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Health Inequity Profiteering by Private Equity Firms

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Abstract

This article explains how some investment practices of private equity (PE) firms generate profit by taking advantage of inequitably underserved patients in the US health care system. In particular, patients with general medical or mental health needs who seek care at safety-net hospitals or in carceral facilities and patients seeking mental health services are vulnerable to the following PE strategies: purchasing low-quality practices where patients lack opportunities to get care elsewhere, maximizing consolidation of deeply fragmented health service delivery systems, and avoiding accountability for poor-quality service that results from regulatory opacity. For each problem area, the article offers a policy response to mitigate harm to patients.

Extracting Increased Profit Margin From Vulnerability

Private equity (PE) firms utilize capital from private sources like institutions and individuals to acquire assets, usually with the goal of significantly increasing the value of the asset over a short time period.[1] PE investment in health care has grown substantially over the past 20 years. The number of buyouts of physician practices increased 6-fold between 2012 and 2021.[2] In 2022 alone, over 850 health-care related PE deals occurred.[3] Traditionally, many of these deals occurred in high-reimbursement specialties.[2] However, PE's investments have increasingly extended to practices that care for patients who are particularly vulnerable due to the nature of their illness or structural inequity in the health care system. Through these investments, PE firms are identifying specific methods by which to profit from this vulnerability—with little evidence of improved care.[4,5,6] Here, we will focus on why PE investments in health care are ethically troubling when PE firms target specific groups of vulnerable patients. To illuminate this argument, we focus on the following cases—safety-net hospitals, prison health care, and behavioral health—although the argument can be extended to other health care settings or sectors serving vulnerable populations.

Ethics Trouble

While for-profit companies have long invested in health care, 3 main features of PE—moral hazard, short-term horizon, and lack of disclosure—make investments in entities that care for vulnerable patients concerning because they allow profit to be reaped from bad behavior rather than fair competition, with no accountability mechanisms in place. First, PE firms acquiring companies through leveraged buyouts results in a classic

problem of moral hazard, wherein the general partner entity is protected from negative consequences of its management decisions but stands to gain from high rates of return because leveraged buyouts are largely funded by debt, with the general partner entity putting up as little as 1% to 2% of equity but receiving as much as 20% of the returns.[7] Second, because PE firms promise investors a high return in a short time period, most PE-backed firms are expected to sell companies within 5 to 7 years of acquisition, which creates an incentive to boost profits quickly rather than focus on long-term, sustainable investments.[7] Third, because there are no consistent regulatory requirements for PE firms to disclose details of their acquisitions,[8] the management practices of PE-acquired health care companies and the practices of PE firms remain opaque, with the result that it is extremely difficult for policy makers or patients to hold PE firms accountable. Rarely do patients know if they are receiving care from a PE-backed provider. As such, if problems do occur, the patient blames the hospital, for example, but not the PE firm that acquired it. As described below, the combining of these features with the structural features of vulnerability highlights PE's bad behavior in pursuit of profit without—or with delayed—accountability.

Exploitation of Lack of Choice

A core principle on which markets rest is choice of provider of a good or service.[9] However, vulnerable populations, particularly individuals who are incarcerated or mandated to receive rehabilitative services, frequently do not have choice or even the ability to advocate concerns about where they receive health care services. Because these patients lack political power, there are few powerful countervailing voices when PE causes harm.

PE firms have invested heavily in prison health care and the "troubled teen industry" that provides behavioral health care to adolescents with significant needs.[10,11,12] Two of the largest companies that provide prison health care across many states are both PE owned. In 2017, these 2 companies were projected to make $2.5 billion in profit.[13] These profits came largely through capitated payments from local governments to provide health care within prisons. As is often the case for stigmatized populations with little political power, most states failed to oversee or monitor the publicly funded care provided to these groups.[14,15] This fact, alongside patients' lack of choice in the care received, allowed PE companies to cut costs significantly, boosting profits. A *CNN* investigation in 2019 found that the focus on "cost containment" of one company that provides prison health care led to the deaths of patients within its care.[16] An analysis by *The Nation* revealed that lowering clinician-to-patient ratios within prisons was a major cost-cutting practice. For example, another prison health care provider only employed 15 physicians for a contract covering 25 000 prisoners in Alabama.[17] In the troubled teen industry, one large provider was controlled by different private equity firms from 1998 to 2015. During this time, state regulatory agencies in Oregon and California shut down or reprimanded the provider's facilities over concerns about safety and quality, including incidents that led to the deaths of children in their custody.[12]

