Recent Policy and Regulatory Initiatives to Address Private Equity's Negative Impacts in Healthcare

By Mary Bugbee, Michael Fenne, and Chris Noble
Contact: mary.bugbee@pestakeholder.org

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PRIVATE EQUITY
STAKEHOLDER
PROJECT

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INTRODUCTION

In response to a growing body of evidence of private equity's negative impacts in the US healthcare system, policymakers and regulators have increased their scrutiny of the private equity industry. The Biden-Harris administration has initiated multiple efforts to address private equity's role in healthcare, and many federal- and state-level legislators and regulators have demonstrated a strong appetite to do so as well.

In 2023 and 2024, multiple states proposed or passed new legislation enhancing oversight of healthcare acquisitions and mergers; two new bills were introduced at the federal level targeting private equity in healthcare; multiple federal agencies have tasked themselves with gathering robust information on the impacts of private equity in healthcare and the broader economy; and congressional committees have launched investigations and hosted hearings about private equity's impacts in healthcare. State attorneys general working with the Department of Justice have also worked to hold private equity-owned healthcare companies accountable for Medicaid and Medicare fraud.

There have been significant positive developments in bringing greater transparency, oversight, and accountability to private equity in healthcare. However, the polarized political landscape has taken the prospect of winning strong, bipartisan legislation at the federal level off the table—at least for now. Additionally, many states, including ones that have been impacted by private equity's abuses in their healthcare system, were unable to get meaningful state legislation across the finish line in their recent legislative sessions.

And in June 2024, the Supreme Court overturned the "*Chevron* deference" standard, a 40-year old standard for decision-making in which federal courts deferred to federal agencies for interpreting statutes. The overturning of *Chevron* will greatly weaken the ability of federal agencies to engage in rulemaking and regulation of the industries they are tasked with regulating, including healthcare.[1] The incoming Trump administration also poses significant challenges to private equity regulation, as weakening the administrative state and deregulating the corporate sector appear to be among its top priorities.[2] There are also likely key agency appointments that will be filled by individuals who are hostile to corporate regulation.[3]

Meanwhile, the private equity industry is ramping up a campaign to shift the narrative in its favor, publishing misleading reports[4] and lobbying lawmakers in an attempt to water down or toss out legislation that would bring greater oversight to the industry and its activities in the healthcare system.[5]

The goal of this report is to highlight and analyze recent developments involving the US policy and regulatory landscape around private equity in healthcare, as well as provide policy recommendations based on the Private Equity Stakeholder Project's (PESP) and other groups' research. Before diving into this analysis, it is important to contextualize why policy change is needed in the first place.

Why policy change is needed to address private equity in healthcare

Despite spending more on healthcare than any other high-income countries, the United States has

some of the worst health outcomes.[6] According to the Commonwealth Fund,

- The U.S. has the lowest life expectancy at birth, the highest death rates for avoidable or treatable conditions, the highest maternal and infant mortality, and among the highest suicide rates.
- The U.S. has the highest rate of people with multiple chronic conditions and an obesity rate nearly twice the average of Organization for Economic Co-operation and Development (OECD) member countries.
- Americans see physicians less often than people in most other countries and have among the lowest rate of practicing physicians and hospital beds per 1,000 population.[7]

The US healthcare system is comprised of a patchwork of industries (e.g. pharmaceutical companies, insurance companies, hospitals, and outpatient providers) that are all trying to make a profit. Patients are caught in the crosshairs as these industries vie for a bigger piece of the pie, and are inherently deprioritized as healthcare businesses put profit first.

The financialization of healthcare in the United States is a multi-faceted issue that cannot be pinned on private equity alone. However, private equity business strategies are an amplification of the typical profit-seeking strategies seen in healthcare, and are having outsized impacts on the healthcare system.

Despite the private equity industry's assertions that it helps improve healthcare,[8] there is sparse evidence to support this claim.[9] Meanwhile, there is a growing body of evidence demonstrating private equity's harms in healthcare.

