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PRIVATE EQUITY INVESTMENT IN FEE-FOR-SERVICE HEALTH CARE:

Lower Quality at Higher Costs

AHIP ISSUE BRIEF

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Key Takeaways

- Private equity investment in fee-for-service health care ventures is at an all-time high. Following a decade of growing interest in short-term investments in hospitals, freestanding emergency departments, nursing homes, and physician practices, the COVID-19 pandemic caused an even sharper rise in recent years.
- Many private equity firms follow a 3 to 7-year time horizon for entering and exiting new markets. When private equity firms apply a short-term profit driven business model to the unique nature of our nation's health care system, the consequences can be dire for patients, consumers, and the availability of quality health care in the future.
- Hospitals owned by private equity firms bring in nearly 30% more income than hospitals owned by other entities by using a number of tactics to boost revenue including cutting staffing and supplies; pressuring providers to bill for unnecessary services, and up-coding claims.
- The need for those private equity firms to achieve high returns on investment on a fast time horizon is in direct conflict with the goal of lower health care costs for all Americans and greater investments in quality and safety.
- Additional short-term profit focused private equity growth could further inflate health care costs. Congress, state governments, and regulators at the federal and state level should prioritize reforms that remove some of the incentives and opportunities for such private equity firms to exploit patients for profit.

Introduction

Over the past decade, private equity acquisitions of health care companies have risen sharply.[1] Estimated annual deal values have gone from $41.5 billion in 2010 to $119.9 billion in 2019, for a total of approximately $750 billion in just 10 years.[2] The soaring interest from some private equity firms in turning a quick profit by acquiring fee-for-service medical providers (such as some physician specialties and ambulance services), raises questions about this type of private equity's role in the nation's health care system and what it means for the future of health care.

What is Private Equity?

Private equity firms use capital from institutional investors to invest in private companies that have potential to return a profit. Some private equity firms acquire a company that could be either struggling financially or showing short-term growth potential and invests in it, loading it up with debt and then extracting value when the private equity firm sells their stake at a price higher than the purchase. Such private equity firms typically sell their shares within 3 to 7 years and aim to deliver 20% to 30% returns in profit. As private equity is a broad term encompassing a wide range of investment types, strategies, and practices, it is important to distinguish this type of short-term profit-driven private equity interest in health care from other firms that make a longer-term investment in, and engage in partnership with, health care entities (including primary care providers) to move to value-based care and facilitate beneficial investments in services.

1 https://publichealth.berkeley.edu/wp-content/uploads/2021/05/Private-Equity-I-Healthcare-Report-FINAL.pdf

2 Richard M. Scheffler, Laura M. Alexander, James R. Godwin. Soaring Private Equity Investment in the Healthcare Sector: Consolidation Accelerated, Competition Undermined, and Patients at Risk. American Antitrust Institute, May 18, 2021. Available at https://www.antitrustinstitute.org/wp-content/uploads/2021/05/Private-Equity-I-Healthcare-Report-FINAL-1.pdf

The Rise of Private Equity in Health Care

Much of private equity's current interest in health care is driven by opportunities to consolidate enterprises in highly fragmented markets. Here, private equity firms typically purchase an established entity, such as a specialty physician group practice, and acquire smaller practices along the way to consolidate their market power. This strategy allows private equity firms to reduce competition, raise health care prices, and exercise greater bargaining power with insurers and medical suppliers.

The private equity business model is particularly attractive in settings where fee-for-service health care is practiced.

Fee-for-service refers to "a method in which doctors and other health care providers are paid for each service performed."[3] Fee-for-service remains the dominant method of paying for physician and hospital services in the United States.[4] Fee-for-service models are in contrast to value-based payment models, including capitation and bundled payments, as well as payment structures such as Accountable Care Organizations (ACOs). Under fee-for-service, financial incentives are tied to providing the highest volume of care, while in value-based models, financial incentives are tied to providing the best quality care, rewarding providers who facilitate more coordinated and effective care that demonstrates improvement and efficacy.

