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How Should We Stop Private Equity Firms From Exploiting Public Health Insurance?

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Abstract

Private equity (PE) investments in health care have grown to over $750 billion in the past decade and include every segment of the US health sector. Although PE investments can provide capital and improve efficiency of health service delivery, PE's emphasis on short-term profitability could raise costs, diminish quality of care, and negatively influence clinician autonomy and career satisfaction. This article first canvasses what is currently known about how PE investments in physician practices influence clinician practice patterns and then proposes regulatory and legislative strategies for restricting harms of PE ownership of clinician practices and for fostering affordable and high-value health services.

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Practice Environment Changes

The environments in which health professionals practice and patients receive care continue to change. Over 3 quarters of physicians in the United States are now salaried employees of hospitals, health systems, or other corporate entities, including private equity (PE) firms, health insurers, and retail firms.[1] A long-standing literature has illustrated how variation in ownership structures of clinicians' practices—including chain ownership, hospital-affiliation, and PE ownership, among others—can affect service delivery.[2,3,4,5,6]

Despite rapid changes in the organization and ownership of physician practices, the role of physicians has largely remained the same: to maintain the patient-physician relationship, which has historically been based on the basic principle of trust. This trust demands that physicians act as agents on behalf of patients with a primary obligation to act in the patient's best interest. As major changes in physician ownership reverberate throughout the US health care system, there is growing concern that corporations employing physicians are not simply providing ancillary operational support but also exerting control over clinical decisions with the potential to challenge the trust that patients have historically placed in clinicians. A key symptom of this broader trend is the

remarkable increase in PE investments in health care focused on generating short-term returns for financial investors.[7] PE investment in health care has increased significantly over the past 2 decades, growing from $5 billion in 2000 to $100 billion by 2018.[7] While physician employment by large organizations is not problematic per se, targeted policy interventions and enhanced transparency can act as guardrails to mitigate the undesirable effects of PE investment on health care quality, access, and patient outcomes.

PE Investments in Physician Practices

Typically, PE firms purchase a majority ownership interest in health care providers, invest resources to drive operational efficiencies, expand market share, increase revenue (eg, by adding more profitable services),[8,9] decrease costs (eg, by changing staffing composition),[10] and then sell the practice within a few years to generate returns for the firm's investors. In recent years, PE investment has focused on physician practices, starting with hospital-based specialties, including anesthesia, emergency medicine, and radiology, and extending to office-based specialties such as dermatology, gastroenterology, ophthalmology, and, more recently, primary care, behavioral health, and cardiology.[11,12,13,14,15] After PE acquisition, physicians generally become salaried employees and might retain some minority ownership stake in the acquired practice, as PE firms want physicians to share in their growth objectives. PE firms grow acquired practices in part through "platform and add-on" consolidation that involves, first, acquiring "platform practices" that could be large, well-managed physician practices and, second, expanding market share through add-on acquisitions of smaller practices that are then merged with the larger platform practice.[16,17] Finally, to realize desired returns on investment, PE firms aim to exit investments by selling practices within 3 to 8 years.[18] PE firms might sell practices to another PE firm, the public via an initial public offering, health systems, or an insurance company, although most PE sales to date have been to other PE firms.[18]

PE firms' exit incentives and need to resell the acquired practice at a profit soon after acquisition can create incentives to change physician practices to make them more profitable. Studies of physician practices have shown that PE-owned practices can drive potential inappropriate use of medical and surgical procedures, ranging from laboratory tests to diagnostic imaging, and retinal drugs[8,9]; increase referrals to other physicians employed by the same multispecialty practice[5,19]; engage in surprise out-of-network and other billing practices[20,21,22] that can erode patient trust; and change the workforce composition of their practices to increase reliance on advanced practice clinicians.[10] Furthermore, PE firms might also limit populations served, such as Medicaid or Medicare patients, due to lower rates of reimbursement or higher complexity procedures.[23]

In theory, PE firms may improve the quality of care by facilitating operational efficiencies, facilitating investments in the use of technology, and providing administrative support for value-based care contracts.[16,24] However, empirical evidence of the effects of PE investment on quality of care, based on studies examining settings other than physician practices (eg, hospitals and nursing homes), is mixed.[25,26,27,28] A recent study of chain ownership of fertility clinics found that such chains can facilitate resource and knowledge transfers needed to enhance quality under certain regulatory conditions.[3] Taken together, these mixed results highlight the need for more targeted research on the effects of PE on quality of care, particularly in physician practices, for which evidence remains sparse. Importantly, the lack of systematic reporting and

disclosure requirements for PE acquisitions prevents our understanding of the exact nature of physician employment arrangements under PE firms, making it difficult to assess PE's true impact on patient outcomes.[29]

Policy Solutions

PE investments in physician practices can offer advantages such as financial stability, practice management assistance, and practice innovation.[3,16] However, studies increasingly show that this organizational setting can also bear powerfully on practice patterns. PE investments in physician practices echo concerns related to the double agent problem, wherein physicians try to be accountable to both their patients and their employers. In particular, PE's short-term financial incentives raise specific concerns about whether physicians' obligations to a firm might conflict with their obligations to patients in ways that undermine quality, access, and outcomes. While physician employment by large organizations is not problematic per se, targeted policy interventions to protect physician autonomy and enhance transparency of ownership can act as guardrails to safeguard patient interests.