While prison health and the troubled teen industry are extreme examples, PE firms take advantage of similar dynamics in nursing home and hospice care. PE-backed nursing homes have reduced clinician-to-patient ratios, which contributes to the higher-than-average mortality rates among these vulnerable institutionalized patients with restricted autonomy in choosing or changing clinicians.[5] After findings demonstrated lower nurse staffing, declining compliance with quality measures, and higher mortality rates in PE-backed nursing homes came to light,[5,18] President Biden passed an executive order

directing the Centers for Medicare and Medicaid Services to write new staffing rules to increase quality of care and protect safety.[19] One new rule, passed in April 2024, is a 24/7 onsite registered nurse requirement for nursing homes.[20] Although staffing regulations are an important way to hold nursing homes accountable, it is noteworthy that the regulations come after many years of abuse and do not target PE behavior or extend to other sectors with significant PE investments. As such, policy makers should proactively consider care quality and labor regulations that target PE behavior in clinical settings where patients have limited or no options instead of waiting many years for abuse to surface. On PE's role in prison health, it might be helpful to follow New York City's lead in eliminating contracts with PE-owned health care providers for correctional health services and instead providing care through a public benefit corporation to reduce the profit motive and lack of accountability.[21]

Exploitation of Fragmentation for Monopoly Power

A common PE investment strategy is to target vulnerable health care sectors characterized as fragmented and undercapitalized. The substance use disorder (SUD) treatment system was historically operated primarily by small treatment provider organizations that received funding through government block grants.[22] When the Affordable Care Act of 2010 required Medicaid programs to cover SUD benefits, these small treatment centers needed capital to invest in the electronic records and billing systems necessary to submit claims to state Medicaid programs and Medicaid managed care organizations.[22] This need for capital created an opportunity for PE firms to acquire small SUD provider organizations through a process referred to as a "roll-up," which provides economies of scale by consolidating administrative and infrastructure costs. Such roll-ups are a win for PE firms because they are assured consistent Medicaid reimbursement while keeping costs down. PE investment also seems like a win for SUD treatment providers because they receive needed capital with the promise of improved patient care.[23] Although an apparent win-win, especially for a sector that has long suffered from lack of investment, the roll-up process over time has contributed to massive consolidation in the behavioral health care sector (and more broadly in the US health care system).[24] Numerous studies concur that higher health care prices is one of the main effects of consolidation.[25] In health sectors serving vulnerable patients, such as behavioral health, monopoly power is also associated with troubling patient care practices. PE acquisitions of opioid treatment programs (OTPs), largely stand-alone clinics known as methadone clinics, provide a telling example. Methadone is one of the most effective medications for opioid use disorder. It is tightly regulated and can only be dispensed through OTPs.[26] A 2020 study found that for-profit methadone clinics were more likely to underdose patients compared to nonprofit providers.[27] Today, 65% of methadone clinics are for profit, a dramatic rise in the last 20 years that is tied to increasing investment by PE firms.[4,24] These firms own 30% of methadone clinics nationally, and every clinic in certain states—providing one firm with a statewide monopoly.[4]

PE-backed OTPs fight to maintain required onsite dosing of the medication, which pays 5 times more on a weekly basis for opioid use treatment than the cost of the medication itself.[4] The funding for onsite dosing is intended to be spent on drug testing and counseling, which, in conjunction with methadone, have mixed evidence of effectiveness.[4] These additional services are not required for dispensing of methadone in other countries, such as the United Kingdom, Australia, and Canada, where general practitioners and pharmacists can prescribe and dispense the drug.[28] The high costs associated with this approach have led addiction treatment providers to call for a

reexamination of these policies to make treatment more affordable and accessible.[28] However, PE firms have collaborated to retain or form lobbying groups aimed at maintaining the status quo, opposing legislation aimed at allowing take-home prescriptions.[4] This example demonstrates how PE's monopoly power translates into political power, which can be used to advocate for the continuation of flawed clinical practices.