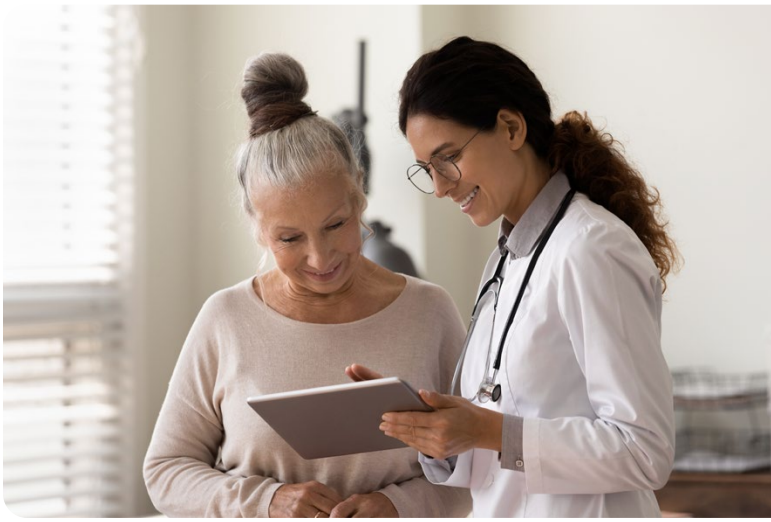
The COVID-19 global health pandemic further accelerated private equity firms' ability to consolidate the health care market due to a shortage of capital among many hospitals and physician practices, which caused them to turn to outside investors for financial support.[5] By 2022, private equity interest in health care was being described as "at an all-time high, spurred by the digital health revolution, value-based care, and an increased demand for a range of consumer-driven health services."[6]

Create – then Exploit – Highly Concentrated Markets

Health care is a prime target for the approach of some private equity firms to consolidate smaller entities to increase profits through greater market power. Today, approximately 80% of hospitals in the U.S. are in "highly concentrated markets"[7] and at least 70% of physicians in the U.S. are directly employed by a corporate entity or employed by a hospital-owned by a corporate entity,[8] most often a private equity firm.

Private equity firms argue that they have much to offer to help curb costs, improve efficiencies, and infuse capital into the health care market. And some do. For example, as noted above, longer term investments in primary care practices have the promise of furthering the movement to value-based care allowing for needed, and beneficial investments. However, "private equity's promise to drive efficiency into health care is not borne out by the initial evidence so far," said Mark Miller, Executive Vice President of Health Care at Arnold Ventures. "We are seeing higher prices from consolidation; surprise bills for patients; and lower quality."[9]

When private equity firms apply a short-term profit driven business model to the unique nature of our nation's health care system, the consequences can be dire for patients, consumers, and the availability of quality of health care in the future.



3 https://www.healthcare.gov/glossary/fee-for-service/#:~:text=A%20method%20in%20which%20doctors,include%20tests%20and%20office%20visits
4 https://revcycleintelligence.com/news/healthcare-reimbursement-still-largely-fee-for-service-driven#:~:text=Whereas%2070%20percent%20of%20physician,health%20systems%20report%20the%20same
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6 https://www.troutman.com/insights/health-care-private-equity-trends-to-watch-in-2022.html
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"The Harvest Period"

Data show that over the last decade, many private equity firms have exited their health care investments on average in less than 5 years - referred to as the "harvest period."[10] Researchers describe this private equity approach to physician practices as "platform and add on" where the "firm first purchases a sizable established group practice and then acquires additional small practices to build market power, economies of scale, capture a stream of referrals and demand higher rates from commercial payers."[11] This approach often drives smaller, independent practices out of business, potentially reducing the availability of physician services in a given geographic region. By consolidating the market, private equity firms can unilaterally set higher prices for health care services covered by commercial health plans with little incentive to deliver high-quality care.[12]