Strengthen laws to protect professional autonomy. The "corporate practice of medicine" (CPOM) doctrine refers to state-specific regulations that prevent corporate entities from owning or exerting control over medical practices. Some state laws make exceptions for all or certain types of nonprofits, and others make no exceptions for nonprofits to own medical practices and employ physicians.[30] Nevertheless, CPOM restrictions have been largely unsuccessful at preventing corporate ownership of physician practices, as some of the states with the most stringent CPOM protections have seen a flurry of PE investments in recent years.[31] This growth is in part due to PE firms relying on a workaround, known as the "professional corporation-MSO," or "friendly professional corporation" model, which relies on management services organizations (MSOs) to exercise functional control over a physician practice.[32] States can strengthen CPOM laws by closing loopholes and directly regulating MSOs to allow medical professionals to maintain ultimate control over key clinical decisions.[31]

Enhance ownership transparency. Policy makers, researchers, and the public currently lack comprehensive data on who owns or controls physician practices, which are often acquired or controlled through complex corporate and contractual structures that obscure the identity of PE or corporate investors.[29] Providing a centralized national database to enhance transparency on practice ownership and control can allow patients, policy makers, researchers, and other stakeholders to understand the extent and effects of corporate ownership, including by PE firms. While steps have been taken to improve ownership transparency in certain settings like nursing homes,[33,34] significant gaps in comprehensive data on ownership structures hinder effective oversight and accountability measures. Greater transparency can beget greater trust.

Strengthen existing fraud and abuse laws. As Brown et al argue, PE firms' incentives "to rapidly increase the profitability of acquired practices raises risks of overutilization, overbilling or upcoding … and self-referrals for ancillary services."[11] Federal and state statutes, such as the 1972 Anti-Kickback Statute and the 1995 Physician Self-Referral (Stark) Law, "restrict compensation of physicians based on their referral behavior," including by banning explicit compensation arrangements that account for the volume or value of physician referrals.[19] Despite these legal and contractual restrictions, in practice violations could be difficult to detect if referral incentives are hidden within newly formed employment relationships or performance incentives. Increasing

enforcement under existing laws (including the False Claims Act, Anti-Kickback Statute, Stark Law, and state law counterparts) and tightening rules for self-referrals for ancillary services could mitigate incentives for potential overutilization and billing fraud.

Enforce antitrust laws. In addition to federal antitrust statutes, many states, including Connecticut, New York, and Oregon, have passed laws to increase scrutiny of health care transactions that fall below reporting thresholds and to improve antitrust monitoring.[35] As my colleagues and I have written elsewhere, "until recently, physician practice consolidation, in general and by PE firms in particular, had faced limited regulatory scrutiny by federal antitrust agencies."[18] Given the Federal Trade Commission and the Department of Justice newly revised Merger Guidelines,[36] examining the cumulative effects of platform and add-on consolidation by PE firms will be key areas for research and policy focus. However, these efforts should be accompanied by enhanced funding and resources for antitrust agencies' oversight of acquisitions most likely to reduce competition.

Reexamine restrictive contract clauses, including non-compete agreements. Non-compete agreements aim to balance the interests of the employer, who has invested in the physician's training, and the interests of the physician, who might leave the practice and seek alternate employment. In practice, non-compete agreements restrict physicians from practicing within a particular geographic region after leaving the practice, for a specific period of time. While data on non-compete agreements is limited due to non-disclosure agreements, anecdotal evidence suggests wide variation in the nature of physician non-compete agreements across ownership types, ranging from a 1-year, 35-mile noncompete agreement to a 2-year, 100-mile noncompete agreement.[37,38] These restrictions can disrupt patient-physician relationships, restrict access to care, and prevent physicians from notifying patients or transferring medical records if a physician leaves a practice. The Federal Trade Commission and several states have proposed or passed laws to restrict non-compete clauses in employment contracts.[39,40] Together, these protections would allow physicians to speak out or leave over ethical or professional concerns they encounter in practice.

Conclusion

Rapid growth of PE investments in physician practices highlights the long-standing tension between medicine as a profession and health care as a business, raising specific concerns about whether PE's short-term financial incentives affect clinical decision-making and the patient- physician relationship by eroding patient trust. By clinicians prioritizing patient interests and regulators enhancing transparency and accountability, in addition to implementing targeted regulatory interventions, clinicians and regulators can foster a high-value and equitable health system.

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