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Can Current Legal Tools Respond Adequately to Risks of Private Equity Investment in Health Care?

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Abstract
As private equity (PE) funds acquire a growing share of America's health care system, their focus has expanded to include not only hospitals and nursing homes but also physician practices. Some PE acquisitions have infused much-needed capital into resource-starved entities, but others have led to higher prices, diminished quality of services, and billing fraud. Some PE acquisitions have also forced viable entities into bankruptcy by stripping their real estate and other assets. This article explains how legal and regulatory responses to these outcomes can be impeded by corporate structures that PE funds commonly use to obscure responsibility. It also suggests reforms that could strengthen enforcement capacity.

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Private Equity's Growth in Health Care
Private equity (PE) funds have been acquiring a growing share of America's health care system, with the value of investments increasing from $41.5 billion to $119.9 billion in the decade between 2010 and 2019.[1] The bulk of these investments were initially in hospitals, nursing homes, and other institutional providers, of which they acquired a considerable number. As of 2024, PE funds owned more than 386 hospitals, representing 30% of for-profit facilities in the country.[2] As of 2022, they owned about 5% of nursing homes enrolled in Medicare,[3] and, as of 2023, they also owned more than 20% of mental health facilities in some states.[4]

Following this start, the scope of interest of PE funds has broadened to include physician practices. Acquisitions of these entities increased from 75 to 484 a year between 2012 and 2021.[5] In 2021, a single PE fund had a market share of at least 30% in 108 metropolitan area practice markets and at least 50% in 50 of those markets.[6]

Supporters of PE investment point to what some see as much-needed capital infusions, streamlining of previously inefficient operations, and paperwork burden reduction for clinicians.[7] PE firms also have a more streamlined governance structure than traditional

investment companies that allows them to be more nimble in making major decisions.[8] However, critics point to evidence of serious deleterious effects, including higher prices, reductions in quality, increases in instances of billing fraud, and financial stress that has forced some viable entities into bankruptcy.[9] Enforcement of laws to mitigate these effects has increased in response, but government regulators often face a number of formidable obstacles.[10]

PE Business Model

The PE investment model uses a fund comprising a small group of investors to acquire an ongoing enterprise that is not publicly traded.[11] The funds are typically structured as partnerships with a general partner managing acquired entities and affiliated corporations providing ancillary services.[12] While private individuals have invested in health care for decades, they have predominantly been health care professionals and individuals with knowledge of the field.[13] PE funds, on the other hand, invest on behalf of wealthy individuals and institutions, who often have no prior knowledge of health care business or specific interest in the ongoing success of acquired entities or in their capacity to offer services.[13] In many cases, the primary goal is to generate short-term profit rather than continued operation.[13]

PE health care acquisitions commonly include 4 elements that tend not to be found in traditional for-profit investments:[14] (1) embedding acquired entities in complex and opaque corporate structures; (2) refinancing and loading the debt onto acquired entities; (3) transferring acquired entities' assets, especially real estate, to a related owned business; and (4) developing business relationships between an acquired entity and providers of ancillary services that they also own.[9] These elements offer several benefits to PE firms. Complex corporate structures can shield individual investors from lawsuits, claims of creditors, and enforcement penalties for substandard care.[9] They can also make it difficult for regulators to determine responsibility for abusive behaviors.[9] Regulatory oversight is further impeded by the private ownership structure of PE firms, which allows them to avoid regulatory filings that would be required of publicly traded businesses.[9] By loading debt from an acquisition onto an acquired entity, they can shield the fund itself and its investors from liability for repaying it.[9] Selling an entity's real estate to a related business generates further revenue from rent that the entity is required to pay for use of its own facility.[15] Intertwined corporate relationships also generate revenue by requiring an entity to make payments to providers of ancillary services, such as billing and purchasing, that the PE fund also owns.[9] The entity may even be required to pay management fees to the fund's general partner for its oversight.[14]

Consequences

On the one hand, the business literature documents many instances of acquired entities benefiting from PE investment.[16] Such benefits are most notable when needed capital has been infused into failing or underperforming companies or service delivery streams.[17] PE funding has also helped financially stable providers expand their range of services. For example, one partnership was developed to create 67 primary care clinics focused on elderly patients with an investment of $800 million.[18] Some smaller independent physician practices stand to realize benefits from PE investment by gaining resources to compete in an increasingly expensive and competitive marketplace.[19]

However, instances of significant negative consequences also abound, including financial ruin for some acquired entities. An analysis of health care bankruptcies in

2023 found that they had been rising for several years and that at least 21% of health care companies filing for bankruptcy that year were owned by PE firms.[20] A study of 484 PE leveraged buyouts found that the probability of bankruptcy for the target firm was about 18% higher than for nonacquired firms.[21] This consequence may be of little concern to many PE funds, as they commonly use bankruptcy as a deliberate exit strategy for the entities they acquire.[21] A recent example is illustrative. A few years after one PE firm became the owner of a network of 31 hospitals in 8 states, the network found itself $400 million in debt.[22] In response, the PE firm arranged for the hospitals' landlord to contribute financial support over the next 4 years.[22,23] It then sold a majority stake in the organization to the chief executive officer and realized an $800 million profit. Soon thereafter, the network filed for bankruptcy.[22]