Policy solutions to address roll-ups and private equity-generated monopolies may already exist through antitrust regulations; federal investigations now target roll-ups for possible anti-competitive behavior. In 2023, the Federal Trade Commission (FTC) began a lawsuit against a an anesthesia group and the private equity firm that created it, alleging that they engaged in rolling-up a significant portion of anesthesia practices in a particular state to "drive up the price of anesthesia services provided … and boost their own profits."[29] For this approach to be effective, however, the FTC needs more capacity to take on very large firms with deep pockets that can lawyer up and stall FTC legal procedures, often for many years.

Exploitation of Regulatory Opacity

Through opaque, purely financial dealings, PE firms can profit from vulnerability. Until recently, PE firms have largely been able to shroud their ownership influence,[30] which allows them to avoid blame when problems emerge. Moreover, due to vulnerable patients' lack of political power, PE firms' opaque financial dealings can go unexamined until it is too late. For example, one academic center serving a primarily low-income community was purchased by a PE firm that ran the hospital in partnership with another PE firm that owned the real estate. The hospital subsequently went bankrupt, but the investors were able to sell the real estate.[31] While it is unclear whether or how much profit was made due to the lack of disclosure, it is clear from reporting after the closure that, while patients were transferred to new hospitals—often with severely fragmented care—the financial actors involved in the deal have recouped their losses.[32] This set of occurrences is not unique: similar events have played out at other vulnerable hospitals, such as a multi-hospital system from which investors garnered nearly $700 million in profits through dividend recapitalization, among other financial mechanisms.[33] In this instance, the diversion of profits did not attract major attention from state regulators until a decade after purchase, at which point the already poor financial state of the system resulted in reductions in services, laying off of workers, and sale of hospital real estate around the country.[33] This lack of oversight was likely worsened by the limited political power of the uninsured patients with low income that the system's hospitals primarily served.

The harm caused by the opaque financial dealings of private equity can hopefully be prevented or mitigated through increased requirements for transparency. California is currently considering a bill to require health care transactions by PE firms to be disclosed in advance, which would be an important first step.[34] However, transparency must also be tied to clear processes for oversight that identify when regulators should step in. Furthermore, to protect vulnerable patients' access to health care, government should consider ways to invest capital in needed community resources like safety-net hospitals, which may not be able to otherwise access it. While PE did not create inequities in the US health care system, allowing unregulated private investments to target distressed safety-net systems has accelerated these trends. There is no evidence of true, positive disruption caused by PE investment. Instead, PE investment seems to focus on devising ways to derive profit from safety-net hospitals' struggle and failure.

Next Steps

Throughout this article, we have called for increased oversight and regulation of PE firms. Oversight can be effective: in the case of one hospital system, Rhode Island regulators made approval of the PE firm's sale of its stake contingent on the firm's putting $80 million in an escrow account to ensure that the firm's 2 Rhode Island hospitals remained open.[33] However, without improved transparency, it is difficult to systematically implement guardrails. At a federal level, there have been bills introduced that would reform the industry by improving transparency and requiring PE firms to take more responsibility for the financial health of their investments.[35] Improved transparency would also allow for more systematic study of the impact of PE, which could shed more light on the concerns we have raised.

It is important to recognize that PE is acting as an accelerant of existing failures baked into the structure of our fragmented, segregated, and inequitable health care system by more efficiently exploiting these failures for profit.[36] Because vulnerable populations face structural barriers to accessing care, clinicians and health care organizations should also consider advocating for the creation of a universal system of care, thus reducing the vulnerability of specific patient populations.

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