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Doctored by Wall Street: Private Equity Bodes Ill for Health Care

Private equity firms seek profits from a dimly lit corner of the financial world, a corner from where they have become increasingly attracted to health care organizations over the past two decades.

Where private equity's strategies and tactics in other corporate sectors may be controversial, when applied to health care they can also be

dangerous and costly. It is time for public policy to shine a light in this area, to understand how the goals of private equity conflict with the imperatives of health care and to rein in destructive activity that benefits few at the expense — financial and physical — of many.

The growing activity by private equity firms in health care is accompanied by growing interest and concern over their impact. From 2000 to 2018, private equity activity in the health care sector grew from five percent of all leveraged buy-out (LBO) activity to 14 percent.¹ In 2021

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alone there were over 1,400 private equity deals in health care, with an aggregate value of over \$208 billion.² Figure 1 below shows the trend over the last decade.

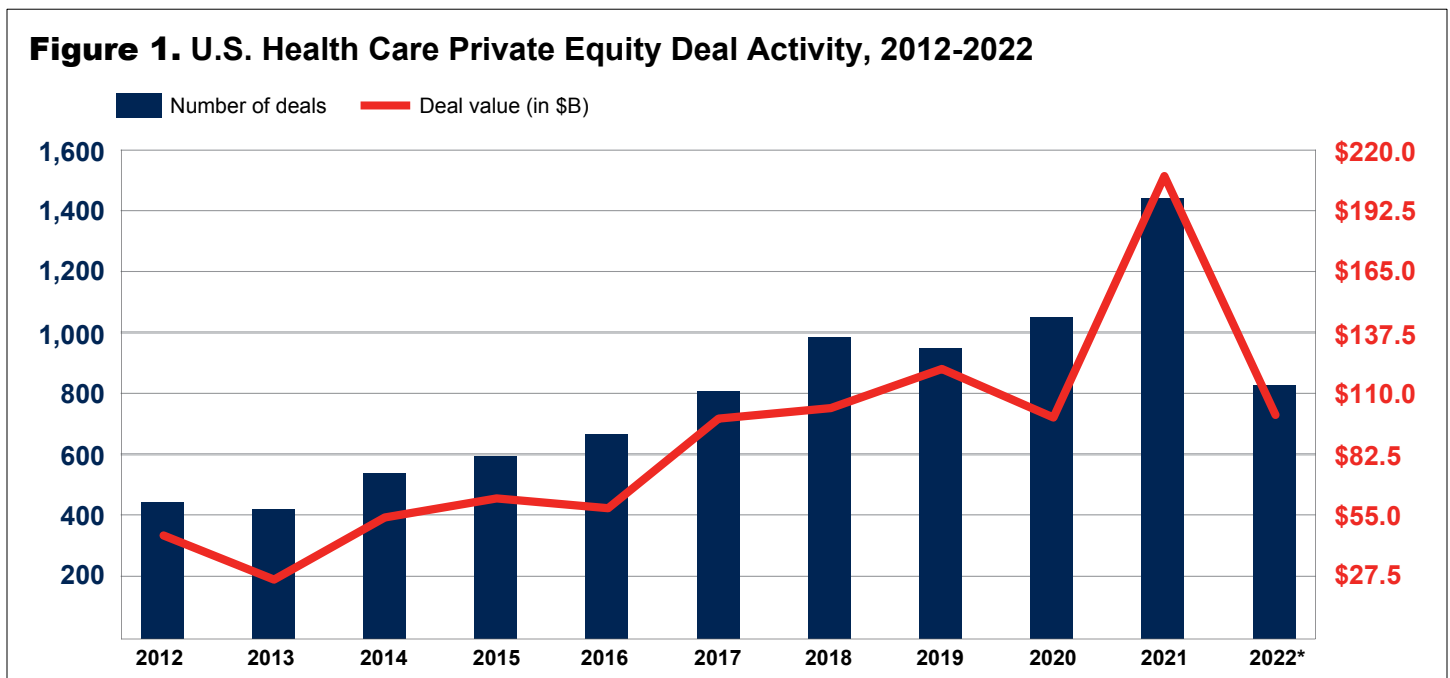
Private equity firms own 11 percent of nursing homes and four percent of hospitals.³ Interest in physician practices is strong, historically in specialties such as dermatology, ophthalmology, radiology, emergency medicine, anesthesiology, and gastroenterology, and increasingly in primary care, women’s health, and pediatrics.⁴ By 2017, one dermatologist in eleven worked in a private equity-owned practice.⁵ Private equity is also investing in behavioral health services for conditions such as addiction and eating disorders,⁶ in autism services,⁷ and in hospice and home care services.⁸ Elsewhere in the health care system, private equity has become a prominent player in medical bill collection businesses.⁹