For those entities that remain ongoing enterprises, PE ownership is often associated with higher prices paid by patients and insurers.[13] A systematic review of 55 studies of PE ownership of health care entities found cost increases to be the most consistently reported outcome.[24] A study using data from the Healthcare Cost Institute Commercial Claims Research Dataset, which includes about 55 million covered lives, found per-patient expenditure increases in 6 of 10 physician specialties, ranging from 4% to 16% after PE acquisition.[5] The price increases in 3 specialties were greater when a PE-owned practice controlled more than 30% of a market.[5] A survey published in 2020 identified the kinds of practices most likely to be acquired as anesthesiology, multispecialty, emergency medicine, family medicine, and dermatology.[25] A study of the effects of PE acquisition on practices in one of those specialties, dermatology, found that the volume of patients seen by each dermatologist was 4.7% to 17% higher than in nonacquired practices 3 years after acquisition and that prices paid for routine visits were 3% to 5% higher 1.5 years after acquisition.[26]

Despite charging more, PE-owned providers do not necessarily produce better quality of care and have been found in numerous instances to produce the opposite.[26,27] For example, a study of 4500 PE-owned dialysis centers found that those in concentrated markets have higher risk-adjusted rates of patient hospitalization and lower survival rates.[28] A study of PE-owned hospitals found that they have fewer full-time equivalent employees, lower patient satisfaction scores, and lower performance on quality metrics.[29] A study that analyzed 662 095 Medicare Part A claims found that acquired entities have a 25.4% higher rate of adverse events—including falls, central line-associated blood stream infections, and surgical site infections—than matched control hospitals.[30] Another analysis of 5.3 million Medicare claims over a 12-year period found significant increases in short-term mortality in PE-owned facilities that might be associated with operational changes, such as shifts in resources away from staffing.[31]

PE-owned health care entities have also been involved in numerous instances of billing fraud.[9] One study of PE-owned physician practices found higher costs, overutilization of many services, upcoding in billing, and constraints on physician autonomy, along with compromised patient care.[32] The cost of such practices to government programs such as Medicare and Medicaid can be substantial.[27]

Legal Responses

The negative consequences of PE health care acquisitions have led to increasing attention from government regulators and legislators. In terms of regulatory enforcement, attention has focused on 3 main areas.[9] The first is violations of antitrust laws related to the effects of PE acquisitions in reducing competition and raising prices.

The second is violations of safety standards by hospitals and nursing homes, which have followed investigations by state regulators. The third is fraudulent billing practices under Medicare and Medicaid, resulting in prosecutions for fraud by federal and state enforcement agencies. Rising concern over PE acquisitions has also led 3 federal agencies—the Federal Trade Commission (FTC), the Department of Justice's Antitrust Division, and the Department of Health and Human Services—to jointly request information about health care dealmaking more broadly.[33] In terms of attention from legislators, some members of Congress have expressed concern that PE health care acquisitions violate antitrust laws, leading to support for legislation that would increase oversight.[34] In addition, several states have enacted laws to curtail PE health care acquisitions, and more are likely to follow.[35]

Actions such as these may be having an effect. Over the past 3 years, total PE health care acquisitions have begun to slow, from a high of 1204 in 2021 to 866 in 2023.[36] At the same time, continued enforcement against abusive practices has encountered significant obstacles.[37] Most notably, regulators face the task of disentangling the complex and opaque structure of PE corporate arrangements to determine responsibility for specific abuses.[38] PE funds are also often able to avoid reporting requirements of transactions to the FTC and other agencies because of the private structure of the acquisitions.[38] Moreover, while there is growing enforcement activity focused on economic issues, such as increased market concentration and higher prices, less has centered on patient care concerns.[29] Yet lapses in quality of care are arguably the most consequential negative outcome that PE acquisitions can produce.

Reform

To address these enforcement challenges, 3 kinds of reforms would be especially helpful. The first would mandate greater transparency by PE firms in ownership arrangements and corporate structure.[2] This requirement would include more extensive reporting to the FTC and state regulatory authorities before transactions are finalized and lowering of financial thresholds for required reporting.[5] The FTC could use this authority to scrutinize transactions more carefully for potential anticompetitive effects, which is a particular concern in acquisitions of physician practices.[13] However, state agencies may have more leeway than the FTC in this regard as a result of the Supreme Court's 2024 ruling in *Loper Bright Enterprises v Raimondo*, which denied federal agencies the decades-old deference that courts had applied in considering challenges to their regulatory initiatives.[39]

A second reform would tie Medicaid reimbursement, the mainstay of financing for most long-term care facilities and many hospitals, more closely to spending on direct care.[40] Allowing reimbursement for ancillary expenses, such as rent and management, to be provided by affiliated entities incentivizes PE-acquired entities to divert spending to such nonclinical functions. The third would enhance the powers of state regulators, who have primary responsibility for patient safety, to monitor quality of care more closely in acquired providers.[36] This is a special concern for nursing homes, in which cost-cutting measures such as reduced staffing levels can have catastrophic consequences.[40] Such enhanced powers could include authority to conduct more frequent inspections, to impose larger fines for substandard care, to issue guidelines on the use of midlevel and unlicensed clinicians, and to implement more comprehensive recordkeeping, along with more resources to implement these measures.

Conclusion

PE ownership of health care entities relies on a model that seeks to maximize short-term profits at the expense of long-term business sustainability. Among its main elements is the vesting of control of acquired providers in investors with little knowledge of or interest in health care. This arrangement produces a corporate structure that may be ill-suited to maintaining a high level of quality in an industry responsible for the lives and health of almost everyone at one time or another. Those charged with protecting the public's health and safety should have the strongest possible arsenal of legal tools to respond.

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