Private equity and the ravaging of U.S. health care

James R. Webster MD, MS, MACP

Dr. Webster (ΑΩΑ, Northwestern University Feinberg School of Medicine 1973, Faculty) is retired Gertz Professor of Medicine at Northwstern School of Medicine, Chicago, IL.

In 1914, William Osler advised graduating medical students that they were joining a calling involving their head and heart, not a business. He, like some contemporary American physicians, such as the leadership of the American College of Physicians[1] would probably be appalled that in 2023 private equity (PE) firms are involved in completing the "financialization" of health care.[2,3] Their goal is to maximize profits by manipulating the fiscal opportunities in the management of business dealings surrounding care without providing any actual care for patients. Rather than being a social good, health care becomes a series of market driven financial transactions.

This trend began 50 years ago with the onset of national for-profit hospitals led by Health Corporation of America (HCA) and Tenet Healthcare. In the past decade, PE investors Kohlberg, Kravis and Roberts (KKR), Bain Capital (a major supporter and investor in HCA), The Blackstone and Carlyle Groups, and 136 others have become major players in health care financing.[2] As such they bring with them access to huge financial resources, arcane financial engineering strategies that benefit only their bottom line and some of the sharpest elbows in capitalism. Their strategic interventions are theoretically promoted to magically improve efficiency and reduce costs.

However, whether acquiring hospitals,[4] physician practices,[5,6] nursing homes,[7] mental health entities,[8] home care services, hospices,[9,10] or ambulance services[11] the effects are the same. Under their stewardship, costs routinely increase,[12-15] while quality and quantity of care decreases. The idea that introducing into the health care equation, a strictly for-profit middleman that promises its investors a 20 percent annual return as its primary goal would improve care is *prima fascia* unrealistic.

The strategies and tactics used by PE are basically the same no matter which of the above care delivery sites or disciplines they touch. These include but are not limited to; cutting costs by reducing staffing positions; hiring less skilled and less costly providers, e.g., physician assistants replacing MDs, nursing aids replacing nurses, totally untrained individuals replacing aids, etc.;[7] and mandating fewer home health or hospice visits.[8-10]

Diagnostic and therapeutic options are limited by denying them at the front end of care. Lucrative leaseback

arrangements are common, as PE sells real estate holdings and equipment of the entity they have acquired, pockets the money, resulting in the hospitals, group practices, nursing homes left paying rent on what they used to own.[15]

Using their financial backing large debts are loaded by PE onto the hospitals, nursing homes, and other clients. These funds are then short-circuited to the PE owners.[1,3] Meanwhile the PE group also charge and pay themselves hefty consulting fees while undertaking dividend recapitalizations.

Once a PE hospital, nursing home, or home care chain can establish local market monopoly power, prices can easily be increased. Profitable procedures can be referred to affiliated hospitals, and underperforming units such as Medicaid, obstetrical, and mental health units can be closed. For-profit hospices (once considered an oxymoron) can be further gamed; cherry-picking less ill patients who will live longer than the usual several weeks of intensive end of life care thus prolonging collection of the daily stipend. They can also use Medicare Part D to pay for expensive medications, and convince families to take the patient to the hospital emergency room if they get too sick for home care.[10]

Studies show how vulnerable nursing home patients experience double jeopardies in PE-owned facilities.[7] Excess mortality, decreased mobility and overall quality of life occur at the same time staff and care are being cut. Costs are being shifted to cover fees, interest, and lease payments as charges per episode of care are significantly increased.[7]

To allow all this to occur, government has, over the years, loosened anti-trust regulations, deregulated the financial industry and reduced oversight.[2,12,16] Much of the money that PE captures comes from government programs, with taxpayers being the ultimate source of such funding.[2] Most of the above PE targets for mergers and acquisitions fall below the $200 million mark so they avoid federal anti-trust attention.[2]

From a strictly investment standpoint all these strategic and tactical activities are financial genius, with devastating results for families and providers. Health care is reduced to a complex, endless pirouette of financial transactions.

Financial engineering

PE financial engineering was promoted as the cure for cost containment through proven business tactics.[12] What were the alleged benefits for partner hospitals, doctors, and nursing homes who collaborated? In truth, there often are some improvements in back office billing procedures, but the efficiencies primarily come at the sharp end of care.[14-17] Profitable specialty practices, especially radiology, dermatology, anesthesiology, ophthalmology, emergency medicine, urology, gastroenterology, and orthopedics, were bought early in the organizational process using leveraged buyouts.[5] They then were made more procedurally efficient with higher fees, staff reductions, and emphasis on physician productivity as the PE group manages the business aspects. Physicians often find that they are no longer in charge and have made a Faustian bargain causing patients harm on a routine basis.[3,4,12]

When feasible, such specialty practices are consolidated into national "Physician Practice Management" organizations, owned by the PE groups such as Oak Street Health and Agilon Health.[6] This fragments care and raises costs at a time when more support of local systems of care is needed, particularly in non-urban settings. It is estimated that up to 35 percent of all physicians in the United States are now employees of PE sponsored management firms[18] such as KKR (Envision Physician Services), and The Blackstone Group (Team Health).