What is the attraction?

Certain features of the U.S. health care system make it attractive to investors. The system is complex and fragmented, and it diverges from many of the principles of a functioning market.

Prices are distorted because of asymmetric information, the presence of third-party payers (dominated in some sectors by government payers, which serve dual functions as a purchaser and protector of health care access), prices being divorced from underlying costs and quality, and a general lack of transparency. Demand for services is growing, owing to an aging population and expansion of insurance coverage, among other factors. Many practices and providers are small, undercapitalized, and disconnected, and as much as one-quarter of spending in the health care system is waste,¹⁰ presenting opportunities for profitable streamlining and revenue enhancement. And, of course, health care is where the money is: the nation spent \$4.3 trillion on health care services and products in 2021, or nearly \$13,000 per person, equal to 18.3 percent of the U.S. gross domestic product.¹¹

Profit-seeking has always been part of the U.S. health care landscape. Though certain health care sectors, notably hospitals, grew from a tradition of charity, this is by no means the only model of hospital organization, and some not-for-profit health systems behave as rapaciously as



*As of October 19, 2022

SOURCE: PitchBook Data, Inc., via Kerry Dooley Young (2022)

the most profit-driven providers.¹² Other providers with a much smaller footprint than hospitals, such as community health centers, rely largely on public financing and have a mission to serve all patients, regardless of their ability to pay; these facilities generate little or no (or negative) profit. But the U.S. determined long ago that health care is a market, not a public good, with private investment playing an important role. In the past few decades, many hospitals and insurance companies were transformed by mergers and conversions to shareholder-owned institutions. Pharmaceuticals, a decidedly for-profit industry, consume a larger share of the health spending pie each year. Horizontal and vertical consolidations of health entities in search of economic leverage remain common today.

The concerns about private equity

Capitalism is no stranger to health care, then. The relatively recent arrival of private equity has upped the ante, however, and set off alarm bells about the effect private equity has had and will have on cost, access, and quality in health care. Why? What makes private equity an “extreme form of shareholder capitalism”¹³ and has led respected commentators and journalists to characterize private equity firms as “termites in the house of health care”¹⁴ and accuse them of “hijacking”¹⁵ and “ruining”¹⁶ the health care system?

The business model¹⁷

Private equity firms are in the business of buying and selling companies to turn a profit. A private equity firm creates an investment fund and raises capital from outside, primarily institutional investors — pension funds, university endowments, foundations and the like. Because contributions to the fund are from more sophisticated investors, the investment funds are less regulated and, consequently, less transparent. The PE firm itself invests just a