Commercially insured patients, namely those covered by employer-provided coverage, are the most attractive group for private equity firms to target due to their ability to force higher reimbursement rates from commercial payers. A claims analysis from three large national insurers examining anesthesia claims data from 2012-2017 found that private equity-backed physician management companies saw their "allowed amounts" – the contractual payment rate with health insurers – rise by 26%, compared to 12.9% for non-private equity owned practices.[13]

Growing Profits, Declining Quality of Care

These incentive structures and tactics used by private equity firms raise concerns over the proliferation of private equity in the ownership of fee-for-service health care entities, such certain as physician specialties and ambulance services.[14] **The need for those private equity firms to achieve high returns on investment on a fast time horizon directly conflicts with the need for lower health care costs and greater investments in quality and safety.[15]**

For example, hospitals owned by private equity firms bring in nearly 30% more income than hospitals owned by other entities.[16] Where does that extra revenue come from? Private equity firms that own hospitals use a number of tactics to boost revenue including cutting staffing and supplies; pressuring providers to see more patients, overprescribing tests, performing low-value procedures; and using inaccurate billing codes to get inflated reimbursements, a tactic called "up-coding." [17 and 18]

One recent, prominent study analyzing data over the course of 12 years among hundreds of private equity-owned hospitals compared to hundreds of hospitals not owned by private equity firms found that at private equity hospitals, total charges per inpatient day averaged $400 higher, and they saw a bigger gap between their costs and the prices they charged.[19] Moreover, "the higher charge to cost ratio we observed may indicate that hospitals acquired by private equity firms began charging more for services, cutting operating costs, or both after the acquisition."

In addition to higher prices, many studies[20] have found that health outcomes for patients are substantially worse at hospitals in highly concentrated markets,[21] where there is little incentive to compete. Often, this is reflected in higher mortality rates, particularly for patients with heart conditions. Furthermore, some research examining the impact of hospital ownership by physician practices finds private equity investment leads to lower quality of care by several measures.[22] One area where quality of care often suffers is in the form of patient referrals. Scholars have raised concerns about the possible impact of consolidated physician practices on where those physicians refer their patients, and whether that is in the patients' best interest.[23] A number of studies have found that patient referrals are substantially altered by hospital acquisition of a physician practice,[24] including the specialists to whom patients are referred and tests and imaging ordered.[25]

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10 https://pws.blackstone.com/wp-content/uploads/sites/5/2020/09/the_life_cycle_of_private_equity_insights.pdf
11 https://link.springer.com/content/pdf/10.1007/s10754-022-09331-y.pdf
12 National Library of Medicine, Potential Implications of Private Equity Investments in Health Care Delivery, February 2019
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Consolidation Leads to Anticompetitive Practices

Consolidation in health care has outpaced other industries, with nearly 1,600 hospital mergers between 2000-2020.[26] This aggressive consolidation has reduced competition for where care is delivered – raising prices and leaving patients with less choice and less control over their health care experience, especially in rural communities. In fact, between 2007-2017, 19% of markets – representing 11.2 million Americans – were served by only one hospital system.[27]

Consolidation between close competitors, such as hospitals, has led to substantial price increases, without offsetting gains in improved quality or enhanced efficiency. An independent study found that hospitals that do not have any competitors within a 15-mile radius have prices that are 12% higher than markets with four or more competing hospitals, resulting in an average increase of over $1,000 per year for families and over $370 per year for individuals enrolled in employer-provided coverage.[28] Hospital concentration has also been linked to average annual Marketplace insurance premiums that are 5% higher than those in less concentrated areas.[29] **Consolidation and anticompetitive contracting practices stunt competition, limiting the ability of competition to contain costs and provide high-value care**. A recent report found that hospitals with fewer competitors or potential competitors are more likely to reject value-based payments in favor of fee-for-service medicine and contractual terms that are highly favorable to the hospital at the expense of patients.[30]

There are various hospital contractual terms used by dominant hospitals to restrict competition, among them *anti-tiering* provisions. Health insurance providers use tiering systems to incentivize patients to choose higher-value, lower-cost providers and give patients clear and actionable information about which providers offer the highest value. However, dominant health systems often use anti-tiering clauses to skew these tiering systems and realize higher profits. Specifically, health systems may demand placement in the most favorable tier in a tiered network, even if some or all their facilities do not meet the cost or quality metrics for inclusion in that tier.