Through all these complicated, hidden dealings, the promised profits of 20 percent annually for the PE groups and funding partners are maintained.[14,15] Favorable exits for all the health pieces of the PE investments are a buy-to-sell strategy negotiated as part of the original plan, often selling to other PE groups. Usually this occurs at five years to six years.[1,14,15]

Complex contracts

An example of the effect of PE is the collapse of Steward Healthcare, owned by Cereberus Capital Management, based in Dallas, TX. They ran 31 hospitals in eight states and filed for Chapter 11 in May 2023,[19] admitting that they were out of operating funds for their hospitals. Attempts to sell their facilities and physician groups were unsuccessful[20] when the potential buyers, primarily other PE entities, found that all the assets were involved in complex buy-back/lease contracts. These are financial transactions where tangible assets are sold to a new owner who then leases them back to the seller who ends up paying rent on what they used to own.

In 2016, Steward had sold these assets to Medical Property Trust, which Cereberus also owns, for $1.75 billion, generating more than $100,000 in profits for Cereberus. As of August 2024, the final outcome of these machinations is unclear.

What if...

An issue of particular interest to physicians should be what happens to PE employees if their owner folds and declares bankruptcy? Not a theoretical question.

The two biggest PE physician employers, who cover a large portion of employed physicians—Envision Health Care (KKR) with $7.7 billion in debt, and Team Health (Blackstone) with $5 billion in debt—have recently filed for bankruptcy relief. American Physician Partners (APP, owned by Brown Brothers, Harriman) which provided emergency room staffing for 150 U.S. hospitals had $472 million in debt, but could not find a buyer and went out of business as of August 1, 2023.[19] This left 2,500 physicians and numerous nurses and technicians without several months of back pay and even worse, no malpractice tail coverage.[21]

The two largest physician staffing groups, which cover 40 percent of employed U.S. physicians,[18] are in serious financial difficulties. Envision, previously owned by KKR and now in the hands of creditors, with debt of $7.7 billion filed, and was approved for, Chapter 11 bankruptcy in 2023.[21]

In addition, Health Partners, property of Blackstone with greater than $5 billion in debt, is trying various solutions to avoid bankruptcy.[22]

Leaders in medicine are aware of these very disturbing, threatening trends,[1] and the fact that PE involvement in medicine is growing each year. However, they lack significant financial enforcement capabilities, or the legislative power, to institute needed changes. The logical remedy for this health care disaster seems to require government involvement to bring full transparency and oversight, with a major goal of turning off the PE money sources. These include, but are not limited to:

- Support by physician organizations of new federal laws to prevent the predatory, unethical, and often legally questionable financial engineering strategies and attempts to develop local provider monopolies.
- Legislation such as:
  - » Full restoration of the Investment Company Act of 1940 without exceptions.
  - » Enforcement for joint liability of PE firms for debt that is loaded onto their acquisitions such as those for leveraged buy-outs.
  - » Tracking all PE merger ventures with vigorous anti-trust prosecutions as indicated.
  - » Reviews of purchased and merged assets.
  - » A dividend moratorium for two years after any purchase.
  - » An immediate lowering of the financial limit for the review of medical M and A activities.
  - » An end to the favorable tax break loopholes, e.g., carried interest.
- Legal enforcement of local standards of care for staffing, and patient safety by federal and local governments, and the aggressive pursuit of false claims. Such plans are starting to have traction led by Health and Human Services, and the White House.[23]

While awaiting these political actions, an important strategy at a local level could be enhanced educational and informational programs for health professionals (physicians, nurses, medical social workers, etc.) who advise patients and families about where and how to receive care. They could be informed by both community and medical organizations to become, and stay, continuously informed about the care quality, staffing, management, and funding of their recommendations regarding nursing homes, hospices, and home care services. Local activism can be powerful.

The medical establishment should provide support—financial and in-kind—of academic health economic experts[2,3,11,23] who provide help and guidance for effective patient funding.

While these legislative and legal solutions are easy to propose—and some are actually coming under consideration—implementation would be challenging. Multiple forces would align against even having a serious discussion of the topic. With profits at risk, some physician and hospital organizations would undoubtedly demure. The PE players would mobilize their political enablers and resources in opposition. The battle would be contentious, but well worth having in order to maintain and improve access[23] to quality, safe, and affordable health care for Americans.

