41] Zachary Levinson, et al., *Fact Sheet: Ten Things to Know About Consolidation in Health Care Provider Markets*, Kaiser Family Foundation (April 13, 2024), https://www.kff.org/health-costs/issue-brief/ten-things-to-know-about-consolidation-in-health-care-provider-markets/ (last visited May 24, 2024).

[42] Fuse Brown and Hall, supra note 18, at 13, n. 55 (noting that Amazon announced its purchase of primary care practice One Medical for $3.9 billion and VS announced its intent to purchase home health primary care provider Signify for $8 billion).

[43] Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, The American Economic Review, at 965-66 (December 1963).

[44] *Id.*

[45] *Id*. at 965.

[46] Fuse Brown and Hall, supra note 18, at 8 ("At bottom, all corporate investors – whether private equity, publicly traded, conglomerate health systems, or health insurers – seek to maximize revenues.").

[47] Anaeze C. Offodile II, et al., *Private Equity Investments in Health Care: An Overview of Hospital and Health System Leveraged Buyouts*, 2003-17, Health Aff., 40:5 at 725 (May 2021) ("The 'social contract' of health care – that is, an expectation that safe, effective, and equitable services will be made available to a community – contrasts sharply with private equity profit-making strategies"); Fuse Brown and Hall, supra note 18, at 13.

[48] Hayden Rooke-Ley, *supra* note 34, at 7.

[49] Corrine Lewis, et al., *Value-Based Care: What it Is, and Why It's Needed,* The Commonwealth Fund (Feb. 7, 2023), https://www.commonwealthfund.org/publications/explainer/2023/feb/value-based-care-what-it-is-why-its-needed (last visited June 3, 2024) (noting that the Centers for Medicare and Medicaid Services is taking the lead on the value-based care movement).

patients or a specific service and is a key part of value-based payment arrangements, supplies the capital and incentive for vertical consolidation of health care services.[50] Specifically, capitation-based financing pays providers more for caring for higher risk patients and for providing higher quality care.[51] Through consolidation, corporate owners of a continuum of health care providers such as primary and specialty care physicians, hospitals, home health, pharmacies and other providers, can more easily control the risk scores assigned to patients (by assigning higher risk scores for higher payments) and the quality of care metrics that determine quality of care bonuses in the value-based payment models.[52] The consolidated health systems can also more easily steer patients to system-owned subsidiaries.[53] This is all to say that large corporate interests are gaming the current value-based health care financing and delivery system to the detriment of health care purchasers and physicians.

### C. Recent Federal Enforcement Efforts Against Health Care Corporatization

The harm to health care affordability and value is not going unnoticed by the federal government, though its slow reaction may have contributed to the widespread proliferation of corporatized health care. Nevertheless, in a 2021 Executive Order on Promoting Competition in the American Economy, President Biden promised action against corporate consolidation in health care, noting that "hospital consolidation has left many areas, particularly rural communities, with inadequate or more expensive healthcare options."[54] The DOJ also agreed to scrutinize private equity transactions, with a senior DOJ official observing the "complexity of the commercial relationships that stand between a doctor and a patient" and that these corporate intermediaries can "influence, or in some cases even determine, the tests to be given, the drugs to be prescribed, the procedures to be offered, and the time spent trying to address a medical issue."[55] Finally, on March 5, 2024 the FTC, Department of Justice (DOJ) and the Department of Health and Human Services (DHHS) launched a public inquiry into "corporate greed in health care" and has promised greater commitment to "promoting and protecting competition in health care markets and ensuring appropriate access to quality, affordable health care items and services."[56]

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[50] Hayden Rooke-Ley, *supra* note 34, at 18.
[51] *Id.* at 25-27.
[52] *Id*.
[53] *Id*. at 28.
[54] *See* Executive Order on Promoting Competition in the American Economy (July 9, 2021), https://www.whitehouse.gov/briefing-room/presidential-actions/2021/07/09/executive-order-on-promoting-competition-in-the-american-economy/.
[55] Andrew Forman, Deputy Assistant Attorney General for the U.S. DOJ, Keynote Speech at the ABA's Antitrust in Healthcare Conference (June 3, 2022), https://www.justice.gov/opa/speech/deputy-assistant-attorney-general-andrew-forman-delivers-keynote-abas-antitrust.
[56] Press Release, Federal Trade Commission, *The Department of Justice and the Department of Health and Human Services Launch Cross-Government Inquiry on Impact of Corporate Greed in Health Care* (March 5, 2024), https://www.ftc.gov/news-events/news/press-releases/2024/03/federal-trade-commission-department-justice-department-health-human-services-launch-cross-government (last visited May 23, 2024). This latest request for information (RFI) builds upon the Centers for Medicare and Medicaid Services'

Despite increasing government interest in health care corporatization, such investments are likely to continue because many of the reasons for investing in health care, such as an aging population, opportunities to scale, and labor shortages remain.[57]

### D. The Impact of Health Care Corporatization on Purchasers and Physicians

The adverse impacts of corporatization in health care include higher costs, lower quality, and shrinking the availability of health care options. This in turn creates lower value health care, which has the potential to lead to patient dissatisfaction and breach of ERISA fiduciary duties by group health plans, as recently demonstrated by class action lawsuits against Johnson & Johnson and the Mayo Clinic.[58] For physicians, corporatization often leads to lower autonomy and more debt.

#### 1. Impact on Health Care Purchasers

Health care purchasers[59] experience higher costs because of corporatization. These higher costs may be the result of higher premiums, higher out-of-pocket spending, and higher prices. Purchasers also may observe decreased quality and access because of health care corporatization.

#### a. Costs

Research thus far concludes that health care costs increase under corporate models of health care.[60] According to a review of studies looking at the impact private equity investment in health care, private equity acquisitions of hospitals show "increased charges, markups over costs, and the proportion of privately insured patients, and decreased staffing ratios."[61] With regard to physician practice acquisitions, the research shows similar risks of higher prices, increased health spending (which reflects higher

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RFI on consolidation and vertical integration in the Medicare Advantage market (*see* 89 Fed. Reg. 5907 (Jan. 30, 2024)) and the FTC and DHHS RFI regarding market concentration among large health care group purchasing organizations and drug wholesalers. *See* FTC nonrulemaking docket, FTC–2024-0018, https://www.regulations.gov/docket/FTC-2024-0018 (last visited May 23, 2024). GIVE DATE OF ITS PUBLICATION, NOT LAST VISITED

[57] Pifer, *supra* note 76 (noting that "the argument that antitrust scrutiny will cause provider mergers and acquisitions to stop is undercut by a number of recent deals"); *see also* Susan Ladika, *The Private Equity Bet on Healthcare*, Managed Healthcare Executive, at 41 (Aug. 2022) (citing a KPMG report that found that "private equity companies slowed their investments in hospitals and health systems due to rising labor and supply costs, although interest in health care IT and physician practices remained strong").

[58] *Infra,* notes 146-152.

[59] For purposes of this article, "health care purchasers" are those who buy health care and insurance, such as individual patients and employer-sponsored group health plans (or union-sponsored plans.

[60] Fuse Brown and Hall, *supra* note 18, at 18 (citing Joseph D. Burch, Suhas Gondi and Zirui Song, Changes in Hospital Income, Use, and Quality Associated with Private Equity Acquisition, 180 JAMA Internal Med. 1428, 1432-33 (2020)).

[61] Fuse Brown and Hall, *supra* note 18, at 18.

utilization of unnecessary or more expensive care), and reduced staffing levels."[62] Higher prices and more spending leads to higher costs for patients and group health plan purchasers.[63] For example, a study of 578 physician practices that were acquired by private equity firms found an increase in health care spending, utilization, and coding intensity of evaluation and management visits.[64] According to the researchers, these findings may suggest "overutilization of profitable services and/or unnecessary or low-value care, which could raise health care spending without commensurate patient benefits."[65] Some studies have found an association between health care consolidation and premium increases.[66] Indeed, the 2023 Kaiser Family Foundation Employee Benefits Survey found that over the last ten years family premium increases have outpaced inflation (47 percent versus 30 percent), with the average family premium now costing workers and their group health plans $23,968.[67] According to a recent poll, when it comes to health care, voters in the 2024 election are most concerned about high out-of-pocket costs.[68]

A report by the North Carolina State Health Plan found that even during the COVID-19 pandemic, North Carolina's seven largest hospital systems recorded $7.1 billion growth from 2019 to 2021, but charity care spending barely improved, and in some cases the hospitals billed disadvantaged patients more than before the pandemic.[69] Two hospital systems even sued patients over medical debt during the pandemic or encouraged patients to open medical credit cards with high interest rates, even while the hospital systems were making record profits.[70]

A recent review of hospital price data shows that major health insurers, who as noted earlier are acquiring physician practices, negotiate "surprisingly unfavorable rates for their customers."[71] According to the review, hospital prices for patients who are uninsured are

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[62] Id.
[63] Levinson, et al., *supra* note 41.
[64] Yashaswini Singh, et al., *Association of Private Equity Acquisition of Physician Practices with Changes in Health Care Spending and Utilizatio*n, JAMA Health Forum, at 8 (Sept. 2, 2022).
[65] Id.
[66] Levinson, *supra* note 40; *see also* Erin E. Trish and Bradley J. Herring, *How do Health Insurer Market Concentration and Bargaining Power with Hospitals Affect Health Insurance Premiums?,* J. of Health Economics, Vol. 42, at 104-114 (July 2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5667641/pdf/nihms914475.pdf (last visited July 2, 2024).
[67] Kaiser Family Foundation, *2023 Employer Health Benefits Survey*, Section 1: Cost of Health Insurance (Oct. 18, 2023). The average premium for single coverage in 2023 was $8,435, which grew by 22 percent over the last five years. *Id*.
[68] Drew Altman, *Why Affordability is the Big Tent*, Kaiser Family Foundation (Feb. 20, 2024) (finding 48% of surveyed voters ranking health care costs as the number one health priority).
[69] Report by North Carolina State Health Plan, *Hospitals Profit During COVID-19*, at 5-6 (2022), https://www.shpnc.org/documents/files/north-carolina-hospitals-profit-during-covid-19-report/download?attachment (last visited May 30, 2024).
[70] *Id*.
[71] Sarah Kliff & Josh Katz, *Hospitals and Insurers Didn't Want you to See these Prices. Here's Why*, N. Y. TIMES (Aug. 22, 2021).

less than for those with insurance.[72] These bad deals from insurers particularly impact patients in high deductible health plans and who must pay out-of-pocket for costs until their deductible is reached.[73] Insurer bad deals also adversely affect self-funded group health plans who may rely on insurers as third party administrators to negotiate prices on the plan's behalf.[74] A Rand Corporation study found that self-funded employers in Indiana were paying on average 358 percent of Medicare rates for outpatient services and up to three and one half times the Medicare rate for inpatient services.[75] "One factor fueling high prices in Indiana has been the diminishing number of independent providers, which often charge less than hospitals and health systems because they have less leverage to negotiate prices and don't add facility fees to outpatient charges."[76]

Most employers select health plans for their employees without knowing what they or their workers will ultimately pay for items and services.[77] And when group health plans do learn of higher prices from health care providers, they may be blocked from removing those providers from their plans because of market consolidation.[78] For example, a union benefits fund wanted to exclude a large hospital system from its plan because of the system's high prices, but the system wouldn't agree to the exclusion until the union paid it $25 million.[79] Such market imbalance makes it difficult for group health plans to save on health costs for employees and themselves.[80]

Most hospitals are not complying with price transparency laws, and when they do, the data is often published in hard-to-use formats.[81] The potential penalty for failing to comply is

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[72] *Id.*

[73] *Id; see also* Kaiser Family Foundation, *2023 Employer Health Benefits Survey*, Section 8: High-Deductible Health Plans with Savings Option (Oct. 18, 2023) (finding that enrollment in high deductible health plans has increased over the past decade, from 20% of covered workers in 2013 to 29% in 2023, only 24% of whom are enrolled in Health Savings Account-qualified high deductible health plans in 2023).

[74] Kliff & Katz, supra note 71.