Adverse events at hospitals, specifically patient falls and hospital-acquired infections, have been shown to increase at hospitals following a private equity buyout.[10] Other research has found that the patient mortality rate is higher at nursing homes owned by private equity firms as compared to other ownership types.[11] Numerous studies have concluded that private equity has had a role in driving up healthcare costs for patients and payers.[12] For patients who cannot afford these growing costs, private equity-owned companies have created healthcare debt through medical credit cards, installment loans, and other payment products – this debt may later be collected by an aggressive debt collector owned by private equity.[13]

Due in part to private equity's tendency to burden portfolio companies with debt, healthcare providers owned by private equity have increased bankruptcy risk. Bankruptcies can lead to layoffs and the disruption of critical healthcare services, which can burden other healthcare providers who must address gaps left by closures.[14]

Recent bankruptcies and financial distress at private equity-owned and formerly private equity-owned companies have resulted in the closures of hospitals and providers, layoffs of healthcare workers, and limited access to care for the communities these businesses served.[15]

It is imperative for policymakers and regulators to update laws and regulations in order to curtail private equity's business practices that harm patients and erode access to quality and affordable healthcare in the United States.

This report will highlight recent state legislative efforts to address private equity in healthcare; will discuss the legislative, regulatory, and investigatory efforts happening at the federal level; will examine federal and state enforcement actions of already-existing laws; and will close with forward-looking policy recommendations that could address private equity's negative impacts in healthcare.[16]

STATE LEGISLATIVE PROPOSALS

Illinois, Indiana, New Mexico, and New York state legislatures have all recently passed legislation that expands oversight of private equity entities in healthcare. Attempts in California, Connecticut, Massachusetts, Minnesota, Oregon, and Pennsylvania to pass legislation addressing private equity in healthcare failed or were tabled during their 2024 legislative sessions and will have to be taken up again next year.

Successful bills

Illinois

Last August, Illinois Governor JB Pritzker signed **House Bill (HB) 2222** into law, legislation designed to enhance state Attorney General oversight of mergers and acquisitions among healthcare entities. This legislation is an important step forward for Illinois to more effectively regulate healthcare transactions that could have the potential to negatively impact communities, patients, and workers.

HB 2222, which was sponsored by 22 Illinois state representatives and 9 state senators,[17] amends the Illinois Antitrust Act, the Illinois Health Facilities Planning Act, and the State Finance Act.[18] The new law requires that healthcare entities provide notice to the AG of any mergers or acquisition activity 30 days prior to the closing or transaction effective date.[19]

The law also empowers the AG to request additional information related to the transaction. Under the law, "If the Attorney General requests additional information, the covered transaction may not proceed until 30 days after the parties have

substantially complied with the request." Healthcare entities in violation of these provisions can face a civil penalty of up to a $500 per day until they are back in compliance.[20]

While the new law does not grant the AG power to halt a transaction based on information it receives related to the transaction, it does allow the AG to enforce compliance with the law via civil penalties as well as court action.[21] According to the AG's office, the new law will "better equip the Attorney General's office with information necessary to determine whether a proposed transaction warrants an investigation and, when necessary, a challenge for anticompetitive conduct that could substantially lessen competition or harm the public or employees."[22]

The AG's enhanced powers come on the heels of **recent controversies** involving investor-owned hospitals in Illinois. Pipeline Health, owned by investment firms Deerfield Management, Davidson Kempner Capital Management, and Stanton Road Capital, acquired three Chicago-area safety net hospitals in 2019. Despite assuring regulators that it would keep the hospitals open for at least two years following the acquisition, Pipeline promptly moved to close Westlake Hospital in Melrose Park. Community outcry[23] and legal challenges ensued,[24, 25] but Pipeline was ultimately able to close the hospital by having it declare Chapter 7 bankruptcy.[26]

During Westlake Hospital's bankruptcy proceedings, it came out that closing and selling Westlake had been a condition of Pipeline's purchase agreement with Tenet Healthcare, a critical detail that Pipeline had failed to disclose to regulators.[27]

Illinois' new legislation went into effect in January 2024. It has the potential to shine a brighter light on mergers and acquisitions among healthcare entities in the state. Overall, it is a step toward more effectively regulating healthcare mergers and acquisitions. However, the AG will not have the power to halt a transaction –only to request more information and postpone a transaction if the relevant entities are noncompliant with the law.