References

1. Crowley R, Atiq O, Hilden D. Financial profit in medicine: A position paper of the American College of Physicians. Ann Intern Med. 2021; 174: 1447-9.
2. Appelbaum E, Batt R. Working Paper: Financialization in Health Care: The Transformation of US Hospital Systems. September 9, 2021. Center for Economic and Policy Research.
3. Scheffler RM, Abdelhadi O. Private equity and your doctor: Profits before patients. Public Policy and Aging Report. 2023: 33; 59-62.
4. Bruch JD, Gondi S, Song Z. Changes in Hospital Income, Use, and Quality Associated With Private Equity Acquisition. JAMA Intern Med. 2020; 180(11): 1428-35.

5. Casalino LP, Saiani R, Bhidya S, Khullar D, O'Donnell E. Private Equity Acquisition of Physician Practices. Ann Intern Med. 2019; 171(1): 78.
6. Shah S, Rooke-Ley H, Fuse-Brown EC. Corporate Investors in Primary Care—Profits, Progress, and Pitfalls. N Engl J Med. 2023; 388: 99-101.
7. Gupta A, Howell ST, Yannelis C, Gupta A. Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes. NYU Stern School of Business. November 12, 2020.
8. Brown B, O'Donnell E, Casalino LP. Private equity investment in behavioral treatment centers. JAMA Psychiatry. 2020; 77(3): 229-30.
9. Braun RT, Stevenson OG, Unruh MA. Acquisitions of hospice agencies by private equity firms and publicly traded corporations. JAMA Intern Med. 2021; 181(8):1113-5.
10. Hawryluk M. Hospices Have Become Big Business for Private Equity Firms, Raising Concerns About End-of-Life Care. KFF Health News. July 29, 2022. https://kffhealthnews.org/news/article/hospices-private-equity-firms-end-of-life-care/.
11. Adler L, Ly B, Duffy E, Hannick K, et al. Ground Ambulance Billing And Prices Differ By Ownership Structure. Health Affairs. 2023; 42(2).
12. Borsa A, Bejarano G, Moriah E, Dov-Bruch J. Evaluating trends in private equity ownership and impacts on health outcomes, costs, and quality: systematic review. BMJ 2023; 382: e075244.
13. Gustafsson L, Seervai S, Blumenthal D. The role of private equity in driving up healthcare prices. Harvard Business Review. October 29, 2019. https://hbr.org>2019/10>the-role-of-private-equity-in-driving-up-healthcare-prices.
14. Appelbaum E, Batt R. Working Paper: Private Equity Buyouts in Healthcare: Who Wins, Who Loses? March 15, 2020. Center for Economic and Policy Research.
15. Offodile II AC, Cerullo M, Bindal M, Rauh-Hain JA, Ho V. Private Equity Investments In Health Care: An Overview Of Hospital And Health System Leveraged Buyouts, 2003–17. Health Affairs. 2021; 40(5).
16. Scheffler RM, Abdelhadi O. Private Equity and Your Doctor: Profits Before Patients. Public Policy & Aging Report. 2023; 33(2): 59–62.
17. Singh Y, Song Z, Polsky B, Bruch JD, Zhu JM. Private equity acquisition of physician practices and healthcare spending and utilization. JAMA Health Forum. 2022; 3(9): e222886.
18. Avalere Health. COVID-19's Impact On Acquisitions of Physician Practices and Physician Employment 2019-2021. Physicians Advocacy Institute. April 2022. https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI%20Avalere%20Physician%20Employment%20Trends%20Study%202019-21%20Final.pdf?ver=ksWkgjKXB_yZfImFdXlvGg%3d%3d.
19. Kacik A. Lawmakers target private equity in healthcare, citing "rot." Modern Health Care. April 4, 2024.https://modernhealthcare.com.
20. Kacik A. Steward landlord says "negative commentary" has scared buyers. Modern Healthcare. August 9, 2024. https://modernhealthcare.com.
21. Team Health holdings, stock probability of bankruptcy. Macro Axis 7/7/2024. https://www.macroax.com. Accessed on Google 7/10/2024.
22. Hallerman S. Envision healthcare files for Chapter 11 bankruptcy. Healthcare Dive. May 15, 2023.https://Healthcaredive.com.
23. Centers for Medicare and Medicaid Services. HHS Proposes Minimum Staffing Standards to Enhance Safety and Quality in Nursing Homes. CMS.Gov Newsroom. September 1, 2023. https://www.cms.gov/newsroom/press-releases/hhs-proposes-minimum-staffing-standards-enhance-safety-and-quality-nursing-homes.

The author's E-mail address is j-webster@northwestern.edu.