[75] Sarah Klein and Martha Hostetter, *Tackling High Health Care Prices: A Look at Four Purchaser-Led Efforts,* Commonwealth Fund, at 5 (April 1, 2022) (citing study performed by RAND Corp. at the request of the Robert Wood Johnson Foundation and The Employers' Forum of Indiana, a coalition of 154 self-insured organizations)

[76] *Id. See, e.g.,* 42 CFR § 413.65 (determining provider-based status for Medicare payment purposes); *see also* Brady Post, et al., *Hospital-Physician Integration and Medicare's Site-Based Outpatient Payments*, 56 HEALTH SERVS. RES. 13 (2021) (finding that by acquiring physician practices, hospitals gain $114,000 more in Medicare revenue per acquired physician per year).

[77] Kliff & Katz, supra note 71 (noting that if employers want prices, they must spend a lot of money to get them).

[78] Anna Wilde Mathews, *Hospital to Union: Pay Up or You're Stuck with Us in Your Health Plan*, Wall Street Journal (May 21, 2024).

[79] *Id.*

[80] *Id.* (noting that employers and unions end up living with the conditions in the contracts, which are typically secret, and paying prices that are often double or more what the government spends for the same medical services).

[81] *Id*. It should be noted, however, that beginning July 1, 2024, price data must be in a template developed by the Centers for Medicare and Medicaid Services (CMS). *See* 45 CFR § 180.50(c)(2). Whether that improves accessibility and readability of the data remains to be seen.

minimal and currently ranges from $109,500 to $2,007,500 per hospital.[82] For hospitals that make billions of dollars in revenue, such penalty may not offer enough incentive to be fully transparent with prices.[83] Furthermore, higher costs leads to patient medical debt,[84] as well as putting off needed medical care.[85]

### b. Quality and Access

A recent study of 51 private equity acquired hospitals across the United States found increases in hospital-acquired infections, even with a healthier patient pool compared to non-private equity acquired hospitals.[86]Nevertheless, studies regarding the impact of health care corporatization on quality of care have not been as conclusive as studies regarding the impact on price.[87] "Studies show mixed findings depending on the quality measures studied, setting, and degree of integration."[88] Some studies show no change in quality measures after horizontal or vertical integration of health care entities, others show a decline in quality, and still others show an improvement.[89]

Mixed results from studies evaluating quality after private equity health care acquisitions suggest that private equity investment can improve health care organization operations. However, as noted by one group of researchers, the "fact that no consistently positive effects of [private equity] in healthcare were identified also provides an evidentiary basis to remain cautious about claims that [private equity] ownership is a self-evident benefit to healthcare provision." [90]

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[82] CMS Fact Sheet, *Hospital Price Transparency Frequently Asked Questions*, at 3 (June 27, 2023), https://www.cms.gov/files/document/hospital-price-transparency-frequently-asked-questions.pdf (last visited May 28, 2024).
[83] Kliff and Katz, supra note 71 (highlighting that N.Y.U. Langone, a system of five inpatient hospitals that had not complied with the transparency law in 2021, reported $5 billion in revenue in 2019).
[84] *Id.* (stating that sixteen percent of insured families currently have medical debt, with a median amount of $2,000); *see also* Lopes et al., *supra* note 6, at 1 (stating that four in ten adults report having debt due to medical or dental bills including debts owed to credit cards, collection agencies, family and friends, banks, and other lenders to pay for their health care costs).
[85] Lopes et al., *supra* note 6, at 1 (noting that one in four adults have skipped or postponed health care needed because of cost).
[86] Sneha Kannan, Joseph Dov Bruch, and Zirui Song, *Changes in Hospital Adverse Events and Patient Outcomes Associated with Private Equity Acquisition*, JAMA, Vol. 330, No. 24, at 2371-2372 (Dec. 26, 2023).
[87] Jodi L. Liu, et al., *Environmental Scan on Consolidation Trends and Impacts in Health Care Markets*, RAND Corp., at vii (2022).
[88] *Id.* As noted by Levinson, et al., interpreting evidence on quality is complicated by the fact that "there are many dimensions and measures of quality that have been or could be used to assess the effects of consolidation and that it could take time for changes in quality to materialize." Levinson, et al., *supra* note 41.
[89] Liu, et al., *supra* note 87, at vii. However, it should be noted that studies of patient outcomes after nursing home private equity acquisitions have shown increased mortality, higher rates of hospitalizations, and emergency room visits. Fuse Brown and Hall, *supra* note 18, at 18.
[90] Alexander Borsa, et al., *Evaluating Trends in Private Equity Ownership and Impacts on Health Outcomes, Costs, and Quality: Systematic Review*, British Medical Journal, Vol. 382, at 13 (June 11, 2023).

Interestingly, the Rand Corporation found no studies that directly assessed the effects of insurer or physician practice consolidation on access to care.[91] The Rand Corporation did find two studies that examined the effect on patient access following hospital consolidation in rural settings.[92] Those studies found that hospitals that merged with larger systems were more likely to reduce maternal, neonatal, surgical care, and mental health and substance use disorder services.[93] Other anecdotal evidence of adverse impacts on patient access to care because of private equity investments in health care include the bankruptcies of Steward Health Care in Massachusetts,[94] Envision Healthcare, and the Center for Autism and Related Disorders.[95] Steward Health Care is a community hospital system that touted itself as an "accessible low-cost alternative to Boston's medical goliaths."[96] In 2010, a private equity firm acquired and converted the Steward Hospitals to for-profit entities, which were previously operated by the Boston Archdiocese.[97] Implementing the typical private equity playbook, the private equity firm sold the hospital buildings in 2016 for $1.2 billion and paid out a $111 million dividend to private equity owners in 2021, leaving the hospitals with multi-million dollar rent obligations.[98] Steward's bankruptcy will likely disrupt care for numerous patients.[99]

In total, there were about 80 healthcare bankruptcies in 2023 and at least 17 of those involved private equity firms. Envision Healthcare is an emergency room staffing company with 70,000 employees across the United States that filed for Chapter 11 bankruptcy on May 15, 2023.[100] The private equity firm KKR acquired Envision Healthcare in 2018 for $9.9 billion, seventy percent of which was debt that was subsequently offloaded onto Envision.[101] Envision blamed the No Surprises Act in its bankruptcy filing because it impacted its business model, which was to surprise patients with higher-than-average rates when using out-of-network emergency services.[102] Envision also spent "millions of dollars on a dark money campaign against surprise billing legislation."[103] Envision is now being sued by the American Academy of Emergency Medicine Physician Group, Inc. for

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[91] Liu et al, *supra* note 87 at 22 and 26.
[92] *Id*. at 17.
[93] *Id*.
[94] Robert Weisman and Jessica Bartlett, *Steward Files for Bankruptcy, Leaving its Eight Massachusetts Hospitals in Limbo*, Boston Globe, (May 6, 2024).
[95] Private Equity Stakeholder Project, *supra* note 26.
[96] Weisman and Bartlett, *supra* note 94.
[97] *Id*.
[98] *Id*.
[99] *Id*.
[100] Private Equity Stakeholder Project, *supra* note 26.
[101] *Id*.
[102] *Id*.
[103] *Id*. (citing Isaac Arnsdorf, *Medical Staffing Companies Cut Doctors' Pay While Spending Millions on Political Ads*, ProPublica (April 20, 2020)).

engaging in unfair business practices, such as California corporate practice of medicine, fee splitting and restrictive covenant law.[104]

Another example of how private equity acquisitions of health centers results in lower quality is revealed in the bankruptcy filings of the Center for Autism and Related Disorders. This Center is an autism treatment provider with 130 centers across the United States that filed for bankruptcy on June 12, 2023.[105] The private equity firm Blackstone acquired the Center for Autism and Related Disorders in 2018 for $600 million and started to close centers soon thereafter, creating access problems for patients who were often given less than six weeks advance notice of a clinic closure.[106] Wait lists at remaining providers were up to one year long.[107] Interviews of staff after the Blackstone takeover revealed cuts to training requirements, deterioration of standards, and poor working conditions such as an increase in patient-to-clinician ratios that increased patient loads from 10-12 patients per clinician to up to 25.[108] The bankruptcies just described are only a sample of the total number of health organization bankruptcies that have occurred. The number of private equity bankruptcies in healthcare increased by 112.5 percent over the last five years and more are predicted to occur.[109] Because studies have found that private equity hospitals are on average located in lower-income, more-rural areas,[110] these areas are likely to be more adversely impacted by health organization bankruptcies than more affluent areas.

In addition to bankruptcy and access problems, another quality issue arising from health care corporatization is data privacy breaches. In February 2024, Change Healthcare, a subsidiary of UnitedHealthcare, experienced a ransomware attack that involved six terabytes worth of patient medical records, social security numbers, and active military

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[104] *American Academy of Emergency Medicine Physician Group, Inc. v. Envision Healthcare Corporation and Envision Physician Services, LLC*, First Amended Complaint, Case No. 3:22-cv-00421 (N.D. Calif.) (Feb. 18, 2022).
[105] Private Equity Stakeholder Project, *supra* note 26.
[106] *Id*.
[107] *Id*. Long wait lists were also listed as a consequence of private equity investment in health care by Wisconsin board for People with Developmental Disabilities in response to the FTC request for information. Letter from Beth Swedeen, Executive Director of Wisconsin Board for People with Developmental Disabilities to Department of Justice, Department of Health and Human Services and the FTC in response to ATR 102, at 3 (May 1, 2024) (on file with author). This is the result of private equity owners shifting client bases toward more private-pay clients leaving few provider options, and thus longer wait times, for Medicaid patients. *Id*.
[108] Private Equity Stakeholder Project, *supra* note 26. The increase in patient-to-clinician ratio is corroborated by allegations from the emergency physician lawsuit against Envision Healthcare. *American Academy of Emergency Medicine Physician Group, Inc. v. Envision Healthcare Corporation and Envision Physician Services, LLC*, First Amended Complaint, Case No. 3:22-cv-00421, at para. 47 (N.D. Calif.) (Feb. 18, 2022) (alleging also that Envision increased patient utilization of physician assistances to replace more costly physician coverage and increased billings to patients, insurers and third-party payors for physician services).
[109] Private Equity Stakeholder Project, *supra* note 26.
[110] Joseph Bruch, Dan Zeltzer and Zirui Song, *Characteristics of Private Equity-Owned Hospitals in 2018*, Annals of Internal Medicine, Vol. 174, No. 2, at 279 (Feb. 2021).

personnel information.[111] In response to the ransomware attack, U.S. lawmakers questioned whether massive consolidation in healthcare leaves the U.S. health system more vulnerable to such attacks.[112] Another cyberattack happened three months later to a large health system, Ascension, blocking access to "many electronic patient records, communication systems, and online ordering and prescribing systems," which is adversely impacting patient care.[113] Although Ascension is not owned by private equity (it is a Catholic nonprofit hospital system), it is a large, consolidated system with 140 hospitals and thousands of affiliates across the United States.[114] Ascension is now facing two proposed class-action lawsuits in Illinois and Texas alleging that Ascension "acted negligently by failing to encrypt patient data" leaving patients at risk of identity theft for years to come.[115]

Each of the above examples of corporatization affirm that it is not benefiting health care purchasers in critical ways. Corporatization is leading to higher costs for purchasers, and at least questionable, if not lower quality. As a result, health care purchasers may be very open to collaborate with other aligned stakeholders who are not satisfied with the status quo and want to improve health care costs and quality.