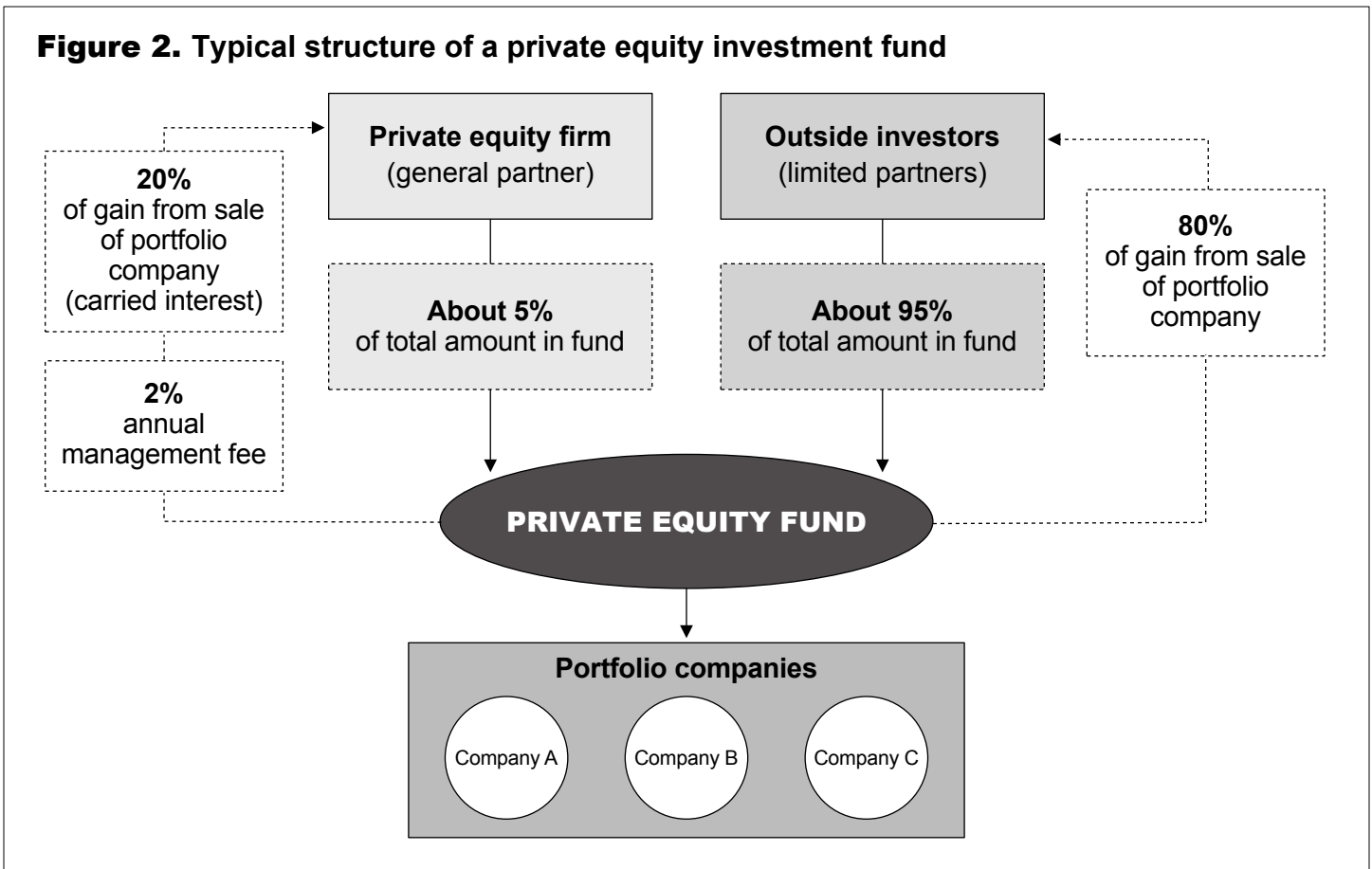
small amount of its own money in the fund — typically one to five percent of the total — but as the general partner of the fund, it has broad control over its activity.

