Episode: *Ethics Talk: Are Private Equity Investments Really Different From Other Ownership Structures in Health Care?*

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[mellow theme music]

[00:00:06] TIM HOFF: Welcome to *Ethics Talk*, the *American Medical Association Journal of Ethics* podcast on ethics in health and health care. I'm your host, Tim Hoff. Private equity continues to increase its holdings in the health sector in clinics, hospitals, physician practices, and, even now, residency program slots. Private equity interest in health care comes from multiple factors. There's low interest rates, which incentivize treatment; commercialization of health care makes profit seeking normatively acceptable to many people; and dramatic shortcomings in US health systems' performance relative to other countries provides room for those offering change. The trouble with private equity investment in health care is, according to a general consensus in the health policy literatures, that private equity involvement in health service marketplaces and delivery streams tends to drive up health care costs and diminish quality. This makes private equity an easy target for critics. But are private equity firms' practices in health care really that much different from other kinds of mergers and acquisitions in the health sector?

On this episode of *Ethics Talk*, we'll explore whether and to what extent private equity firms' increasing presence in health care deserves our scrutiny, and what policymakers, clinicians, and patients should know about responding to private equity ownership stakes in the organizations where they work and where they go for health services. Joining me to do that is Dr Robert Field, who holds a joint appointment as professor of law at the Kline School of Law and as professor of health management and policy at the Dornsife School of Public Health, both at Drexel University, where he is also faculty director for Drexel's Center for Law and Transformational Technology. Dr Field is also an adjunct fellow of the University of Pennsylvania's Leonard Davis Institute of Health Economics, and he is also the author of *Mother of Invention: How the Government Created Free-Market Health Care*. Dr Field, thank you so much for being here.

DR ROBERT FIELD: Thanks for having me. [music fades]

[00:02:12] HOFF: Let's start with the question that we just outlined in the introduction: What justifies the scrutiny of private equity firms' involvement in the health sector in particular, as opposed to other nominally similar business interests?

FIELD: Yeah, it is different in some fundamental ways, although all ownership structures for health care have resulted in abuses: raising prices, substandard care, neglect of indigent patients and so forth. But private equity is a beast unto itself in many ways. It's not publicly traded. Private equity is privately owned funds, so it's not accountable to Wall Street or to the Securities

and Exchange Commission or to state and other regulators. There are regulations, but not the way a publicly-traded firm would be in terms of mandated disclosures and investigations. They have been investigated, and there have been enforcement actions with regard to antitrust and anti-competitive behaviors. So, as they accumulate providers within a market, for instance, large shares of physician practices in a specialty or of long-term care facilities, for instance, in a market, that has attracted the attention of the Federal Trade Commission, Department of Justice, state regulators and so forth. It has more of a short-term focus than other ownership structures.

[00:03:50] If you look at them along a spectrum, non-profit hospitals, non-profit health care institutions generally, have a commitment to their community. They have boards that reflect their communities, and they're not likely to pick up and move to another city. For-profit chains have much less of a commitment to their communities, but they're in it for the long game. They want hospitals to do well, and they want to make money off of them. Private equity is private ownership, but most of those funds want to cash out in a shorter timeframe, often as little as five years. And so, they're not accountable to shareholders who might want their investments to last longer, and they're less accountable to the government. And they will do things like transferring valuable real estate to a separate entity, so that they can financially handcuff the facility itself. Cutting back on expenses like staffing, nurse staffing, even physician staffing so that they can load up assets into another subsidiary. And then if the basic facility goes bankrupt, they can let it go, sever the ties, and then allow the other subsidiary to cash in on all of the assets it's acquired that it stripped from the original facility. Not all private equity funds do that, but many of them do. And that's different from the way other health care entities do business.

[00:05:43] HOFF: You mentioned that PE firms are not accountable to the SEC, among other regulators. Can you briefly clarify the scope of regulations to which PE-owned facilities are subject?

FIELD: There are certainly investigations by state and federal regulators. The issue is the transparency on the financial side. We recently saw controversy over Steward Health Care, a chain, national chain based in Massachusetts. And the state felt it was blindsided because the company was not reporting financial information. And in fact, Massachusetts recently passed legislation to increase reporting requirements. Yeah. So while there's less regulation and less scrutiny on securities issues and ownership issues, there's absolutely scrutiny and enforcement in terms of billing fraud, patient care, and so forth.