### 2. Impact of Corporatization on Physicians

Health care purchasers are not the only stakeholders adversely impacted by the corporatization of health care movement. Many physicians also find themselves in losing positions because of corporatization efforts. Almost 61 percent of surveyed physicians have a negative view of private equity involvement in health care.[116] Indeed, over half of the

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[111] Giles Bruce, *Change Healthcare Confirms Ransomware Attack, Hackers Claim Massive Data Haul*, Becker's Hospital Review (Feb. 29, 2024), https://www.beckershospitalreview.com/cybersecurity/change-healthcare-confirms-ransomware-attack-hackers-claim-massive-data-haul.html (last visited May 31, 2024).
[112] Tina Reed, *Lawmakers Target Mergers in First Hearing on Change Healthcare Hack*, Axios (April 17, 2024), https://www.axios.com/2024/04/17/congress-change-healthcare-cyberattack (last visited July 2, 2024).
[113] Neelam Bohra, *Delayed Care, Closed Pharmacies, Hospitals on Diversion: Two Weeks Into the Ransomware Attack on Ascension*, Healthcare Brew (May 22, 2024), https://www.healthcare-brew.com/stories/2024/05/22/delayed-care-closed-pharmacies-hospitals-on-diversion-two-weeks-into-the-ransomware-attack-on-ascension?mbcid=35547967.35556&mblid=7ae0bf1cddcd&mid=a9d2c3da5e9b28889fe8e809a696d12a&utm_campaign=hcb&utm_medium=newsletter&utm_source=morning_brew (last visited May 31, 2024).
[114] *Id.*
[115] *Id.* Change Healthcare was also hit with multiple class-action lawsuits because of its cyberattack, as was HCA Healthcare for a cyberattack that occurred in 2023. Brendan Pierson, *Lawsuits over Change Healthcare Data Breach Centralized in Minnesota*, Reuters (June 7, 2024) (noting the centralization of 49 lawsuits accusing Change Healthcare of failing to protect personal data), https://www.reuters.com/legal/litigation/lawsuits-over-change-healthcare-data-breach-centralized-minnesota-2024-06-07/#:~:text=June%207%20(Reuters)%20%2D%20A,February's%20cyber%20attack%20in%20Minnesota. (last visited July 2, 2024).
[116] Jane M. Zhu, et al., *Physician Perspectives on Private Equity Investment in Health Care,* JAMA Internal Medicine, Vol. 184, NO. 5, at 579-581 (May 2024).

respondents viewed private equity ownership as worse or much worse than independent ownership of physician practices, and 49.3 percent viewed private equity ownership worse or much worse than not-for-profit health system ownership of physician practices.[117] The surveyed physicians viewed private equity ownership in health care as adversely impacting: 1) physician wellbeing; 2) health care prices or spending; and 3) health equity.[118] A survey of a small group of physicians currently employed by private equity owned practices reported "lower satisfaction, autonomy, and likelihood of staying with their employer."[119]

Other studies reveal that private equity owned practices pressure clinicians to increase revenue by performing more procedures and ancillary services, as well as to use more expensive drugs, which can lead to higher spending by health care purchasers.[120] These practices may also replace physicians with nonphysician practitioners without adequate physician supervision.[121]

Some physicians have sued private equity firms for unfair business practices and violating the state laws like the corporate practice of medicine, which prohibits lay persons from owning or operating medical clinics. One such lawsuit is *American Academy of Emergency Medicine Physicians Group, Inc. v. Envision Healthcare Corporation*.[122] As noted earlier, Envision Healthcare is owned by private equity firm KKR and has currently filed for bankruptcy.[123] In the lawsuit, the physician plaintiffs allege, among other things, that:

> Envision exercises profound and pervasive direct and indirect control and/or influence over the medical practice, making decisions which bear directly and indirectly on the practice of medicine, rendering physicians as mere employees, and diminishing physician independence and freedom from commercial interests, in violation of California's corporate practice of medicine ban.[124]

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[117] *Id*. at 579.
[118] *Id*.
[119] *Id*. at 581. Indeed, another study found higher turnover of physicians in private equity-acquired practices than non-private-equity-acquired practices. Joseph Dov Bruch, et al., *Workforce Composition in Private Equity-Acquired Versus Non-Private Equity-Acquired Physician Practices*, Health Aff., Vol. 41, No. 1, at 127 (Jan. 2023).
[120] MedPac Report to Congress, *Medicare and the Health Care Delivery System*, at 100 (June 2021), https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun21_medpac_report_to_congress_sec.pdf (last visited July 3, 2024).
[121] *Id*.
[122] First Amended Complaint of *American Academy of Emergency Medicine Physicians Group, Inc. v. Envision Healthcare Corporation*, Case No. 3:22-cv-00421, dkt. #18-2 (N.D. Calif. Feb. 18, 2022).
[123] Private Equity Stakeholder Project, *supra* note 26.
[124] *American Academy of Emergency Medicine Physicians Group, Inc.,* supra note 119, at11. As noted in the First Amended Complaint, "California (and many other states) bar lay entities from owning physician practice groups, employing physicians, or violating the Corporate Practice of Medicine Bar" and that Envision's business model is to circumvent the corporate practice of medicine by creating a separate subsidiary licensed Professional Medical Corporation. *Id*. at 7, para. 27.

Despite these downsides to corporatization of health care, many physicians are willing participants. According to a recent physician survey by the American Medical Association (AMA), physicians are selling their practices to larger health systems and private equity firms because without the help of these larger conglomerates, they can't survive financially.[125] Indeed, the number of physicians who own their medical practice has decreased in the last ten years, from 53.2 percent in 2012 to 44 percent in 2022, and new physicians are much less likely to own their medical practice than retiring physicians.[126]

**Why Are Physicians Selling?**

The negative press regarding private equity eating up health care ignores the important question of why physicians sell their practices in the first place.[127] According to an AMA survey, physicians sell their practices because on their own, they cannot negotiate favorable payment rates with payers, they have trouble managing payers' regulatory and administrative requirements, and it is too expensive to access costly resources.[128] "Stagnant payment rates in the face of the rising costs of private practice were also cited as a reason for selling to a hospital over a decade ago."[129]

One legal scholar pointed out that the ability for physicians to sustain an independent practice has become financially "daunting" given that physician practices are now expected to have sophisticated and expensive information technology.[130] What private equity offers physicians is a chance to reduce their personal risk of meeting all these administrative and regulatory burdens, which lead to burnout, while still being able to practice medicine, and perhaps receive an influx of cash from the sale of their practice.[131]

**3. How the Interests of Purchasers and Physicians Align**

In the march toward greater health care consolidation, the losing stakeholders are health care purchasers and physicians. Purchasers and physician stakeholders are losing the

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[125] Kane, *supra* note 32, at 7 (finding responses to the 2022 Benchmark Survey "indicated that the need to be3tter negotiate favorable (higher) payment rates with payers, better manage payers' regulatory and administrative requirements, and improve access to costly resources were the most important motivations for private practices selling to hospitals or health systems.")
[126] *Id*. at 8-9.
[127] Yashaswini Singh & Christopher Whaley, *Private Equity Is Buying Up Health Care, but the Real Problem Is Why Doctors Are Selling*, THE HILL (Dec. 21, 2023), https://thehill.com/opinion/healthcare/4365741-private-equity-is-buying-up-health-care-but-the-real-problem-is-why-doctors-are-selling/.
[128] Kane, *supra* note 32, at 7.
[129] *Id*.
[130] Robert I. Field, et al., *Private Equity in Healthcare: Barbarians at the Gate*?, 15 Drexel L. Rev. 821, 838 (2023).
[131] *Id; see also* Jeffrey M. Smith, Eric A. Boe, & Ryan Will, *Physician Wellness in Orthopedic Surgery: Challenges and Solutions*, Orthop. Clin. N. Am, Vol. 52, at 48 (2021) (stating that physicians experience moral injury from the "death by a thousand cuts" of electronic medical records, administrative burdens, and competing business demands versus patient care).

ability to negotiate more favorable prices and higher value care. Group health plan purchasers and physicians also both have a fiduciary responsibility to ensure high value care to beneficiaries.

### a. Loss of Negotiating Power

As noted above, physicians disapprove of private equity investment in health care, and most surveyed physicians experience less autonomy and satisfaction working in corporate environments. Corporatization is also leading patient purchasers to experience higher costs and less access to health care, especially health care that they want (such as preventive, holistic health care).

Studies have shown that self-insured group health plans are paying higher prices as a result of health care market consolidation than insured health plans.[132] Self-insured group health plans have an incentive "to lower costs, given their responsibility for the medical costs of enrollees."[133] Yet, self-insured health plans have "limited ability to negotiate with highly consolidated hospitals and other providers."[134]Relying on third party administrators (TPAs) to negotiate a better price has not worked.[135] This is because TPAs are often health insurance companies, which as noted earlier, are a huge part of the health care consolidation phenomenon.[136] TPAs often hinder self-insured group health plans' "awareness of the prices they are paying, limit their ability to lower spending, and potentially introduce additional costs."[137]

The additional costs to which TPAs may expose self-insured group health plans may include processing fees for making payments to health care providers.[138] These processing fees may be shared with companies supplying private equity-backed repricing tools that end up shortchanging the self-insured group health plan, patient, and health care provider.[139] The lack of market power in the face of large, consolidated health systems has led some purchasers and physician groups to file lawsuits against the systems. For example, Kraft Heinz Company group health plan sued its TPA, Aetna, for breaching its ERISA fiduciary duty when, among other things, it repriced claims and failed to pass any

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[132] Aditi P. Sen, Jessica Y. Chang, and John Hargraves, *Health Care Service Price Comparison Suggests that Employers Lack Leverage to Negotiate Lower Prices*, Health Aff., Vol. 42, No. 9, at 1247 (Sept. 2023) (finding self-insured plans pay moderately higher prices for most services when compared to insured plans).
[133] *Id*.
[134] *Id*.
[135] *Id*.
[136] *See e.g.*, Setting the Record Straight, *supra* note 33.
[137] Sen, Chang and Hargraves, *supra* note 132, at 1247.
[138] Chris Hamby, *In Battle Over Health Care Costs, Private Equity Plays Both Sides*, The New York Times (April 7, 2024).
[139] *Id*. (describing repricing tool DataiSight, which sets provider prices based on pre-determined treatment costs, causing providers to receive lower than their usual and customary rates and for employers and patients to pay higher out-of-pocket costs).

savings to the self-insured group health plan.[140] Another case brought by emergency room physician groups against UnitedHealthcare similarly alleges that UnitedHealthcare conspired with Multiplan (the private equity-backed owner of the repricing tool) to underpay physicians and then UnitedHealthcare and Multiplan share in the "savings."[141]

### b. Fiduciary Duty to Plan Beneficiaries

ERISA requires group health plan fiduciaries to discharge their duties with respect to a plan solely in the interest of the participants and beneficiaries and with the care, skill, prudence and diligence that a prudent person acting in like capacity would use.[142] According to the U.S. Department of Labor, a fiduciary is a "person using discretion in administering and managing a plan or controlling the plan's assets."[143] ERISA fiduciary duty is not about one's title. Rather, the duty applies when a person has discretion and control over plan administration or assets.[144] Thus, a plan fiduciary could be an employer sponsor of a plan, but also could be a vendor, such as a third-party administrator or pharmacy benefit manager, depending on how much discretion or control they have over plan decisions or assets. ERISA fiduciary duty does not include whether an employer or union should offer a health plan - that is a business decision.[145] However, when the employer or union does decide to offer such a plan, it is then obligated under the ERISA fiduciary obligations to do the following:

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[140] *The Kraft Heinz Company Employee Benefits Administration Board v. Aetna Life Insurance Company*, Complaint, Case No. 23-cv-317, dkt. # 1, at 18 (E.D. Tx. June 30, 2023) ("Aetna never refunds, credits, or reconciles with the Plans the difference between any amount taken from the Plans and the amount ultimately paid to the provider pursuant to the reprocessed claims."). The plaintiffs in this case voluntarily dismissed the action under FRCP 41(a). *Id.*, dkt. #14 (Order granting Plaintiffs' Notice of Dismissal). Other ERISA breach of fiduciary duty lawsuits brought by group health plans against plan administrators include suits against Elevance, Inc. and Blue Cross Blue Shield of Massachusetts. *See* Sara Hansard, *Employer Lawsuits Heat Up Against Health Plan Administrators*, Bloomberg Law (July 6, 2023), https://news.bloomberglaw.com/employee-benefits/employer-lawsuits-heat-up-against-health-plan-administrators (last visited June 3, 2024).