There is also little transparency, oversight, or accountability in private equity firms' acquisitions of health care practices. Typically, private equity firms amass market power by buying up smaller practices and reducing competition in a given geographic area. Most of these transactions fall below the threshold for reporting to federal antitrust authorities, such as the Federal Trade Commission (FTC), under the Hart-Scott-Rodino Act.[31] As a result, regulators are often unable to combat private equity firms' anticompetitive consolidation practices. Furthermore, there is little information about the extent of private equity investments in physician practices, as not all acquisitions are publicized, and the firms often sign non-disclosure agreements.[32]

Prey on Patients: Surprise Medical Bills and Medical Debt

At a time when private equity owned firms are driving up the costs of medical care, they are simultaneously hounding patients to pay their bills even as they often face insurmountable medical debt.[33] Surprise medical bills – the practice of providers or facilities directly billing consumers for balances beyond the amount paid by a health plan – soared after private equity firms began purchasing specialty physician staffing firms. Private equity owned companies that employ physicians, such as Envision, TeamHealth, and EmCare, found a lucrative business model in surprise billing.[34] By acquiring hospital-based physicians that have a guaranteed steady stream of patients with private insurance, these private-equity owned staffing firms could take their providers out-of-network with insurers before increasing claim amounts and high-intensity coding practices. It represents the purest form of fee-for-service

26 https://www.judiciary.senate.gov/imo/media/doc/Gaynor_Senate_Judiciary_Hospital_Consolidation_May_19_2021.pdf
27 https://pubmed.ncbi.nlm.nih.gov/32919591/
28 https://doi.org/10.3386/w21815
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32 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6682417/
33 Institute for New Economic Thinking, Private Equity Buyouts in Healthcare: Who Wins, Who Loses?, March 2020
34 https://www.nber.org/system/files/working_papers/w23623/w23623.pdf

health care. Should those consumers be unable to pay these massive bills, the private-equity firm could sue them. An investigation found that after a private equity company bought one of the largest physician staffing firms in the country, aggressive debt collection and lawsuits against consumers became commonplace.[35] The headline read: **"This Doctors Group Is Owned by a Private Equity Firm and Repeatedly Sued the Poor Until We Called Them."** When the Blackstone Group, a major private equity firm, acquired TeamHealth, a leading physician staffing firm, low-income patients with unpaid bills became defendants in civil suits. TeamHealth's subsidiary went from never suing a patient for unpaid bills to suing more than 600 in a single year, all while instituting policies "that made it difficult for patients to access charity care, a form of financial assistance for low-income patients."

Case Studies

Private equity transactions are far from simple. Typically, investors are purchasing or financing various stakes in entities over time, selling or spinning off subsidiaries, mortgaging assets, restructuring debt, changing employment structures, and retooling entire business models. And yet, for all the complexity of the transaction over time, for private equity firms venturing into fee-for-service medicine, the model is often quite simple: extract as much short-term profit as possible from the assets acquired, and then get rid of them.

Dermatology

Private equity couldn't resist popping pimples for a profit. As a specialty, dermatology is attractive to private equity investment because it lends itself to fee-for-service medicine with ample opportunities for profit. Despite comprising 1% of practicing physicians in the U.S., dermatologists were involved in 15% of medical-practice acquisitions by private equity in 2015 and 2016.[36] As a result, dermatology practices were transformed in a few short years to a specialty where non-physician ownership by private equity groups was commonplace.