Indiana

In March 2024, an Indiana bill titled "Reporting of Health Care Entity Mergers and Acquisitions" was signed into law, which went into effect July 2024. Law firm Holland & Knight reports that the law "appears to be one of the broadest state healthcare transaction review laws enacted to date."[28] The new law requires various healthcare entities to provide 90 days' notice to the state Attorney General for a broad array of healthcare transactions, including both asset and equity transactions, as well as direct and indirect changes in control.[29]

The threshold triggering review is not related to the size of the transaction, but rather the total assets of the transacting healthcare entities being $10 million or higher. According to Bloomberg Law's analysis of the new law, it "doesn't appear to require approval by the attorney general, it does give the attorney general 45-days after the required notice has been submitted to review the information. During that period, the attorney general may analyze antitrust concerns, and issue a civil investigative demand requesting additional information from the entity that has submitted notice."[30]

According to WSJ, Indiana is the first red state to enact a private equity merger review law.[31] Market consolidation in Indiana's healthcare was a driving force behind the legislation. The bill's author, Representative Chris Garten told the *Indianapolis Business Journal*, "As a conservative, I want to see a thriving, competitive market that drives down health care prices through consumer choices. Today, Indiana is increasingly far from that goal because market consolidation in the state's health care space has gone unchecked for years."[32]

New Mexico

In New Mexico, lawmakers passed a temporary bill (**[Senate Bill 15]**) that the NM governor signed into law on March 1, 2024, that gives the NM Office of Superintendent of Insurance (OSI) oversight power over hospital mergers, acquisitions, and changes of ownership.[33] Some legislators were wary of passing legislation they feared would deter investment in their state health system, and so they opted to pass this temporary bill that expires in July 2025.[34]

In the meantime, lawmakers are working on drafting more comprehensive legislation by gathering community input and learning from other states. Their goal is to pass an updated bill in 2025's two-month legislative session.[35] During the summer of 2024, the OSI held 24 public meetings for various stakeholder groups to provide feedback and comment on the legislation.[36]

According to the Private Equity Risk Index, New Mexico is among the top 10 states for both the share of hospitals (24.4%) and the share of nursing homes (35.3%) controlled by private equity.[37] In June 2024, a Lifepoint hospital in Las Cruces, NM was exposed in an *NBC News* investigation for denying care to cancer patients or requiring up-front payments. Lifepoint is owned by private equity firm Apollo Global Management.[38] The following month, the state Attorney General launched an investigation into the hospital.[39]

New Mexico's Senate Bill 15 presents a unique example of a state moving to act quickly to address private equity in its health system by passing a temporary measure, while buying time to gather more information in order to draft robust legislation.

New York

Last year, **New York enacted a new law** that targets private equity-backed physician practices. The new law requires 30 days advance notice given to the New York State Department of Health prior to the close of a material transaction involving physician practices, management services organization (MSO) or similar entity that provides all or substantially all administrative or management services under contract with at least one physician practice, provider-sponsored organization, a health insurance plan, or any other kind of healthcare facility, organization, or plan that provides healthcare services in New York.[40]

Material transactions under the law are defined as those that would increase a healthcare entity's total gross in-state revenues by $25 million or more, and includes mergers, acquisitions, affiliation agreements, and joint ventures.[41]

The original version of the bill would have afforded the Department of Health approval power over such transactions based on potential impact on cost, quality, access, health equity and competition in the healthcare service market.[42] The final version of the law is a watered down version that will be step forward in increasing transparency around private equity-sponsored healthcare transactions, but provide little in the form of enhancing state regulatory powers to intervene in such transactions.

Failed and tabled state bills

California

Assembly Bill 3129, intended to strengthen state oversight of private equity abuses in healthcare, was **first introduced in February 2024** by California Attorney General Rob Bonta and Assembly Speaker pro Tempore Jim Wood (D-Healdsburg).It ultimately passed both the General Assembly and state Senate, but was vetoed by Governor Newsom in September 2024.[43]

In announcing the new bill, AB 3129, **AG Bonta wrote**:

> "At the California Department of Justice, we believe that the healthcare system should serve patients. Yet, too often, private equity has served corporate profiteers by maximizing their profits at the expense of access, quality, and affordability of healthcare for Californians. Today's legislation not only curtails harmful transactions but also stops practices that undermine the practice of medicine."

California has had its share of problems with private equity healthcare investments. Prospect Medical Holdings owns seven acute care and behavioral health hospitals in southern California. Pipeline Health also owns hospitals in southern California.