[141] *Emergency Physician Servs. of N.Y. v. UnitedHealth Grp.*, Case No. 20-cv-9183, Opinion and Order, dkt. #65, at 6 (S.D. N.Y. Sept. 28, 2021) (stating that "United compensates MultiPlan based on the amount by which the claims were underpaid- that is, MultiPlan was "paid a fee equal to between 6% and 9% of the difference between the target amount that United sent and the amount of the new, lower payment that MultiPlan calculated using DataiSight. Both companies profit: United profits by lowering its costs, while MultiPlan profits when United shares money obtained through the scheme."). The court dismissed the physicians' claim under the federal Racketeer Influenced and Corrupt Organizations Act (RICO) but allowed the claims involving unjust enrichment and declaratory judgment to go forward. *Id.*

[142] 29 USC § 1104(a).

[143] Whitepaper, *Understanding Your Fiduciary Responsibilities Under a Group Health Plan*, U.S. Department of Labor, at 1, https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/understanding-your-fiduciary-responsibilities-under-a-group-health-plan.pdf (last visited June 13, 2024).

[144] *Id.*

[145] *Id.* at 2.

- Act solely in the interest of plan participants and beneficiaries and with the exclusive purpose of providing benefits to them;
- Carry out plan administration and asset management prudently;
- Follow plan documents (unless inconsistent with ERISA);
- Hold plan assets (if any) in trust; and
- Pay only reasonable plan expenses.[146]

If there are any plan losses or improper uses of plan assets because of fiduciary action or inaction, such fiduciaries may be personally liable for those misdeeds.[147]

Indeed, self-insured group health plans are at risk of being sued by plan participants if they do not comply with their ERISA fiduciary duties of loyalty and prudence. Group health plan participants brought breach of fiduciary duty lawsuits recently against Johnson & Johnson's health plan and Mayo Clinic's health plan. In the *Johnson & Johnson* lawsuit, a class of plaintiffs allege that Johnson & Johnson mismanaged its prescription drug benefits program, through its Pharmacy Benefits Manager (PBM), "costing employees millions of dollars in the form of higher payments for prescription drugs, higher premiums, higher deductibles, higher coinsurance, higher copays, and lower wages or limited wage growth."[148] Specifically, plaintiffs allege that Johnson & Johnson contracted with Express Scripts, a PBM, and Aon, an insurance broker, who all benefited financially from marking up drugs 498% above what it costs pharmacies to acquire the same generic-specialty drugs.[149] The markups represent profit for the PBM and no corresponding benefit to the group health plan or beneficiaries.[150] The plaintiffs allege that Johnson & Johnson "squandered its bargaining power" and instead agreed to make the group health plan and its beneficiaries "pay more than someone would pay if they just walked into a retail pharmacy and filled the same prescription without using insurance."[151] Because Johnson & Johnson, as the group health plan sponsor, did not ensure that the plan paid only reasonable amounts for prescription drugs and instead followed the "conflicted advice" of their broker or PBM, the plaintiff class alleges Johnson & Johnson breached its fiduciary duty of prudence under ERISA.[152]

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[146] *Id*.
[147] *Id*. at 3.
[148] *Lewandowski v. Johnson and Johnson, et al.,* Case No. 24-cv-671, Class Action Complaint, dkt. #1, at 2 (D. N.J. Feb. 5, 2024).
[149] *Id*. at 32-33.
[150] *Id*.
[151] *Id*. at 32, para. 98.
[152] *Id*. at 69, para. 197-198 ("In making decisions about the prescription-drug program, Defendants were required to consider all relevant factors and options under the circumstances, including alternative arrangements that were available to the Plans, the conflicts of interest of its vendors, whether the prices of drugs under its contract were reasonable, and steps taken by other companies that successfully lowered their prescription-drug costs.").

In another class action lawsuit against Mayo Clinic's group health plan and its TPA, plaintiffs allege the defendants overcharged them for seeing out-of-network providers, saddling the plaintiffs with "enormous balance bills all while reaping large profits from these supposedly premier insurance plans."[153] As a result of this overcharging scheme, the plaintiffs claim defendants violated RICO as well as their fiduciary duty under ERISA.[154]

Lawsuits are not the only legal mechanism drawing attention to employer health plan obligations. The Consolidated Appropriations Act of 2021 (CAA) requires employer-based health plans to submit information about prescription drugs and health care spending as well as submitting an attestation of compliance regarding gag clauses.[155] The prescription drug and health care spending disclosure includes disclosure of spending on health care services and premiums paid by members and employers.[156] Although these obligations under the CAA may seem onerous to group health plans, as pointed out by a group health plan coalition, the goal of the CAA is to ensure employers access to data about their health plans.[157] Thus, the CAA can be a tool group health plans can use to access data to win back some negotiating power with corporate health care conglomerates. Nevertheless, a recent employer survey shows that rising healthcare costs and complying with fiduciary duties, particularly in light of the *Johnson & Johnson* lawsuit described earlier, are issues that keep employers "up at night."[158]

Group health plans are not the only stakeholders with fiduciary obligations. Some legal scholars argue that physicians should have, if not do have, fiduciary obligations to their patients. Principle VIII of the American Medical Association (AMA) ethical principles for physicians states that "a physician shall, while caring for a patient, regard responsibility to the patient as paramount."[159] The law recognizes fiduciary duty in two types of persons: 1) those who have power over property rights of others (which would encompass the group health plans discussed above); and 2) those who are professionals.[160] Physicians are professionals who could take advantage of the party to whom they provide services and the

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[153] *SMO v. Mayo Clinic*, Case No. 24-cv-1124, Class Action Complaint, dkt. #1, at 1-2 (D. Minn. April 2, 2024).
[154] *Id*. at 19-25.
[155] 29 CFR § 2590.725-4 (prescription drug and health care spending reporting requirement); 29 USC § 1185m(3) (gag clause attestation requirement defining gag clauses as agreements that restrict health plans from providing provider-specific cost or quality of care information or data to health care purchasers); *see also* Fact Sheet, *Consolidated Appropriations Act, 2021 (CAA)*, Centers for Medicare and Medicaid Services, https://www.cms.gov/marketplace/about/oversight/other-insurance-protections/consolidated-appropriations-act-2021-caa (last visited June 13, 2024).
[156] 29 CFR § 2590.725-4(5).
[157] Press Release, *Employers Want Greater Accountability from Intermediaries to Ensure CAA Compliance per National Alliance of Healthcare Purchaser Coalitions Survey*, National Alliance of Healthcare Purchaser Coalitions (May 16, 2024), https://www.nationalalliancehealth.org/news/employers-want-greater-accountability-from-intermediaries-to-ensure-caa-compliance-per-national-alliance-of-healthcare-purchaser-coalitions-survey/ (last visited July 3, 2024).
[158] *Id*. (finding that 77% of surveyed employers are worried about health care costs, 39% are worried about fiduciary duties and 35% are worried about recent litigation).
[159] Maxwell J. Mehlman, *Can Law Save Medicine?,* 36 J. Legal Med. 121, 136 (April-June, 2015).
[160] *Id.* at 139.

services provided are essential both to the other party and to society.[161] That is the essence of a fiduciary relationship.[162] Applying a fiduciary standard to the physician-patient relationship could arm physicians with a legal tool to fight against the corporatization of health care.[163] But physicians need to know that the tool is available and how best to wield it. Legal advocates could help teach physicians about that tool through a Wellness-Legal Partnership model described in Part III.

As the previous studies, laws, and lawsuits demonstrate, corporatization of health care is harming patients, group health plans, and physicians. Each of these stakeholders loses negotiating power as health care market consolidation and corporate takeover marches forward, leaving these stakeholders to opt for litigation to reclaim some of the power they have lost. Corporatization also threatens the fiduciary duties owed to plan beneficiaries by group health plans and physicians. But litigation should not be the only avenue that purchasers and physicians should try to fulfill their duties to health care beneficiaries. By seeing their shared interest in health care as a socially valued construct, and not a profit-making machine, these three stakeholder groups could work collaboratively to resist the changes brought by corporatization.

### c. Purchaser-Physician Collaboration Precedents

There is precedent for such collaboration. In the 1990s, when managed care changed the health care landscape through privatization and decentralization of critical coverage decisions, the Center for Public Representation (CPR), a public interest law firm, helped lead a consumer, physician and "progressive insurer" collaboration to help pass a Patients' Bill of Rights that included quality assurance, strengthened grievance procedures, and an external review system for patients with insurance claim denials.[164] With the expansion of managed care, physicians felt "demeaned, losing both their autonomy as professionals and, in many cases, income."[165] Consumers feared that managed care was mostly interested in controlling costs and increasing profit rather than delivering services.[166] The health insurer added valuable perspective to the health plan grievance process.[167] This collaborative group was called the Collaboration for Healthcare Consumer Protection (CHCP) and met with representatives from private insurance, administrative agencies,

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[161] *Id*.
[162] Professor Mehlman points out that several legal authorities, including the U.S. Supreme Court in *Pegram v. Herdrich*, 530 U.S. 211, at 215 (2000), have declined to apply a fiduciary relationship to physicians and instead apply a malpractice and/or confidentiality standard. *Id*. at 140-147.
[163] Mary Anne Bobinski, *Law and Power in Health Care: Challenges to Physician Control*, 67 Buff. L. Rev. 595, 646 (May 2019) ("Affirming the physician-patient relationship's fiduciary character could support efforts by physicians to strengthen their ability to follow non-market ethical principles and to protect the treatment relationship itself from the impact of swirling market forces and pressures.").
[164] Louise G. Trubek*, Public Interest Lawyers and New Governance: Advocating for Healthcare*, 2002 Wis. L. Rev. 575, 592.
[165] *Id*.
[166] *Id*.
[167] *Id*.

employer coalitions and the state legislature in Wisconsin.[168] CHCP advocated together to enact more patient protections in Wisconsin, which helped each group "influence health care policy in a more effective way."[169] Critical players in this collaborative group were the lawyers, albeit in a non-traditional public interest lawyer role. Instead of engaging in impact litigation or testifying before regulatory agencies, the lawyers provided knowledge of how public and private institutions function, helped analyze data, reassured consumers that their voices would be heard, and spoke out when there were malfunctions in the advocacy process.[170]

A more current example of purchaser and physician collaboration is the partnership between the National Alliance of Healthcare Purchaser Coalitions (NAHPC) and the Council of Accountable Physician Practices (CAPP).[171] This partnership issued a report that among other things, identifies opportunities for "Employer-Physician" collaboration.[172] These opportunities include determining the value of vendor add-ons such as care navigators and telehealth, incentive strategies for employees to choose high-value providers, removing financial barriers that hinder access to high-quality care, evaluating the impact on affordability of care, and generating more employee engagement with preventive services and wellness.[173] Glaring absences from this partnership, in contrast to CHCP, are lawyers and patient group representatives.[174]

The interests of health care purchasers and physicians align around having health care that is affordable and accessible and that provides value. This stakeholder alignment presents a unique opportunity to harness that alignment and create WLPs. The lawyers leading

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[168] *Id*.
[169] *Id*. at 593.
[170] *Id*. at 600-601.
[171] Press Release, *Employer/Physician Collaborative Announces Strategies to Work Together to Improve Patient care,* National Alliance of Healthcare Purchaser Coalitions (Feb. 2, 2021), https://www.nationalalliancehealth.org/news/collaborative-announces-strategies/ (last visited June 13, 2024). It should be noted that CAPP operations are currently paused because of the impact of COVID-19. Announcement, *Better Together Health* (Sept. 1, 2021), https://bettertogetherhealth.org/ (last visited June 13, 2024).
[172] Stephen Parodi, MD, et al., *Better Together: Exploring Employer-Physician Collaborations to Deliver Quality Care,* CAPP (July 2020), https://accountablecaredoctors.org/wp-content/uploads/2020/07/capp_bth_employer-physician-collabs.pdf (last visited June 13, 2024).
[173] *Id*. at 22.
[174] *See id*. A review of the "Strategic Partners and Collaborators" of NAHPC shows that although some partners and collaborators of NAHPC claim they have consumer representation, one such group did not have any consumer or public interest legal group listed as a member (Better Solutions for Healthcare), the Centers for Disease Control (CDC) is a government agency that protects the public's health, one coalition included a union as a member (Coalition Against Surprise Billing included Unite Here, a union organization), one NAHPC member included a consumer health interest group as a member (Health Care Payment Learning and Action Network included Families USA as a member) and one NAHPC member was merely an educational website (National Coalition on Health Care). See NAHPC website, *Strategic Partners and Collaborators*, https://www.nationalalliancehealth.org/strategic-partners/ (last visited June 13, 2024). None of the strategic partners or collaborators included any public interest law groups or lawyers.