Dermatologists have expressed concern that private equity ownership may create an emphasis on profitability, which negatively influences patient care. According to one recent study, "The volume of patients per private equity dermatologist ranged from 4.7% to 17% higher than the volume per non–private equity dermatologist" and "prices paid to private equity dermatologists for routine medical visits were 3–5% higher than those paid to non–private equity dermatologists."[37] Other concerns included up-coding and significant reliance on physician assistants in unsupervised settings, which raises questions about patient safety and low-value care.

Freestanding Emergency Rooms

Freestanding emergency room facilities (FSER or FSED) have also attracted attention from private equity firms due to their potential for high profit at low operating margins. Like urgent care clinics and hospitals, these facilities are licensed to provide emergency medical care. However, unlike urgent care clinics and hospitals, they do not provide inpatient services, ambulatory services, or services for critical conditions. Furthermore, these facilities charge rates that can be 22 times higher than a physician's office and 19 times greater than an urgent care center, despite most treatment consisting of non-emergency care.[38] In fact, only 2.3% of FSED visits in the U.S. are emergent and treatable in lower cost sites of care, including physician offices or urgent care centers.[39]

Not only do these facilities hike health care prices, they also disproportionately serve relatively affluent communities with a high concentration of commercially insured individuals to increase profit potential.[40] FSEDs growth mirrors that of the explosion of private equity acquisitions in health care, with policymakers finding great concern with the role of independent and freestanding care centers in health care.[41]

35 https://www.propublica.org/article/this-doctors-group-is-owned-by-a-private-equity-firm-and-repeatedly-sued-the-poor-until-we-called-them
36 https://jamanetwork.com/journals/jamadermatology/article-abstract/2664345
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39 Ibid.
40 https://www.healthcaredive.com/news/study-freestanding-eds-not-filling-gaps-in-emergency-care/506439/
41 https://www.ineteconomics.org/uploads/papers/WP_118-Appelbaum-and-Batt-2-rb-Clean.pdf

Hahnemann University Hospital

Hahnemann University Hospital opened in Philadelphia in 1885. For more than 130 years, it served primarily lower income residents, until in early 2018 it was purchased by Paladin Healthcare, a private equity firm. Over the course of about 18 months, Paladin Healthcare laid off physicians, nurses, and other workers, while steering the hospital towards bankruptcy and closure.[42] If private equity could design a way to up-code, surprise bill, or sue their way to profitability, they would simply exit the deal by finding profitability in the real estate. The value of the land on which the hospital sat was seen as more valuable to the firm than the nearly 500-bed charity hospital.[43] Despite the local community's longstanding reliance on this centrally located hospital, Hahnemann University Hospital closed its doors in August 2019, with the real estate put up for sale. [44]

The Bottom Line

Additional short-term profit focused private equity growth could further inflate health care costs and lower care quality at a time when the nation needs affordable, accessible and high-quality care more than ever.[45] Congress, the Administration, and state lawmakers should prioritize reforms that remove some of the incentives and opportunities for such private equity firms to exploit patients for profit.

Policy and Legislative Recommendations

- Enact policies to require public reporting of all private equity or hedge fund purchases of air or ground ambulance providers or facilities, emergency room physicians, and other specialty groups where there is evidence of high levels of concentration or low levels of network participation.
- Strengthen antitrust enforcement at the federal and state levels, including additional funding and new FTC and Department of Justice (DOJ) regulations for enforcement of competition in health care.
- Stop consolidated health systems from using their monopolistic position to stifle negotiation and innovation through the use of all-or-nothing, anti-tiering, and other take-it-or-leave-it contract terms.
- Require simple reporting of small transactions that fall below the Hart-Scott-Rodino Act reporting requirements, so that the enforcement agencies can track physician practice mergers and hospital acquisitions of physician practices.
- Advance site-neutral payments to defend consumers against having to pay more for the same services depending on the site of care, discouraging use of more expensive sites of care as profit engines.
- Advance policies that limit the unchecked proliferation of free-standing emergency departments.

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44 https://www.bizjournals.com/philadelphia/news/2020/07/30/hahnemanns-center-city-real-estate-up-for-sale.html
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