[00:06:38] HOFF: I see, I see. Yeah. And one of the tools used to prosecute those kinds of fraud and abuses is the False Claims Act, which was passed in the 1860s and is used with renewed urgency today to prosecute some private equity firms' acquisitions and fiscal practices in the health sector. So can you please help our listeners understand a couple of examples in which the federal fraud investigators have used the False Claims Act to address PE practices?

FIELD: Yeah. So, some of the billing practices against which there's been enforcement—there's also been enforcement against non-profit and traditional for-profit facilities—but there seems to be more of a concentration of enforcement or violations when private equity's involved. You see instances of upcoding where a service will be billed at a level of higher intensity than it actually was rendered; incentives for referrals, both overt and covert; incentives to reduce the amount of care in the interest of cutting costs; some cases of billing for services not rendered; and states

have been involved when Medicaid is involved since that's a state-administered program and heavily reliant on state funding. So those are all violations that have been investigated and have been prosecuted, particularly with regard to private equity-owned firms.

[00:08:22] HOFF: Can you offer an example or two—and you've sort of touched on it, mentioning the Steward Health Care issue in Massachusetts—of how private equity firms manage to make money off the backs of patients who are poor or vulnerable without necessarily tripping the radar of federal oversight or ways that they are perhaps creatively getting around [chuckles] federal oversight?

FIELD: Right. Well, I live in Philadelphia, and one of the biggest examples is Hahnemann Hospital. It now goes back to 2017, 2018. It had been acquired around the year 2000 by a national chain, Tenet Healthcare. They were losing money and sold it to a private equity firm, which began transferring out assets and eventually closed the hospital. And it was seen by many as an attempt to isolate the real estate, which is right near the center of Philadelphia, very valuable, and be able to make money off of that rather than the hospital, which was losing money. That was halted by a public outcry. It wasn't really legal proceedings. But that hospital is at the northern end of downtown Philadelphia, near North Philadelphia, which is one of the poorest areas in the city. And it served as a provider for many of the residents of that area, particularly its emergency room. And many of the smaller hospitals in North Philadelphia had closed in recent years because of financial pressures, so it left people without a relatively convenient source of emergency care. The slack was taken up by Jefferson Hospital, which is another mile, mile and a half away. But that was an instance where the private equity business model put indigent patients from a low, very low-income area at risk.

[00:10:37] HOFF: As you mentioned in that response, public outcry can draw attention to these practices and perhaps stem some of them. But patients could easily be getting services from a private equity-owned health care facility without knowing it, or if they do, as you noted, not really having any other options.

FIELD: Right.

HOFF: So if PE ownership of an organization compromises patients' health outcomes, it seems like they should know or at least should be able to find out that information. What and whom should they ask about this? Which questions might you suggest that a smart, aware patient should be asking?

FIELD: Right. Well, it is a challenge for patients because that information is not often publicly available. If you are simply going to a for-profit hospital as opposed to a non-profit hospital, even that information may be hard to find without going into the financial filings or corporate structure. A lot of hospitals whose names suggest religious affiliations are former religious hospitals that've been bought by for-profits. The clearest clue would be to look at their website. Is it .com or .org? You see a lot of religiously-named hospitals that are .com, which means that they're not non-profits. But if it's got a .com in its URL that still doesn't tell you if it's a traditional, publicly-owned for-profit or if it's a private equity. That's really tough. Even calling the hospital, the employees who you contacted might not be able to say or might not even know. It might be easier with a physician practice where a private equity fund has acquired many of the

practices in a specialty in your area. The personnel are more likely to know who the owners are, but you'd have to be assertive in finding out. And there's so many things that you want to know when you're using a new doctor. You want to know about their track record, their reputation, their fee schedule, to also ask about the intricacies of their ownership would require some sophistication.

[00:13:09] One of the areas where private equity has been particularly aggressive in acquisitions has been emergency room staffing. And patients often find that they've gone to the ER and received a bill, and it's an out-of-network provider because the private equity firm has not joined networks to the same extent that the hospital or other health care entities have. If it's an emergency, there's not much you can do. You can, after the fact, negotiate with the insurer and the provider. You may or may not be successful. You can look beforehand at the kind of arrangements that the local hospitals have, so you know where you want to get taken if you have a choice in an emergency. That's an example where patients at all income levels are vulnerable.

[00:14:10] HOFF: Mm-hmm. You mentioned that some employees might not know or also might not be able to say. Is that something that private equity firms put in place, sort of NDAs—or I don't know exactly what the legal mechanism would be—to prevent employees from talking about the ownership structure?