WLPs would be trained to address employee wellbeing and leverage collaborations of these stakeholders.

Corporatization of health care and fiduciary expectations of employers and physicians demand health lawyer involvement, but currently there is a gap in that kind of health law practice.

## II. Current Gaps in Health Law Practice

An article from ten years ago declared that the practice of health law was undergoing a transformation due in part to the Affordable Care Act (ACA), transforming the health care industry to a more patient-centered, collaborative care model that is also value-based ("Transformations" article).[175] The article identified three primary worksites for health lawyers: 1) in-house counsel; 2) corporate law firms; and 3) medical-legal partnerships.[176] The Transformations article also noted that "[h]ealth law is a significant field of specialization."[177] It did not, however, foresee how the corporatization of health care, which has grown exponentially since the publication of that article, would impact the practice of health law in each of these practice sites and undermine patient wellbeing.

The rapid corporatization of health care requires another transformation of health law practice. This new practice should adopt legal practice frameworks involving systems leadership, lawyer fiduciary duty and health justice to address societal needs that current health lawyers do not meet. The result of this new health law practice is one that aims to rectify the lack of power faced by purchasers and physicians by forming collaborations to improve group health plan patient wellbeing. As explained below, the current environments in which health lawyers practice are poorly suited for this task.

### A. The Impact of Corporatization on In-House Law Practice

As noted in the *Transformations* article, health care organizations hire in-house lawyers for strategic advice on both business and legal issues.[178] Health organizations value in-house lawyers' understanding of the organization's goals and the legal advice that can help the organization achieve those goals. However, because in-house lawyers are so "absorbed" by their client, they sometimes seek outside counsel advice to get a more independent analysis of the issue.[179]

Thus, in-house counsel faces an ethical dilemma when working as an employee for a corporate client. Indeed, the Model Rules of Professional Conduct inform in-house counsel

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[175] Louise G. Trubek, Barbara Zabawa and Paula Galowitz, *Transformations in Health Law Practice: The Intersections of Changes in Health Care and Legal Workplaces*, 12 Indiana Health L. Rev. 183, 184-186 (2015).
[176] *Id*.
[177] *Id*. at 185.
[178] *Id*. at 195-196.
[179] *Id*. at 198-199.

that their client is the organization that employs them.[180] In-house lawyers owe their professional duty to the organization and not the directors, officers and other constituents of the organization.[181] In the health care corporatization era, exercising one's professional duty in service to a profit maximizing health care organization will likely not be what is best for health care purchasers or physicians.

To the extent in-house counsel does consider patient, physician, or purchaser impact from their organization's strategy, those lawyers may face "Organizational-Professional Conflict ("OPC").[182] OPC is a phenomenon in which the ethical demands of the external profession (i.e., law) and the employer conflict.[183] Part of a health lawyer's ethical duty in the era of corporatization is to address the adverse impacts of corporatization of health care on patients.[184] In the group health plan context, patients suffer because their employers and physicians lose bargaining power with corporate health care conglomerates. As noted earlier, all three of these stakeholders have lost bargaining power with corporate health care organizations.[185]

Current in-house lawyers may not be ideally situated to solve the problem of unequal bargaining power by purchasers and physicians in the new corporatized health care landscape. One recent study of in-house counsel demonstrates organizational "capture" of in-house counsel.[186] The study looked at behavior from a variety of in-house counsel in Canada when faced with a hypothetical ethical dilemma.[187] Based on a vignette, researchers asked in-house counsel to decide either talk to management "off the record" about management making racist comments (i.e., an "organizational response") versus making a formal report about the incident to management explaining that if the situation does not change it will be reported to the board (i.e., the "professional response").[188] The researchers found that the more involved the counsel in the operations and strategic thinking of the company, the more likely the lawyer would choose the organizational response.[189] But as legal scholars have pointed out, in-house counsel who opt for the professional response isolate themselves from the organization's management and may be

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[180] William W. Horton, *Serving Two (Or More) Masters: Professional Responsibility Challenges for Today's In-House Healthcare Counsel*, 3 J. Health & Life Sci. L. 187, 201 (Jan. 2010) (citing Model Rules of Prof'l Conduct R. 1.13(a), (f) (2009)).
[181] *Id*.
[182] Hugh Gunz and Sally Gunz, *Ethical Challenges in the Role of In-House Counsel*, 69 Case W. Res. L. Rev., 953, 956-957 (Summer 2019).
[183] *Id*.
[184] Barry R. Furrow, *The Role of the Lawyer as Deal Maker in Health Care Acquisitions: From Amoral to Immoral?*, at 17 (2024) (unpublished article, on file with author) (stating that lawyers are not simply agents of clients but also licensed fiduciaries of the legal system and have obligations to third parties) (citing ABA Model Rule 1.6)).
[185] *See supra*, Section I.D.3.a.
[186] Gunz and Gunz, supra note 182, at 970-972.
[187] Id.
[188] Id.
[189] Id.

seen as "not earning their keep."[190] So, it can be argued quite convincingly that current in-house health care counsel are not well-positioned to tackle the adverse impact of their corporate employers' corporatization efforts on health care purchasers and physicians.

### B. The Impact of Corporatization on Outside Health Lawyers

Current outside health lawyers may not be in a much better position to address the unequal bargaining power of health care purchasers and physicians either. Health lawyers working in "Big Law" have become "legal engineers," facilitating private equity ownership of health care organizations like nursing homes in the name of three "magic words": innovation, efficiency, and markets.[191] "The lure of high salaries and the pressures of big firm values can corrupt lawyers' judgment, rationalizing harms to third parties as little more than 'collateral damage' of an efficient market mechanism."[192]

Indeed, in house counsel go to outside law firms to get a "yes" regarding a plan or strategy desired by management.[193] If in-house counsel plays a critical role in the business strategies of their client, and in-house lawyers lean on outside lawyers to approve of that strategy, then it is in the outside lawyer's financial interest to legally engineer a way to move that strategy forward. In the case of private equity investment in health care, outside lawyers find ways to circumvent state and federal barriers to corporate ownership of health care providers. For example, a common legal engineering tactic to "out-maneuver" state corporate practice of medicine laws is to create a management services organization (MSO), whereby the corporate entity contracts with a physician-owned professional organization to provide administrative services.[194] In reality, however, the MSO controls most aspects, if not all, the medical practice, such as patient scheduling, staffing levels, payer contracts, and quality and performance metrics.[195] Until outside health lawyers shift their view of their role in the health care marketplace and the need to protect third parties from profit-maximizing abuses, they will not be reliable advocates for health care purchasers and physicians.

### C. The Impact of Corporatization on Medical-Legal Partnerships

Medical-Legal Partnerships (MLPs), as currently structured, are also not equipped to advocate for better conditions for health care purchasers and physicians. MLPs integrate legal assistance into the health care delivery model.[196] MLP lawyers, who are often employed by civil legal aid nonprofits or law school clinics or work pro bono, provide "legal

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[190] *Id*.
[191] Furrow, *supra* note 184, at 3-4.
[192] *Id*. at 19.
[193] Trubek, Zabawa and Galowitz, *supra* note 175, at 199.
[194] Fuse Brown and Hall, *supra* note 18, at 39-41.
[195] *Id*. at 41.
[196] Trubek, Zabawa and Galowitz, *supra* note 175, at 203-209.

advocacy in a medical setting for clients referred by medical professionals."[197] But MLPs also, theoretically, exist to help change the way health care organizations operate as well as to advocate for broader policy change.[198] Thus, the MLP mission is trifold: 1) to offer direct legal assistance to patients referred by medical professionals that aims to address social determinants of health (such as access to public benefits, substandard housing conditions, unlawful barriers to education or employment, guardianship matters, or immigration issues); 2) to advocate for change within health care organizations to better identify and address social determinants of health; and 3) to advocate for broader policy change at the local, state and national levels that will lead to greater health equity.[199]

The MLP model of practice is rooted in traditional poverty law services and links those services to the provision of health care services.[200] The MLP model depends upon health care organizations for support and funding and offers a means for those organizations to meet their community benefit obligations.[201] A large proportion of MLPs are integrated into hospitals and health systems,[202] which play a significant role in the corporatization of health care.[203] Because the current MLP model embeds health lawyers into corporatized health care organizations and because MLP lawyers are focused on helping patients from a poverty law lens, MLP lawyers likely do not have the capacity or interest in helping health care purchaser or physician stakeholders.[204] In the wake of corporatization, however, health care purchasers and physician stakeholders could benefit from advocacy assistance by competent WLP lawyers.

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[197] *Id; see also* Jennifer Trott, Alanna Peterson and Marsha Regenstein, *Issue Brief: Financing Medical-Legal Partnerships: View From the Field*, National Center for Medical Legal Partnership, at 1 (April 2019), https://medical-legalpartnership.org/wp-content/uploads/2019/04/Financing-MLPs-View-from-the-Field.pdf (last visited July 3, 2024) (stating that the MLP model embeds attorneys specializing in civil law into the health care setting to address patients' unmet legal needs and that MLP attorneys are usually sourced by civil legal aid nonprofits or law schools).

[198] *See e.g.,* Monica Carmean, *Medical-Legal Partnerships: Unmet Potential for Legislative Advocacy*, 19 Geo. J. on Poverty L. & Pol'y, 499, 501 (Summer 2012).

[199] Trubek, Zabawa and Galowitz, *supra* note 175, at 204.

[200] *Id*. at 208; *see also* Carmean, *supra* note 198, at 501 ("Medical-legal partnerships stand at the intersection of poverty and healthcare and are especially well situated to assist low-income clients.").

[201] Trubek, Zabawa and Galowitz, *supra* note 175, at 205-206 (citing IRC § 501(c)(3) and the community needs assessment requirements); *see also* Trott, Peterson and Regenstein, *supra* note 193, at 3 (noting that the Affordable Care Act requires nonprofit hospitals to complete and document a community health needs assessment every three years and about half of nonprofit hospitals with MLPs feature MLPs in their community benefit annual reports).

[202] *See* National Center for Medical Legal Partnership statistics at https://medical-legalpartnership.org/partnerships/ (showing that 175 of the 450 MLPs in the United States are with hospitals or health systems) (last visited June 19, 2024).

[203] *See infra*, notes 37-41.

[204] Indeed, a number of MLPs are funded by sources whose mission is to serve low-income individuals and families, such as Legal services Corporation funding, Interest on Lawyers Trust Accounts (IOLTA) Funds and funding from the federal Health Resources & Services Administration (HRSA). Trott, Peterson and Regenstein, *supra* note 197, at 4. As a result, representing group health plan purchasers or physicians would not serve the mission of most, if not all, MLPs.

## D. **Legal Practice Frameworks for WLP Lawyers**

Missing from existing collaborations between employers and physicians described earlier are legal advocates. Health care purchasers and physician groups should consider adding lawyers trained in promoting patient wellbeing through various legal avenues as a valued coalition member. These lawyers could help purchasers and physicians honor their fiduciary duties by working with WLPs. I offer three legal practice frameworks to inform WLP creation. These three frameworks are systems leadership, lawyer fiduciary duty, and health justice. These frameworks can guide lawyers who wish to create WLPs to better understand their role in the health care corporatization environment and when working with health care purchasers and physicians.