And the problems extend beyond hospitals – private equity-owned healthcare companies across the state have come under fire in recent years for business practices that hurt patient care, ranging from private equity-owned **group homes for people with disabilities** to the **company that provides healthcare in many of California's jails**.

According to its backers, the original version of AB 3129 would have created stronger oversight of PE and hedge fund acquisitions of healthcare companies through the Attorney General's authority as well as strengthen the bar on the corporate practice of medicine. The proposed law would:

- Require a private equity group or hedge fund to provide advance written notice prior to a change of control or acquisition of a healthcare facility at least 90 days before the change in control or acquisition.
- Require a private equity group or hedge fund to provide advance written notice to the Attorney General prior to a change of control or acquisition between a private equity group or hedge fund and a nonphysician provider, or a provider with specified annual revenue.
- Authorize the Attorney General to grant, deny, or impose conditions to a change of control or an acquisition between a private equity group or hedge fund and a healthcare facility, provider group, or both, if the change of control or acquisition may have a substantial likelihood of anticompetitive effects or may create a significant effect on the access or availability of healthcare services to the affected community.
- Prohibit private equity group or hedge fund involved in any manner with a physician or psychiatric from controlling or directing that practice.
- Prohibit physician or psychiatric practice from entering into an agreement or arrangement with an entity controlled in part or in whole directly or indirectly by a private equity group or hedge fund in which that private equity group or hedge fund manages any of the affairs of the physician or psychiatric practice in exchange for a fee.[44]

The Private Equity Stakeholder Project submitted testimony in support of the original bill with the **Senate Health Committee** and the **Senate Judiciary Committee**.

However, after the bill was introduced in February, it underwent key changes. *CalMatters* reported that

"Between April and June, a coalition representing hospitals, investors, some dentists and doctors spent $583,000 lobbying against the measure, according to state financial reporting records."[45] Lobbyists succeeded in having for-profit hospitals and dermatology practices excluded from the bill, which went up for a final vote in late August.[46]

In July 2024, the FTC **submitted a letter** in support of the legislation, in which FTC Chair Lina Khan wrote, "States are powerful antitrust enforcers in their own right and can serve as force multipliers to federal enforcement efforts. States can also be critical partners in addressing the continued financialization of healthcare markets, and legislation like AB-3129 can be a valuable part of that effort."[47]

Despite passage of the bill by the California state legislature, Governor Gavin Newsom vetoed the bill in September 2024.[48] In a letter he wrote explaining his decision, he argued that the Office of Health Care Affordability, created in 2022 would be the more appropriate office to oversee private equity and hedge fund deals in healthcare.[49] However, this office cannot block transactions, as even the governor's letter pointed out.[50]

Newsom's veto of AB 3129 is a major setback for the state of California. As *CalMatters* reported, this was not the only bill where Newsom sided with the healthcare industry by vetoing.[51] It is also a setback for the larger project of winning enhanced regulations for private equity in healthcare.

Connecticut

During its 2024 legislative session, Connecticut's state legislature failed to pass **Senate Bill 9**, a healthcare reform bill that was aimed at increasing financial oversight of hospitals and revising the state's certificate of need program.[52] A **house bill targeting private equity acquisitions of healthcare facilities**[53] passed out of the Joint Committee on Public Health but failed to advance to a larger vote in the House.[54]

Connecticut lawmakers were pursuing legislation aimed at better oversight and regulation of private equity and hospitals in response to issues at three safety net hospitals formerly owned by private equity firm, Leonard Green & Partners. The hospitals, owned by parent company Prospect Medical Holdings, are struggling financially and in danger of a deal for a local nonprofit system to purchase them falling through.[55] Adding to the sale's troubling future, Prospect is currently the subject of multiple regulatory investigations, including by the Department of Justice, Connecticut Commissioner of Consumer Protection, and Connecticut Attorney General.[56]

Massachusetts

Massachusetts, which is ground zero for the Steward Health Care crisis, failed to pass legislation this year to protect its health system from private equity's harms.