The typical lifespan of an investment fund is about 10 years. In the early period of the fund, the PE firm acquires “portfolio companies” with the goal of improving their financial performance and later selling them for a profit. Typically, a fund will make 10 to 20 acquisitions. A recent trend is the “buy and build” strategy, in which a PE fund will acquire a larger “platform company” and then execute horizontal mergers with small companies, which can be acquired less expensively, thus diluting the overall purchase price and making a profitable exit from the investment more likely. This growth strategy is often more attractive to the PE owner than investing in and growing the original portfolio company. In health care, many of the smaller acquisitions PE firms make using this strategy fall below the threshold that triggers federal anti-trust scrutiny.¹⁸

A key to the private equity model is that transactions are highly leveraged, with debt financing as much as 70 percent of an acquisition. The acquired company, rather than the investment fund, bears most of the risk for repayment of the loans, while the potentially large profits accrue to the fund. The PE firm makes most of its money from the sale of the portfolio companies — typically 20 percent of the profits if they exceed a minimum threshold — but the firm can also extract money from the companies while it owns them, by requiring the portfolio companies to pay it management fees, directing the company to sell its real estate holdings and distributing some of the proceeds to investors, or through “dividend recapitalizations.” Figure 2 on page 4 presents a simple diagram of this structure.

The low risk, high reward characteristics of the private equity leveraged buyout model serve

Figure 2. Typical structure of a private equity investment fund



SOURCE: MedPAC, "Congressional request: Private equity and Medicare"

investment funds well, but they put health care organizations and the people they serve in precarious circumstances. Key features of the model depart from other kinds of for-profit ownership and create danger for the health care system. For example:

Reliance on debt financing

Leveraged buyouts saddle health care facilities with high levels of debt. Servicing the debt can threaten a provider’s ability to serve patients. In the case of a hospital, high debt can affect the quality of care, the ability of the hospital to update its technology, and decisions about discontinuing lower-margin services. This is particularly disruptive in markets where there is little choice of hospitals, such as in rural communities.¹⁹ Private equity-owned hospitals carry higher debt levels and experience challenges meeting loan obligations, compared to hospitals with other types of ownership.²⁰

Debt obligations can drive a provider to reduce costs through staff reductions (labor is the largest cost component for a health care facility) and purchasing fewer or lower quality supplies,²¹ or by raising the price of services; both strategies affect access to care and health outcomes in a community. Patient care revenues that might otherwise go to improving care instead are used to pay down debt. In the extreme, a facility or practice may not be able to survive the financial pressure and declare bankruptcy, further restricting access.

Any business that takes on debt adjusts its operations to service the debt and accepts the risk of possible default. In the case of health care businesses owned by private equity, the risk is high and the adjustments may come at the expense of people’s health.

Short time horizon and the promise of high returns

Private equity ownership is typically short-term, with outsized returns on investment often sought within three to seven years. The focus during that time, therefore, is on generating the return, through financial maneuvers such as acquisitions, revenue enhancements, and cost reductions. As noted earlier, private equity owners may also sell off a facility's real estate, extracting value for investors but further burdening the facility's finances with rent payments. These are common strategies across private equity, but are especially troublesome in health care, because they threaten the quality and safety of medical care.

Opacity of ownership and operation

Private equity is, well, private. Investment partnerships managed by private equity firms are not subject to the same transparency and disclosure requirements imposed on publicly traded corporations. A fund's investors and its portfolio of holdings are difficult to discern. The actual owner of a local health care facility may be distant and its identity unclear. But health care delivery is local; needs are particular to a community or region, and the resources to meet them also are largely local. Private equity owners lack the accountability for understanding and adequately responding to a community's health care needs.

Sequel Youth and Family Services

operated teen residential treatment facilities, group homes, and other community-based behavioral health programs for children and youth, at one time operating in 50 locations across 21 states.²² It had three different private equity owners from 2010 to 2021. Most recently, Sequel was owned by Altamont Capital Partners, which acquired it from Alaris Royalty, a Canadian PE firm, through a leveraged buyout in 2017. Alaris acquired Sequel in 2013 from the PE firm Levin Leichtman, which bought Sequel in 2010.²³

Sequel has generated high profits for its investors — a 23 percent annual return under Alaris's ownership, for example. It has employed key elements of the private equity playbook, executing a \$175 million dividend recapitalization under Alaris in 2016, and taking on an additional \$94 million of debt following Altamont's leveraged buyout.²⁴ Its revenues were reliable, coming primarily from public programs administered by states and the federal government.