### 1. **Systems Leadership**

Legal scholars have recently promoted the need for lawyers to engage in systems leadership in the context of the climate crisis.[205] "Systems leadership" is defined as "a set of skills and capabilities that any individual or organization can use to catalyze, enable, and support the process of systems-level change. It combines collaborative leadership, coalition-building, and systems insight to mobilize innovation and action across a large, decentralized network."[206] In the climate context, proponents of systems leadership argue that lawyers have the opportunity, skills and responsibility to confront the climate crisis by serving individual clients and the public good.[207]

Lawyers can combat larger societal problems through finding a balance between advancing client interests while advocating results that will not exacerbate the larger problem.[208] The achievement of this balance can occur by the lawyer fulfilling their duty of competence under ABA Model Rule 1.1, which requires lawyers to provide competent representation to clients.[209] Competent representation requires lawyers to understand the facts, science, and other aspects of the particular representation.[210] To successfully achieve competent representation, lawyers must immerse themselves in their clients' world. Only with knowledge of the issues facing the client and the impacts client actions have on the larger society can the lawyer find creative solutions that achieve the balance

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[205] *See e.g.*, John C. Dernbach, Irma Russell and Matt Bogoshian, *Lawyering to Make a Difference: Ethics and Leadership for a Sustainable Society*, 23 Wake Forest J. of Bus. & Intellectual Property L. 20 (Summer 2022) (hereinafter "Sustainable Society"); Irma Russell, Dernbach, and Matt Bogoshian, *The Lawyer's Duty of Competence in a Climate-Imperiled World*, 92 UMKC L. Rev. 859 (2023) (hereinafter "Competence article").
[206] Sustainable Society, *supra* note 205, at 31.
[207] *Id.* at 22.
[208] *Id.* at 25-27 (citing the Preamble to the ABA Model Rules of Professional Conduct that states lawyers "should cultivate knowledge of the law beyond its use for clients, [and] employ that knowledge in reform of the law.").
[209] *Competence article*, supra note 205, at 865.
[210] *Id.* at 866.

between helpful advice and achieving social good.[211] Because lawyers are in positions of influence in their communities, they are also key stakeholders in solving any complex problem.[212]

Health care corporatization is a complex societal problem that lawyers must also solve for health care purchasers and physicians. Lawyers should take a step back from legal engineering corporate deals and understand how these corporate buy-outs hurt patient health and wellbeing. Lawyers must also understand that receipt and access to health care is only one aspect of overall wellbeing; other behavioral, social and structural barriers play a significant role in one's wellbeing.[213] By employing systems leadership concepts, lawyers incorporate the environment, such as the physical or socioeconomic environment, into the decision-making process instead of treating those environments as an afterthought.[214] So, rather than just finding a way to say "yes" to corporate health care strategies, under a systems leadership approach, lawyers would be cognizant of and explain the risks of the strategies on patient and provider wellbeing and try to find a solution that minimizes those risks. Even better would be a cadre of WLP lawyers who were dedicated to seeing the bigger picture of corporatization and finding solutions to improve patient wellbeing.

### 2. Lawyer Fiduciary Duty

Another helpful concept to guide WLP lawyers is fiduciary duty. As noted earlier, group health plans and physicians have fiduciary duties to plan beneficiaries/patients. Lawyers do as well. "Lawyers are not simply agents of clients – they are also licensed fiduciaries of the legal system and have obligations to third parties."[215] These obligations stem in part from ABA Model Rule of Professional Conduct 1.6(b), which allows lawyers to reveal information relating to the representation of a client to the extent the lawyer believes it is necessary to prevent substantial bodily injury or substantial financial injury because of a client's crime or fraud.[216] This rule arguably establishes a minimum fiduciary duty owed by lawyers to third parties, such as patients.[217]

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[211] *Id.* at 888 ("Part of leadership work is being creative and finding new ways to add value for clients and communities while simultaneously reducing greenhouse gas emissions and adapting to a changing climate."); *see also* Sustainable Society, *supra* note 200, at 23 (noting that innovative solutions are often generated from individuals and small groups of dedicated people).
[212] Sustainable Society, *supra* note 205, at 25.
[213] Lindsey F. Wiley, *Health Law as Social Justice*, 24 Cornell J. L. & Pub. Pol'y 47, 89 (Fall 2014) ("Putting access to health care in its place as one among many social determinants of health runs counter to decades of health law reform, activism, and scholarship.").
[214] Sustainable Society, *supra* note 205, at 31 ("Sustainable development transforms the decision-making process because it incorporates the environment into the decision-making process instead of treating it as an afterthought or an issue where damage is tolerable as long as it does not arouse significant opposition.").
[215] Furrow, *supra* note 184, at 17.
[216] *Id.* (citing ABA Model Rule 1.6(b)).
[217] *Id.*

This fiduciary concept can apply to lawyers who engineer corporate investments in health care with no consideration of the impact the for-profit enterprise may have on patients and families. This concept could also apply more broadly to any corporate venture in health care wherein the voices and needs of important stakeholders are being drowned out by powerful corporate owners. At a minimum, health lawyers should consider how the corporate deals they arrange may cause serious harm to patients, those who help patients pay for care, and those who provide care. Unfortunately, many health lawyers who work in large corporate law firms do not consider as part of their client duties consideration of third-party harm. Instead, the private practice of law has "become big business rather than a 'noble profession.'"[218] Private equity investment in health care brings large sums of money to corporate law firms, and lawyers justify their work for these clients, and disregard any third-party harms, in the name of market innovation and efficiency.[219] Ideally, corporate health lawyers should aim to minimize patient harms while still creating value for their corporate clients. But this may be a challenge for in-house and outside health lawyers. As noted earlier, in-house lawyers are absorbed by their client's business, and their legal expertise and insight about that business' strategy is what makes them valuable. In-house lawyers depend on outside lawyers to get to a "yes" on strategy, which promotes the legal engineering disapproved by some in the health law field.[220]

If these lawyers do not create value for those who pay them, they risk losing their job or client. This should not be read at all to diminish the importance of educating health lawyers about the impact of legal engineering on third parties, but it is not practical to expect them to be dedicated advocates for the third parties being most harmed by health care corporatization. Instead, a new kind of health lawyer needs to surface to take on that role.

### 3. Health Justice

A third legal practice framework that can be helpful to the WLP lawyer is the health justice framework, which has been described as a "distinct alternative to the 'patient rights' and 'market competition' paradigms that currently dominate health law scholarship, advocacy, and reform." [221] These paradigms focus primarily on improving health care access through a patient rights or market competition approach and view access usually in the most narrow sense (i.e., being able to access health care providers and facilities).[222] Health justice derives from the social justice framework which emphasizes collective problems and collective problem-solving.[223] Applying the social justice framework to the practice of health law leads to looking further upstream at the social and structural influences on

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[218] *Id.* at 4.
[219] *Id.*
[220] Id. at 17 (noting that in the mindset of a legal engineer, law or regulation is a not a legitimate and authoritative command to be taken at face value, respected and obeyed but rather a nuisance, an obstacle to be overcome, and a material to be worked with and reshaped to one's advantage).
[221] Wiley, *supra* note 213, at 51.
[222] *Id*. at 91.
[223] *Id.*

health and wellbeing."[224] The practice of health justice incorporates the law of health care financing and delivery, public health, as well as interventions that address social and structural determinants of health and wellbeing, such as socioeconomic status, race and ethnicity, disability, gender expression, and geographic location.[225]

Rather than a "blame the victim" approach to disease and disadvantage, or a laser focus on patient rights in the health care financing and delivery system, the social justice framework offers an ecological approach to individual health behavior and status. It places health and wellbeing into a social context, emphasizing structural explanations for health behaviors and outcomes.[226] It allows for exploration of class, racial, and other forms of bias as well as legal and structural barriers beyond those in health care that contribute to poor health and wellbeing.[227]

Social justice interventions require a different way of lawyering. First, lawyers must probe proposed laws and policies for evidence of social, cultural and structural bias.[228] Second, lawyers need to approach solutions to complex problems through community engagement and empowerment.[229] Social justice lawyering is democratic, participatory, and collaborative.[230]

### 4. Tying together the systems leadership, lawyer fiduciary duty, and health justice frameworks

The common thread connecting these three frameworks is an obligation for lawyers to look beyond their client relationship and consider the broader consequences of their own and their client's actions. Whether that obligation is defined in terms of systems leadership, a fiduciary duty, or health justice objectives, they each envision a lawyer who sees the bigger purpose of health care and not just the immediate legal issue at hand. This lawyer, the "WLP lawyer," has as their core mission to improve overall wellbeing of all patients and to do that, they must look beyond the health care system to other social and structural contributors to health. Looking beyond the health care system demands collaboration with other actors to improve overall individual wellbeing. WLP lawyers are comfortable with not being seen as the heroic, independent figure.[231] WLP lawyers also recognize the unique

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[224] *Id*. at 52.
[225] *Id*. at 51, 88.
[226] *Id*. at 97-98
[227] *Id*. at 94 (advocating for health justice scholarship to push for expansive and rigorous examination of the causal pathways by which social disadvantage translates to poor health and the role of law and policy (and not merely health law and policy) in reinforcing or disrupting those pathways). "Rhetoric that frames health disparities in terms of personal responsibility for unhealthy behavior choices also implicates class, racial, and other forms of bias and structural disadvantage." *Id.* at 98.
[228] *Id*. at 100.
[229] *Id*. at 101.
[230] *Id*.
[231] Trubek, *supra* note 164, at 600 ("Implicit in the new model is a loss of the vision of the lawyer as a heroic, independent figure.").

opportunity that health care corporatization creates by aligning the interests of health care purchaser and physician stakeholders, of whom many are looking to improve patient wellbeing through high value, holistic care. Ready to seize on this opportunity to help deliver more affordable, high value and holistic care, WLP lawyers seek to create WLPs with health care purchaser and physician stakeholders to drive change.

## III. Mapping out the WLP Model

The systems leadership, lawyer fiduciary duty, and health justice frameworks provide an outline for the WLP mission, which should be primarily to improve health plan beneficiary wellbeing. In the health care context, the MLP serves as an excellent example of applying these frameworks.[232]

### A. Borrowing from the MLP Model

Lawyers who work in MLPs already recognize that medical care is responsible for only a fraction of overall health and wellbeing and that collaboration is necessary.[233] MLPs employ a three-fold approach to improve patient wellbeing through direct legal representation, institutional policy change, and systemic policy change. To be successful at systemic policy change, lawyers must know how to collaborate with others and learn from them.[234] MLP lawyers can leverage data and expertise they acquire through their work with the partnership to add value to community stakeholders when advocating for change.

However, MLPs as currently structured are not equipped to address health care purchaser and physician harms from health care corporatization. Because of MLP roots in poverty law, the core of MLP work is to help underserved, marginalized, impoverished communities, and not necessarily patients with group health insurance or entities that fund such insurance.[235] Yet, because about 153 million people in the United States obtain health insurance through their employer, a wide swath of patient interests are unaddressed.[236] Corporatization of health care is increasing the need for group health plan patient advocacy and the stakeholders who share similar frustration with corporatization. Advocacy for these patients can benefit not only group health plan patients, but any patient who is disadvantaged because of corporate profit-making priorities in health care.

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[232] Alicia Turlington, Jonathan Young, and Dina Shek, *Quantifying "Community Power" and "Racial Justice" in the Medical-Legal Partnership Literature*, 51 J. L. Med. & Ethics 748, 749 (Winter 2023) (stating that "[m]uch of the foundational health justice scholarship has grown out of the work of many MLP scholars and practitioners.").

[233] Trubek, Zabawa and Galowitz, *supra* note 175, at 206 ("Medical care is only responsible for approximately 10 to 15 percent of what determines health…physicians cannot do it all by themselves. The need to work collaboratively with other professionals to address the root causes of disease.").

[234] Turlington, Young, and Shek, *supra* note 232, at 749.

[235] The author acknowledges that MLPs may occasionally assist patients who have group health plan coverage, but that is not the defining factor or characteristic of the assistance.

[236] Kaiser Family Foundation, *2023 Employer Health Benefits Survey, Section 3: Employee Coverage, Eligibility, and Participation* (Oct. 18, 2023) (hereinafter "KFF Report").