Three Steward hospitals in Massachusetts have already closed this year.[57] Steward Health Care was owned by Cerberus Capital Management from 2010 to 2020; despite the private equity firm making at least $800 million from its investment in Steward,[58] the multi-state health system has been financially struggling since before Cerberus divested.[59] In recent years, the situation worsened, with the health system declaring bankruptcy in May 2024.[60]

The crisis at Steward hospitals prompted Massachusetts lawmakers to draft legislation that would prevent a similar crisis from happening in the future. In May, the Massachusetts House of Representatives passed comprehensive legislation it described as aiming "to restore stability to the healthcare system, bolster accountability within the industry, and control healthcare spending to ensure that everyone in Massachusetts has access to quality, affordable healthcare."[61]

The bill included language banning the sale of hospital real estate to real estate investment trusts (REITs) like MPT, as well as language granting the Commonwealth and its regulators much greater oversight powers over private equity, REIT, and other types of investors.[62]

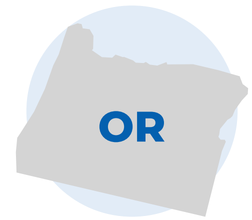
In July, the Massachusetts Senate passed its own version of the healthcare bill to then send back to the House for reconciliation.[63] While both bills have sections that are generally aimed at safeguarding hospitals and other healthcare businesses from harms associated with private equity and increasing oversight of healthcare transactions, the two bills differ in multiple ways, including that the Senate bill would not ban sale-leasebacks of hospital real estate.[64]

Despite the passage of separate legislation in both the House and Senate, the Massachusetts legislative session, which one local news outlet described as "unproductive and contentious,"[65] ended on July 31, 2024, without a reconciled healthcare bill being signed into law by Governor Healey.[66] Ultimately, Massachusetts legislators failed to meet the moment despite the immense momentum that could have been channeled from the Steward crisis unfolding throughout the state.[67]

Minnesota

In Minnesota, **state lawmakers introduced a bill** that would prohibit private equity companies and real estate investment trusts from acquiring or increasing control over providers of healthcare services. The bill defines healthcare providers as "any entity that provides health or medical care services for a fee," covering a wide range of companies including nursing homes, dental clinics, and physician practices. It is currently tabled until the legislative session resumes in January 2025.[68]

Oregon



In Oregon, state Representative Ben Bowman introduced a bill, **H.B. 4130**, in February 2024 aimed at addressing a loophole in the state's corporate practice of medicine law.

Most states have prohibitions on the corporate practice of medicine (CPOM). However, there are many loopholes in these laws, such as the ability to form professional corporations. Many states also have exceptions allowing certain types of entities, like hospitals, to employ physicians.[69]

CPOM laws are relevant to private equity because private equity firms have increasingly invested in physician practice management corporations (PPMs) or managed services organizations (MSOs).[70] These types of platform companies "partner" with physician practices to handle non-clinical aspects of business, such as scheduling, billing, negotiating insurance rates, etc. Some physicians are reporting that PPMs and MSOs operate in ways that impact clinical decision-making,[71] and some physicians are organizing against private equity's influence in medicine.[72] The physician practice management industry was created in order to skirt around state bans on CPOM laws.[73]

Oregon's bill would have prohibited physicians and others from having leadership positions in both the physician practice company and the PPM or MSO with which it partners. *Milbank Quarterly* explains that:

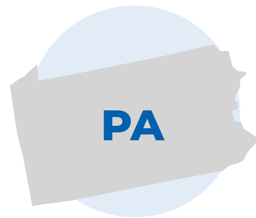
> "The bill specifies numerous activities that would constitute impermissible control by a lay-owned management service organization, including ultimate authority over physician employment terms and decisions, time spent with patients, clinical standards and policies, diagnostic coding decisions, as well as billing practices. Moreover, it prevents these individuals from influencing the hiring, firing, or terms of employment for the medical professionals within the corporation."[74]

Although the measure ultimately died, H.B. 4130 was the most ambitious example of legislation designed to address the loopholes in state CPOM laws in the United States.

The measure is expected to be reintroduced in 2025.[75]

PESP submitted testimony **in support** of the legislation.