But Sequel's strong financial performance — an SEC filing in 2017 valued it at \$421 million²⁵ — came at the very high cost of mistreatment and abuse of the children and youth it purported to serve, owing to low-paid, ill-trained staff and poor oversight. Many states where Sequel operated facilities cited Sequel multiple times for violations such as inappropriate and dangerous restraints and verbal abuse. Staff have been investigated for and charged with child abuse. There have been allegations of sexual abuse and rape, with police called to some residential facilities dozens of times a year. A review of a Sequel facility in Alabama found “unsafe, squalid living conditions and a disturbing cultural and programmatic environment that further traumatizes extremely vulnerable children.” Then in 2020, Cornelius Fredrick Jr., a 16-year-old in a Michigan Sequel facility, died after being restrained by seven staff members.²⁶

NBC News called Sequel a “profitable death trap” in a 2020 investigative report.²⁷ After Fredrick's death, which was recorded on surveillance video, a number of states stopped sending children to Sequel's treatment centers. Sequel closed half of its residential facilities since 2017, 11 since 2020. Most of Sequel's remaining assets have been acquired by Vivant Behavioral Healthcare, founded in 2021 by Jay Ripley. Ripley was a co-founder of Sequel in 1999.²⁸

Audrain Community Hospital in Mexico, Missouri, was acquired by Noble Health in March 2021. Noble, which also acquired nearby Callaway Community Hospital, was launched by the private equity firm Nueterra Capital little more than a year earlier. Noble was led by executives without experience in hospital administration, including co-founder Donald Peterson. Peterson had earlier been accused of Medicare fraud and was on an exclusion list barring him for five years from Medicare, Medicaid, and other federal programs. By March 2022, Noble had suspended hospital services at Audrain and Callaway, furloughed 181 employees, and agreed to sell the two hospitals to Platinum Neighbors. In the foregoing year, Noble had taken on \$45-50 million in debt, accumulated \$4 million in unpaid bills, was paying employees erratically, and had stopped paying for employee insurance benefits, leaving many employees who thought they were insured with 5- and 6-digit medical bills.²⁹ While apparently struggling, Noble also received \$20 million in federal COVID-19 relief funds, including \$4.8 million in paycheck protection funds, during this period.

In September 2022, new owner Platinum Neighbors terminated the remainder of the hospital staff and was looking for buyers. One prospective buyer, after reviewing the financial conditions of the hospitals, commented that “private equity and venture capital need to be kept the heck out of health care.” Platinum sold the hospitals to Clifford Sullivan on December 7, 2022; a local legislator said of Platinum’s brief ownership, “There is a question as to whether Platinum Health ever had any intention to operate the hospitals.”³⁰ The state denied an extension of the hospitals’ voluntary license suspensions, meaning that they would need to go through a new licensure process if they were to reopen.

The prospect seems remote at this point. On January 6, 2023, Clifford Sullivan sold “some part” of his investment to Kangaroo Partners, a firm in Connecticut, apparently after the county demanded repayment of a \$1.8 million loan. The property itself, however — hospital and clinic buildings, as well as the equipment inside them — is still owned by Noble Health Real Estate II, LLC.³¹

The small cities where Audrain and Callaway once operated are without hospitals; the closest acute care hospitals to Mexico are in Columbia, Missouri, nearly 30 miles away.