Extrapolating the MLP concept to the group health plan market is one way to for the new health lawyer to practice and incorporate systems leadership, fulfill fiduciary duty to patients and employ social justice concepts of collaboration to achieve greater patient wellbeing. To avoid neutralizing the importance and necessity of MLPs, I propose that WLPs hitch on to current employer efforts to improve employee wellbeing through workplace wellness programs and employee health benefits. WLPs could help ensure that both workplace wellness programs and the group health plan offer more comprehensive, holistic services that go beyond personal responsibility and address social and structural determinants of health.

Although employee wellness programs have not brought the return on investment results employers initially hoped for,[237] most employers still invest in them.[238] For example, in 2023, 39% of small firms and 61% of large firms offered programs to help workers lose weight, and 46% of small firms and 68% of large firms offered some other lifestyle or behavioral coaching program.[239] Overall, 62% of small firms and 80% of large firms offered at least one wellness program activity, such as a smoking cessation, losing weight or lifestyle/behavioral coaching.[240]In 2021, large employers budgeted on average $238 per employee for wellbeing programs.[241] A 2024 survey of human resource professionals found 48 percent of respondents stating that wellness benefits are "very important" or "extremely important" and offering health-related benefits was rated "very important" or "extremely important" by 88 percent of the respondents.[242] Another employer survey found that employers are concerned about health plan affordability and health inequities.[243]

Implementing WLPs in the workplace could address many employer concerns about employee wellbeing. And for at least some employers, employee wellbeing is a genuine

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[237] *See e.g.,* Al Lewis, *The Outcomes, Economics and Ethics of the Workplace Wellness Industry*, 27 Health Matrix, 1, 11-13 (2017) (noting that research involving corporate wellness program do not confirm or show negative returns on investment).

[238] KFF Report, *supra* note 236, at *Section 12: Health Screening and Health Promotion and Wellness Programs and Disease Management*.

[239] *Id*. (defining "small firms" as those with 3-199 workers and "large firms" as those with 200 or more workers).

[240] *Id*.

[241] Kathryn Mayer, *How much are Employers Investing in Wellness Programs?,* Human Resource Executive (June 10, 2021), https://hrexecutive.com/how-much-are-employers-investing-in-wellness-programs/ (last visited June 25, 2024).

[242] Society of Human Resource Management, 2024 Employee Benefits Survey, https://www.shrm.org/topics-tools/research/employee-benefits-survey#accordion-27d9ec37e7-item-9017a1dd02 (last visited June 25, 2024).

[243] Business Group on Health, *2024 Large Employer Health Care Strategy Survey, Executive Summary*, at 9, 12, https://www.businessgrouphealth.org/resources/2024-large-employer-health-care-strategy-survey-executive-summary (last visited July 3, 2024) (stating that employers are focusing on outcomes improvement, lowering the total cost of care, reduction in unnecessary services and prioritization of prevention and primary care and that 95% of surveyed employers will implement at least one strategy to address health inequities by 2024).

concern.[244] Like their MLP counterparts, WLPs could adopt a three-fold approach to advocacy: 1) direct plan beneficiary representation; 2) organizational policy change; and 3) systemic policy change. The first prong, direct plan beneficiary representation, could provide more holistic attention to employee wellbeing needs. Like MLPs, WLP lawyers could improve employee social determinants of health. Instead of implementing employee wellness programs that focus exclusively on lifestyle and behavior change, WLPs could help employees address health harming situations involving housing, domestic violence, access to benefits and other social and structural barriers to better wellbeing. Workplace wellness programs are not yet paying attention to these social determinants of health.[245] In fact, some scholars believe that workplace wellness programs are just a legal mechanism to covertly collect data on participants and shift health plan costs onto employees.[246] Usually, it is the most vulnerable employees that pay higher costs for health coverage because they fail to participate in the wellness program or "pass" the wellness program metrics.[247]

WLPs could help change institutional policy, the second prong of the three-fold approach, by offering insight into what internal policies and practices contribute to poor employee wellbeing. They could also hold employers accountable to their fiduciary obligation to operate employee benefit plans in the sole interest of plan beneficiaries and to ensure that

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[244] Anya E. R. Prince, *Hidden Trade-Offs in Insurance Wellness Programs*, 2021 Mich. St. L. Rev., 341, 364-65 (2021) (noting that some employers invest in wellness programs because those programs may save on health care plan expenditures (healthier employees equals fewer hospitalizations) and some employers want to establish a culture of health and wellbeing where employees feel valued and important, translating into greater worker loyalty and productivity).

[245] *Id.* at 345 ("Wellness programs are designed to incentivize individuals to take personal responsibility for their health behaviors, but they do little to address the underlying social determinants of health that may have led to those unhealthy behaviors, making lasting and meaningful improvement across the board difficult.").

[246] *Id*. at 346; *see also* Lewis, *supra* note 237, at 27 (noting that workplace wellness programs allow employers to take money from employees who refuse to submit to wellness or cannot lose sufficient weight in the form of forfeitures and that such programs disproportionately harm employees from lower socioeconomoic backgrounds).

[247] Anya E. R. Prince, *supra* note 239, at 408-09. I dive into this unjust outcome of many workplace wellness programs in my Wellness Bias Article. Specifically, I focus on the first and second prongs of the three-fold approach to WLPs – individual employee assistance and organizational change – to combat racial and ableist bias in workplace wellness programs. I show that racial and ableist bias is rampant in current workplace wellness programs, particularly with the use of racially biased measures like Body-Mass Index (BMI), lifestyle and behavior focus, stereotypical body images and cultural appropriation of popular wellness activities like yoga and meditation. This embedded bias in much of workplace wellness programming ignores the social and structural drivers of wellbeing and I argue that the first and second prongs of the WLP three-fold approach can begin to correct that. In this article, I contend that the utility of WLPs to address workplace wellness program still holds true but expand the model to also address health care corporatization by leaning heavily into the third prong of the three-fold WLP approach. Thus, WLPs offer a much-needed shift in workplace wellness programming from a focus on individual behavior change to a view of wellness that includes addressing social and structural drivers of wellbeing. See generally, Wellness Bias Article, *supra* note 1.

the wellness programs actually improve employee wellbeing with the data they collect.[248] WLPs could help employers use the data to help drive change in the organization, improve working conditions, and design wellness programs that improve patient health outcomes. Finally, WLP lawyers could apply their system leadership and social justice skills by collaborating with health care stakeholders, such as employer, physician and patient groups, to advocate for systemic policy change, the third prong of the WLP model.

It is through this third prong of the WLP model that WLPs could have the greatest influence on curbing the adverse impact of corporatization of health care. WLP lawyers could lead efforts to advocate for state laws such as stronger corporate practice of medicine laws, such as those passed in Minnesota and Oregon,[249] that will make corporatization of health care more difficult and facilitate alternatives to corporatized health care.[250] It is beyond the scope of this article to identify all the legal changes for which WLPs could advocate, and Professors Erin Fuse Brown and Mark Hall have already created such a roadmap that WLPs could follow with regard to curbing health care corporatization.[251]

As for facilitating alternatives to corporate models of health care delivery, WLPs could advocate for legal environments that make direct contracting between employers and physicians more feasible and accessible. "Direct Primary Care" (DPC) or "Direct Contracting" between employers and physicians are examples of existing and growing collaborative concepts into which WLPs could plug to advance patient wellbeing. Direct contracting involves a contract for health care services between a provider organization (such as a physician clinic) and an employer or group of employers.[252] DPC is a subset of direct contracting, involving a contract between a primary care provider and an employer or patient.[253] Importantly, direct contracting removes third party insurance; instead, the provider group charges subscribers a "per member per month" (PMPM) fee, ranging from

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[248] Prince, *supra* note 247, at 345 (noting that wellness programs have the potential to collect copious amounts of data and shift costs to policyholders under the guise of health promotion and personal responsibility without a guarantee that they will actually improve health).
[249] See *supra*, note 31.
[250] Fuse Brown and Hall, *supra* note 18, at 39 (noting that corporate practice or medicine laws are still on the books in most states and that the doctrine can be revived and redeployed to address commercialization convers over private equity investment in health care).
[251] *Id.* at 52-62 (identifying laws relating to greater transparency of corporate ownership, stronger fee splitting laws, altering Medicare Part B payment loopholes, tax reform efforts, and sharpening antitrust enforcement tools).
[252] Alison M. Howard, *Back to the Future: Provider-Employer Alliance Direct Contracting for Health Benefits*, 30 Health Lawyer 1, 3 (April 2018).
[253] Jessie Gibbons, *Direct Primary Care: State Approaches to Regulating Subscription-Based Medicine*, Wisconsin Legislative Reference Bureau, at 1 (January 2020) https://docs.legis.wisconsin.gov/misc/lrb/wisconsin_policy_project/direct_primary_care_3_2.pdf (last visited July 3, 2024) ("Direct Primary Care (DPC) is a health care payment model in which physicians contract directly with patients to provide care outside the traditional insurance-based system.").

$25 to $125, in exchange for access to unlimited primary care services at no additional cost.[254]

Interest in direct contracting models between health care purchasers and physicians is growing because of the rising costs of health care driven by corporatization.[255] By removing the insurance intermediary, employers have more direct knowledge and control of the costs and quality of the health benefits provided and physicians have more autonomy in how they practice medicine.[256] For example, the Self Fund Health Plan in Wisconsin is a DPC product offering employers lower cost, personalized and comprehensive primary care benefits to employees.[257] Currently, employers who choose to adopt the Self Fund Health Plan have more than 86 DPC practices in Wisconsin from which to choose.[258] One of those DPC clinics stated that in addition to offering primary care services to employer groups, DPC is replacing corporate wellness programs.[259] That is, rather than having a separate budget for corporate wellness, this DPC clinic owner envisions employers adopting DPC as a way to provide employees both primary care and wellness services.[260]

If direct contracting is to expand, employer and physician groups need to advocate for state laws that will facilitate, or at least not inhibit, these arrangements. One type of state law these groups could address is exempting DPC arrangements from state insurance regulation. Unless state insurance law specifically excludes DPC from insurance

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[254] *Id*; *see also* Howard, *supra* note 252 at 3 (stating that other modes of financial risk in direct contracting arrangements include fee-for-services with a substantial withhold, a percentage of premium paid, or bonuses/ penalties associated with meeting cost/utilization goals).

[255] Todd Shryock, *High Cost of Health Care may be Boosting Direct Primary Care Membership*, Medical Economics (April 28, 2022). It is important to note that a direct contracting movement also occurred in the 1990s in response to managed care. Howard, *supra* note 247, at 1. However, many of these direct contracting between employer and providers failed because they could not compete with insurers, achieve economies of scale and the values of employers and providers were not aligned around reimbursement and utilization rates. *Id.* at 3. As acknowledged by Alison Howard, times have changed with the corporate takeover of health care, employer and physician groups may be more aligned to make direct contracting more viable. *Id.* at 3 ("The [Provider Sponsored Organization] of today is not much different from its younger nineties self, but the environs may be more welcoming."). Furthermore, in April 2018, the Centers for Medicare and Medicaid Services (CMS) requested information from the public on adopting a direct provider contracting model for Medicare and Medicaid. *See* CMS website, https://www.cms.gov/priorities/innovation/innovation-models/direct-provider-contracting. Comments received in response to the request were unretrievable.

[256] Howard, *supra* note 247, at 4 (stating that direct contracting purports to give employers more control over the way in which they spend health care dollars, improve access to high-quality care at affordable and more transparent cost, increase provider accountability through provider risk-bearing, and encourage competition and choice in the health care market); *see also* Gibbons, *supra* note 248, at 3 (stating that direct primary care can reduce administrative burden for physicians and allows them more time to spend with patients, noting that one study of a large DPC model found patients spend an average of 35 minutes per visit with DPC providers and an average of eight minutes in more traditional practices).

[257] *See* Self Fund Health Plan, at https://selffundhealth.com/plan (last visited June 29, 2024).

[258] *Id*.

[259] Telephone Interview between Barbara J. Zabawa and Dr. Brian Woodbridge, owner of Customized Health Care Services, LLC (June 28, 2024).