Pennsylvania



Pennsylvania lawmakers have yet to get legislation to the finish line that would bring more oversight to private equity ownership of hospitals in the state, despite multiple issues at Prospect hospitals, the same health system that owns three struggling hospitals in Connecticut. This year, there have been multiple bills considered in the state House and Senate that would require specific notification requirements to the state Attorney General's office for healthcare facilities, systems or providers engaging in certain healthcare transactions. The 2024 session adjourned on November 13 without any further movement on the bills.[76]

The Pennsylvania House passed HB 2344 in July 2024, which would amend the Health Care Facilities Act to provide oversight "from the Office of the Attorney General when for-profit and non-profit hospitals change hands or undertake major corporate or financial restructuring" according to one of the bill's sponsors, Rep. Paul Takac's, press release.[77] The bill is similar to Pennsylvania Senate Bill 548, although the house bill goes further by including non-profit hospitals.[78] Although HB 2344 was under consideration in the Senate,[79] it did not get brought to a vote before Pennsylvania's legislative session adjourned on November 13, 2024.[80]

Pennsylvania's Prospect hospitals (under the name Crozer Health) have been experiencing the fallout from years of private equity ownership. Prospect's failed attempt to sell its four Crozer Health hospitals in 2022 has been followed with layoffs and service cuts,[81] including of 215 employees in early 2023.[82]

In October 2023, the state Attorney General agreed to suspend a lawsuit filed in 2022 related to Prospect's attempted closure of one of the Pennsylvania hospitals in order to provide a 270-day period for Prospect to sell the Crozer system.[83]

In August 2024, Prospect-Crozer and CHA Partners announced a deal for CHA Partners to acquire the hospitals and convert them to nonprofit status.[84] By October, CHA had pulled out of the deal, and on October 29, the Pennsylvania Attorney General (AG) filed a lawsuit against Prospect and its former investors, including Leonard Green and Partners, alleging that they violated the original 2016 asset purchase agreement by cutting services and closing facilities while diverting funds to private shareholders and investors.[85] In an unprecedented move, the AG has petitioned the court seeking state control of the hospitals.[86]

In recent months, Crozer has ended a surgical residency program and announced plans to shutter the operating room at one of its hospitals.[87] The eastern Pennsylvania communities served by Crozer Health have been negatively impacted for years as a result of Leonard Green's pillaging of the health system. In 2022 alone, Prospect/Crozer laid off hundreds of workers,[88] shuttered the maternity ward at Delaware County Memorial Hospital,[89] shuttered the hospice unit at Taylor Hospital,[90] and threatened municipalities with severing paramedic services in just 90 days if they didn't pay up.[91]

Pennsylvania's proposed legislation addresses just hospital changes of ownership. However, private equity has a foothold in far more than hospitals in PA. An October 2024 report from PESP identified approximately 900 private equity-owned healthcare companies in the Philadelphia metropolitan area, alone.[92]

FEDERAL LEGISLATIVE PROPOSALS

2024 saw two federal bills introduced in Congress that target private equity's abuses in healthcare. Both were drafted partially in response to the bankruptcy of Steward Health Care, a multi-state hospital system that was owned by private equity firm Cerberus Capital Management for a decade.

Both bills are comprehensive, but do not have a likelihood of passing, or even being brought to a vote, in the current Congress.

Corporate Crimes Against Healthcare Act

On June 11, 2024, Senators Elizabeth Warren (D-MA) and Ed Markey (D-MA) introduced the Corporate Crimes Against Health Care Act of 2024 to root out corporate greed and private equity abuse in the healthcare system.[93]

The **Corporate Crimes Against Health Care Act** would:

- Create a new criminal penalty of up to 6 years in prison for executives who loot healthcare entities like nursing homes and hospitals, if that looting results in a patient's death.
- Provide state attorneys general and the DOJ with the power to claw back all compensation, including salaries, issued to private equity and portfolio company executives within a 10-year period before or after an acquired healthcare firm experiences serious, avoidable financial difficulties due to that looting.
- Authorize an associated civil penalty of up to 5 times the claw-back amount.
- Prohibit payments from federal health programs to entities that sell assets or use assets for a loan collateral made to a REIT, with an exemption for current arrangements;

repeal a rule in the Tax Code that allows taxable REIT subsidiaries to exert influence on the operations of healthcare entities; and remove the 20 percent pass-through deduction, passed in the 2017 Trump tax cuts, for all REIT investors.
- Require healthcare providers receiving federal funding to publicly report mergers, acquisitions, changes in ownership and control, and financial data, including debt and debt-to-earnings ratios.
- Mandate a US Department of Health and Human Services and Office of Inspector General report to Congress on the harms of corporatization in healthcare.[94]

PESP endorsed the legislation, alongside Americans for Financial Reform, American Federation of Teachers, Take Medicine Back, Massachusetts Nurses Association, American Economics Liberty Project, Groundwork Collaborative, and Community Catalyst.