FIELD: No, they're more likely to use NDAs for higher-ranking corporate officials or maybe actual providers. No, but it's getting down into the weeds for most people, and they're not going to advertise their ownership structure. So I think it's more a question of the employees are not sure or don't really understand it than there being a specific legal document that closes their mouths.

[00:14:57] HOFF: Mm-hmm, mm-hmm. One of the articles in this month's issue of the Journal explores how residency training programs now have slots owned by private equity firms. This means that some PE firms are investing in health professions education, which can influence the goals of health professions training in ways that might ultimately undermine trainees' educations.

FIELD: Right.

HOFF: So, what should residency programs' applicants ask about private equity-owned residency slots? Assuming that there is anything to ask, and it's not quite as difficult as a patient coming to these places.

FIELD: Right. Well, there I think the inquiry would be easier. The medical students are likely to be more sophisticated consumers than the average patient. I think they could ask the different programs or certainly check out their websites to see whether any of the slots are owned privately and what the implications of that would be. They would still presumably be getting the same training, so it might not affect them as directly as it would affect the hospital. But I would certainly want to know if my future professional training was in the hands of someone with a direct financial interest.

[00:16:14] HOFF: Mm-hmm. You say they would presumably be getting the same training. Do we know anything about training outcome from PE-owned firms versus non or anything like

that? I can imagine cuts to faculty or to employees in general might, like we say, compromise these educations. Is there any literature on that that you're aware of?

FIELD: I am not aware of any research on that, and it is relatively new. I think that the interest of private equity in residencies is to get the difference between the salaries that residents are paid and the amount that Medicare pays, and realizing that margin. Once those slots exist, they're subject to oversight by professional bodies and by CMS and so forth. But there's a big margin between the salary and the payment, and a lot of teaching hospitals rely on that for financial stability. So I think that's really what they're looking at rather than skimping on the actual training.

[00:17:29] HOFF: Sure. Yeah, that makes sense. What are some of the most important things health professions societies should do to advocate the interests of their member clinicians—like the AMA, for example—working in health systems in which some of the business units have been sold to private equity firms?

FIELD: Right. I think the most important element, which is the same as what lawyers and regulators have been calling for, is transparency. So, you were asking, how could a patient find out about the ownership of a facility? How could a medical student find out about the ownership of a residency program or slot? It's very difficult. Many of the private equity ownership structures are extremely complex. Even financial people have trouble parsing what's going on and who's responsible for what. I mentioned previously the practice of stripping the real estate from the facility to a separate subsidiary, then leaving the facility itself quite vulnerable to financial pressures, but the structures get much more complicated than that.

The new law in Massachusetts I mentioned aims at greater transparency and more disclosure to state regulators. There was a federal task force that the Department of Justice and the Federal Trade Commission put together looking into issues of private equity ownership and particularly transparency. I'm not sure what we're going to get from Congress in the next few years, but certainly on the state level, we might get more laws like what we see in Massachusetts. I think from the professional perspective, that's the most important element, and that would be the clearest starting point, so that at least everyone knows who owns the entity and what their financial incentives are. And perhaps those with the expertise could then parse the corporate structures and then evaluate whether this ownership structure could have negative effects. Or perhaps some private equity investments are actually advantageous, actually pump funding into needy organizations. But you're not going to know that if you don't know that it is private equity that's involved, and you know the corporate structure and the financial incentives.

[00:20:09] HOFF: A couple follow-up questions. You mentioned who knows what might come out of Congress in the next couple years. Is there anything that our listeners should be aware of that is in the works, something that might be on the table that just requires further negotiation? Anything you think that they should know about as far as federal legislation goes?

FIELD: I'm not aware of anything that's pending. I think a lot will depend on the new leadership of Department of Justice and the Federal Trade Commission and whether they wanted to continue the inquiry into private equity in health care. Given the deregulatory emphasis of the incoming administration, it doesn't seem likely. But there's a lot of constituents out there of

politicians who care about this, who've been reading about it, so it's possible that they will continue that effort. And I think if they do, that could produce information, disclosures that would prod Congress. [theme music returns]

[00:21:16] HOFF: Dr Field, thank you so much for your time on the podcast today.

FIELD: Thank you.

HOFF: That's all for this episode of *Ethics Talk*. Thanks to Dr Field for being here. Music was by the Blue Dot Sessions. To read the full issue on Private Equity in Health Care for free, visit our site, journalofethics.org. Find us on Bluesky @amajournalofethics, and we'll be back next month with an episode on Embodiment in Arts Practice. Talk to you then.