[260] Id.

regulation, which is administratively burdensome and expensive, DPC models risk being treated as insurance products under state law because of the capitated payment arrangement and the risk the provider assumes in agreeing to treat patients for a set PMPM fee.[261] As of 2020, 32 states have passed laws allowing DPC to be exempt from state insurance regulation.[262] That means in eighteen other states it is at the very least unclear whether DPC arrangements can operate legally unless the DPC provider is licensed as an insurer in that state. WLPs could advocate for such legal clarity in those states.[263]

Another law for which WLPs could advocate to benefit health care purchasers and physicians is allowing employees to enroll in DPC models while also benefiting from Health Savings Accounts (HSAs). Currently, the IRS views individuals who have access to DPC arrangements that offer an array of primary care services such as physical exams, vaccinations, urgent care, laboratory testing, and diagnosis and treatment of sickness and injuries to be ineligible to contribute to an HSA.[264] Allowing employees to maintain HSA eligibility while enrolled in a DPC program will improve health care affordability for health care purchasers.

WLPs could also help advocate for laws and policies that reduce the administrative burden on group health plan DPC models, such as premium collection, claim payment, fraud investigation, case management, cost containment, continuation coverage, protection of personal information, physician credentialing, quality reporting, and nondiscrimination in benefits, to name a few.[265] Lower administrative burdens will help make private equity buyouts of physician practices less desirable to physicians.

In sum, there are a multitude of laws and policies in which the interests of health care purchaser and physicians are aligned and for which WLPs could advocate on the organizational and systemic levels. For WLPs to work optimally, WLP lawyers who form them need to find the right partner.

### B. Potential WLP Partner Candidates

There are four possible entities with whom WLP lawyers can partner: 1) Employee Assistance Programs (EAPs); 2) business coalitions; 3) wellness vendors; or 4) DPC arrangements. Some of these entities may be better than others, depending on the circumstances.

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[261] Howard, *supra* note 252, at 6 (noting that one commenter indicates most direct contracting arrangements are currently illegal, at least under some states' law).
[262] *See* Direct Primary Care Coalition Fact Sheet, State Policy, https://www.dpcare.org/state-level-progress-and-issues (last visited June 29, 2024).
[263] In fact, one state prohibits DPC arrangements between providers and employers. In Idaho, DPC arrangements are allowed only between providers and individual patients. *See* Idaho Statute § 39-9208.
[264] *See e.g.,* 85 Fed. Reg. 35398, 35402 (June 10, 2020).
[265] Howard, *supra* note 252, at 4.

### 1. Employer EAPs

A large majority of workers in the United States have access to an EAP, which provides a wide range of services, including legal services.[266] Thus, the legal partner to the WLP could offer legal services through an employer's EAP offering. To the extent an employer already offers legal services through its EAP, this reimagined use of EAP legal services would be in coordination with the employer's workplace wellness initiative. The legal partner would help employees facing employment or societal discrimination, or issues with housing, immigration, or family, as examples. The WLP lawyer would also advocate for organizational and broader systemic change. This advocacy role would aim to improve employee wellbeing and access to more valuable health services through community stakeholder collaborations, similar to CHCP.

Initially, lawyers forming these WLPs may need to target Certified B Corporations, who are already committed to advancing social and environmental issues.[267]Certified B Corporations recognize the plurality of business purposes, which is not just to make profits, but also to promote fundamental values such as "individual freedom, autonomy, responsibility, dignity, loyalty and equality."[268] This plurality approach to business is not necessarily isolated to Certified B Corporations, but should be applied to all business particularly in the wake of the climate crisis.[269]The business community needs to be reminded of its greater role in society rather than just maximizing profits. Businesses have the power and authority to devote a reasonable amount of resources to public welfare, humanitarian, educational, and philanthropic purposes.[270] WLPs that partner with an EAP could help businesses fulfill that duty.

### 2. Business Coalitions

Another partner that could also fulfill employers' duty to help the broader community through WLPs are business coalitions. There are numerous business associations and groups throughout the United States. For example, the National Alliance of Healthcare Purchaser Coalitions has as members 44 smaller, usually state-based healthcare purchaser coalitions.[271] Each of these smaller coalitions consist of employers from the private and public sector who wish to drive health, equity, and value in the marketplace.[272] Promoting a WLP offering to business coalitions may allow smaller employers who are

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[266] Zabawa, supra note 1, at 32.
[267] *Id*. at 33.
[268] Eric W. Orts, *Toward a Theory of Plural Business Purposes*, J. of Corporate L. Studies, at 78-79 (forthcoming 2024) available on SSRN at https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4686182 (last visited July 3, 2024).
[269] *Id*. at 79.
[270] *Id*. at 21 (citing the American Law Institute Principles of Corporate Governance).
[271] National Alliance of Healthcare Purchaser Coalition website, Business Coalitions, https://www.nationalalliancehealth.org/who-we-are/business-coalitions/ (last visited June 30, 2024).
[272] *Id*.

members of these coalitions and who do not have the resources to improve employee wellbeing to take advantage of WLP services. The bonus of offering a WLP by a business coalition is that there is already a built-in collaborative group of health care purchasers. The WLP could leverage those coalitions' impact in systemic change by expanding the collaborations to include physician and consumer groups.

### 3. Wellness Vendors

Another candidate with whom the new health lawyer can partner to form a WLP is wellness vendors. Wellness vendors are businesses that provide wellness services to employee wellness programs.[273] Currently, these vendors look at wellness through a very narrow lens of personal responsibility.[274] They do not consider the social or structural drivers of employee wellbeing.[275] Convincing these vendors to incorporate WLPs into their service offering to employers will give wellness providers an opportunity to broaden their scope and view of what it means for employees to be well. Rather than just offering behavior change activities, wellness vendors could assist employees with SDOH. Expanding wellness to include SDOH acknowledges that not everyone can engage in healthier behaviors and that institutional, structural and social bias plays an important role in employee wellbeing.[276]

Although wellness vendors may embrace the direct employee assistance prong of the three-fold WLP approach, those vendors may not have a vested interest in organizational or systemic change prongs, particularly when compared to working with the employer groups directly. Wellness vendors may not be willing to expand their scope of delivering wellness services to include advocating for laws and policies that aim to weaken the corporatization of health care. These vendors may view advocating for organizational or societal change and holding employer health plans and physicians accountable to their fiduciary duties as too much of a business risk if the employer client paying for the wellness services is not supportive of the idea. Only a very unconventional wellness vendor and plural purpose business client may embrace the three-fold approach of WLPs and make organizational and systemic advocacy part of the WLP services.

### 4. Direct Primary Care Arrangements

A fourth candidate for a WLP partner is the medical provider in a DPC arrangement. This avenue most closely resembles the MLP model, in that the partnership is with the medical/wellness provider. Partnering with DPC providers may be the most forward-thinking of the options, particularly if more DPC providers begin replacing more conventional wellness service providers. Because DPC providers may have experience with

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[273] Zabawa, *supra* note 1, at 24 (noting that employers often contract with wellness vendors to provide or lead wellness programs and activities such as diet, exercise, or stress relief programs).
[274] *Id*.
[275] *Id*.
[276] *Id*.

MLPs delivering more comprehensive and holistic medical care, they are more likely to understand and appreciate the need to address employee SDOH in the workplace wellness context. MLPs also give DPC-based WLPs the most closely aligned funding models. Most MLPs are funded in part by the medical provider partner, such as through in kind support of space and staff time or as a line item in the health care organization's operating budget.[277] One could envision funding for WLPs that partner with DPC providers deriving from the PMPM fee paid by employers.[278] That is, DPC providers could build into the PMPM charged to the employer clients the cost of operating a WLP as another benefit to employees who use the DPC model.[279] In this way, DPC could address the SDOH of employees and thereby offer more holistic primary care services to the beneficiaries of the employer's DPC plan. Because of the alignment of interests of physicians, who staff DPC arrangements, and the employer clients of the DPC provider in the wake of health care corporatization, DPC partners are more likely to see the value in the three-fold approach to WLP services.

### C. WLP Ethical Considerations and Solutions

With any of these WLP candidates, lawyers will need to navigate the rules of professional conduct. Model Rule of Professional Conduct 5.4 requires lawyers to maintain their professional independence when delivering legal services.[280] To preserve their independence under Model Rule 5.4, WLP lawyers should work within a law firm, either their own firm or as part of a larger firm. WLP lawyers will need to ensure that any contractual agreement between the lawyer and WLP partner allows the lawyer to maintain their professional judgment and independence, ensure client confidentiality and the need for client consent when sharing information within the WLP, and how to handle client conflicts of interest.[281] WLP lawyers must be very transparent with the stakeholders for whom they advocate through the three-fold approach so that they understand when and how information will be shared.[282]

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[277] Trott, Peterson and Regenstein, *supra* note 197, at 3 (stating that virtually all health care organizations with an MLP devote some amount of resources to the partnership).

[278] *Id.* at 5 (highlighting innovative Medicaid financing models where the Medicaid managed care contract or other value-based payment arrangement or innovative delivery system reform model integrate legal services into the contracts).

[279] The best evidence to support that funding WLPs is possible is the fact that employers continue to pay for workplace wellness programs even after mounds of evidence shows they do not work. There are likely some pioneering health care purchaser or physician stakeholders who would be willing to try WLPs as an alternative to exclusively behavior-focused wellness programs and a way to address health care corporatization harms. *See supra*, notes 237-243.

[280] Model Rules of Professional Conduct R. 5.4 (2024).

[281] Stacy L. Brustin, *Legal Services Provision through Multidisciplinary Practice – Encouraging Holistic Advocacy while Protecting Ethical Interests*, 73 U. Colo. L. Rev. 787, 838 (Summer 2002) (stating that lawyers practicing in multidisciplinary practices must agree on the types of information that will be kept strictly confidential and take steps to ensure that this information will not be shared with nonlawyer staff members without the client's consent).

[282] *Id.* at 841.

WLP lawyers must also prepare in advance through WLP agreements how to address potential client conflicts of interest. Model Rule 1.7 generally prohibits lawyers from representing clients if the representation involves a concurrent conflict interest.[283] However, the Model Rules permit lawyers to continue representing a client even when a concurrent conflict exists as long as: 1) the lawyer reasonably believes they will be able to provide competent and diligent representation to each affected client; 2) the representation is not prohibited by law; 3) the representation does not involve the assertion of a claim by one client against another represented by the lawyer in the same litigation or other proceeding before a tribunal; and 4) each affected client gives informed consent in writing.[284]

WLPs may encounter conflicts when attempting to address the first and second prongs of the three-fold approach, for example when an individual employee encounters an organizational barrier to their wellbeing, such as employment discrimination, and the WLP lawyer attempts to address that discrimination through organizational change. The WLP lawyer may find themselves discussing an employee's accusations of workplace discrimination with the same decisionmakers who approved the WLP in the first place. In those situations, the lawyer may feel conflicted about who the client is and will need to decide if the conflict will impede the lawyer's ability to stay true to the overall objective of the WLP, which is to improve employee wellbeing. This type of conflict could also arise in an MLP where the health care provider funds the lawyer's services but is the cause of the patient's barriers to care. Using Model Rule 1.7(b) as a guide, WLP lawyers should be able to navigate those conflicts of interest and refer clients to other legal representatives if necessary. At a minimum, employers and employees who assent to WLP services should be informed at the outset of the relationship of potential conflicts and if amenable, consent in writing to allow the WLP to try to resolve the organizational barrier for the purpose of improving employee wellbeing. Improving employee wellbeing is, after all, the goal of the WLP lawyer, which can make for a very personally and professionally satisfying legal career.

**Conclusion**

Health care corporatization is quickly dominating the health care marketplace, leaving health care purchasers and physicians at a disadvantage. Health care corporatization has aligned the interests of these stakeholders, and this alignment creates a window of opportunity to leverage that alignment by creating WLPs to help them. As highlighted throughout this article, lawyers bring a valuable skill and perspective to efforts working to improve patient wellbeing. It will be up to these WLP lawyers to adopt concepts of fiduciary duty, systems leadership and health justice to effectively lead collaborations that will combat health care corporatization and improve patient wellbeing.

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[283] Model Rules of Professional Conduct R. 1.7(a) (2024).
[284] Model Rules of Professional Conduct R. 1.7(b) (2024).