Evidence of Impacts

There is no shortage of rigorous research on the impact of private equity ownership on the cost and quality of health care and on access to care. In the words of one recent review of the research, “Findings from some of the studies so far are concerning.”³² For example: one study of nursing homes found an increased probability of mortality in private equity-owned facilities, along with lower nurse-to-patient ratios and a greater chance of receiving anti-psychotic medications. Despite these results, the amount billed to Medicare increased 11 percent in these facilities.³³ Another nursing home study found significant increases in potentially preventable emergency department visits and hospitalizations, important quality

metrics, along with an increase in the cost per resident, compared with other for-profit nursing homes not owned by private equity.³⁴

Studies of private equity-owned physician practices have shown increases in cost. A study of dermatology, gastroenterology, and ophthalmology practices found increases in charges per claim of 20 percent.³⁵ Privately insured patients who received outpatient anesthesia services faced prices over 18 percent higher in facilities that contracted with a physician management company (PMC), and the price increases were higher still if the PMC received private equity investment.³⁶ Another study of private equity-owned dermatology practices raised issues of revenue-enhancing practices such as

pressure on doctors to meet production numbers, sell products, and refer patients to affiliated businesses. This study also reported quality and safety concerns, including the use of physician assistants providing services while unsupervised by a physician.³⁷ The horizontal mergers resulting from private equity's "buy and build" strategy bring consolidation and market power, for hospitals³⁸ and specialty physician practices.³⁹

Private equity-owned firms can also hinder access. Facilities and practices may not be able to survive the debt burden and extraction of resources that private equity ownership often entails. This is not just a rural phenomenon: the bankruptcy and closure of Hahnemann Hospital in Philadelphia, following its acquisition by a private equity firm, led to access bottlenecks, overtaxed emergency rooms in other area hospitals that became the setting for "daily human tragedies," and ambulance diversions that may have contributed to an elevated level of deaths among Black cardiac patients.⁴⁰

Medical debt is a barrier to health care, and private equity is playing an increasing role in its persistence. One person in four in the U.S. had unpaid medical bills in 2020, when there was about \$140 billion of medical debt in collection.⁴¹ In addition to causing financial hardship, medical debt causes health problems (stress and anxiety), while at the same time limiting access to health care. Many people with medical debt forgo needed care because they do not want to accrue additional bills or because providers may deny them care until a bill is paid.⁴² The problem is exacerbated by hospitals' aggressive bill collection practices and their outsourced collection agents, known as revenue cycle management companies. Collection practices include lawsuits over unpaid bills resulting in wage garnishments, liens on homes and bank accounts, and even civil arrest warrants.⁴³ The Healthcare Financial Management Association (HFMA) has adopted "Patient-Friendly Billing" principles to discourage these and other types of extraordinary collection actions.⁴⁴

Private equity has increasingly looked for opportunities in revenue cycle management. In 2018, 18 percent of hospitals outsourced their bill collection activities, up from 11 percent just three years earlier.⁴⁵ A number of major private equity firms acquired RCM companies in recent years, and private equity now accounts for a sizable portion of RCM acquisitions. In pursuit of their profit targets, private equity-owned RCM companies use some of the aggressive collection practices described above, violating fair debt collection laws and HFMA principles, and sometimes offer potentially exploitive medical loans, increasing levels of medical debt and its detrimental effect on health care.⁴⁶

Reining in private equity

These findings are just a sampling of the research on private equity's impact on the health care system. From an academic standpoint, there is still more to know; indeed, much of the research calls for additional research. It is clear, however, that the goals and methods of private equity investment are incompatible with sustained support for a well-functioning, improving health care system, and this clash has harmed patients, increased costs, and deprived communities of essential resources. As one doctor put it, "You can't serve two masters. You can't serve patients and investors."⁴⁷

While private equity owners might claim to have achieved marginal improvements in efficiency in isolated instances, they come at far too high a price, as the documented negative impacts show. Public equity investors are virtually unfettered by public regulation and oversight. Policy makers must ask themselves: are health care organizations simply an investment vehicle, or are they more important to the public good? The honest answer will lead to policy initiatives that protect health care by addressing predatory behavior and bringing private equity out of the shadows to hold it accountable.

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