Health Over Wealth Act

On July 25, 2024, Senator Ed Markey (D-MA), chair of the Health, Education, Labor, and Pensions (HELP) Subcommittee on Primary Health and Retirement Security, and Congresswoman Pramila Jayapal (D-WA-07), member of the House Judiciary Subcommittee on Health, Employment, Labor, and Pensions, **introduced the Health Over Wealth Act**, legislation that would require greater transparency for private equity firms and for-profit companies that own healthcare entities, including hospitals, nursing homes, and mental or behavioral health facilities.

The Health Over Wealth Act would:

- Require that private equity-owned healthcare entities report on their debt, executive pay, lobbying and political spending, healthcare costs for patients, and any reductions in services to patients or wages and benefits for staff.
- Require that private equity-owned firms set up escrow accounts for healthcare entities they own to cover five years of operation and capital expenses to ensure that essential healthcare is still being provided in the event of financial disruptions that could risk hospital closure or service reduction.
- Require that private equity firms obtain a license from the Department of Health and Human Services (HHS) in order to invest in healthcare entities. If the firm price gouges, understaffs its facility, or reduces access to care, HHS can revoke this license and force divesture from healthcare facilities.
- Require that healthcare entities who wish to sell or lease from Real Estate Investment Trusts (REITs) submit to HHS for review and potential block if the sale would mean the entity is weakened financially or public health is at risk.
- Close tax loopholes for REITs for rental income from healthcare properties to disincentive selling health entities selling their property and being forced to pay unsustainable rent to REITs.[95]

A discussion draft of the bill was first announced in Boston on April 3 at the HELP Subcommittee on Primary Health and Retirement Security hearing titled, "When Health Care Becomes Wealth Care: How Corporate Greed Puts Patient Care and Health Workers at Risk," chaired by Senator Markey.[96] **PESP participated in that hearing**, and **subsequently endorsed the legislation**.

Both the Corporate Crimes Against Healthcare and Health Over Wealth bills provide a helpful baseline for future federal legislative work targeting private equity's and other investors' harmful investment behaviors in the healthcare sector.

FEDERAL RFIs

Multiple federal agencies have launched Requests for Information (RFIs) in the past year to solicit information from various stakeholders on private equity's impacts in the US health system and in the broader economy. RFIs are typically used by federal agencies in drafting new or updating current regulations.

FTC/DOJ/HHS Healthcare RFI

In March 2024, the Federal Trade Commission (FTC), Department of Justice (DOJ) Antitrust Division, and US Department of Health and Human Services (HHS) jointly **launched** a public inquiry into private equity firms' and other corporate owners' involvement in healthcare system transactions. Specifically, the RFI called for public comment on deals conducted by health systems, private payers, private equity funds, and other alternative asset managers that involve healthcare providers, facilities, or ancillary products or services. The RFI also requested information on transactions that would not typically be reported to the Justice Department or FTC for antitrust review.

In June, a coalition of 11 attorneys general **submitted** a comment letter in response to the FTC, DOJ, and HHS RFI. The letter advocated for enforcement and regulatory action where federal and state governments can collaborate, and it laid out possible action to address the detrimental effects of private equity healthcare transactions.

A coalition of over 90 organizations and individuals representing patients, workers, communities, public interest advocates, and healthcare researchers also **called on federal authorities** as part of the RFI to take action to curb the abuses of private equity and safeguard the ability of doctors to deliver quality care to all patients and achieve equitable health outcomes. PESP participated in this coalition, and also submitted **an individual comment letter to the Agencies** expanding on the industry examples found in the coalition's comments.

Serial Acquisitions RFI (FTC/DOJ)

In May, the FTC and DOJ Antitrust Division jointly **launched** a public inquiry on serial acquisitions and roll-up strategies used by corporate actors, including private equity firms, across a wide array of markets and industries. The inquiry complements the parallel inquiry on healthcare system transactions.

The press release announcing the RFI included a quote from FTC Chair Lina M. Khan: "Firms can use serial acquisitions to roll up markets, consolidate power, and undermine fair competition, all while jacking up prices and degrading quality. As the FTC scrutinizes these stealth consolidation schemes, we invite the public to submit information about where serial acquisitions have occurred and their effects."[97]

The Hart-Scott-Rodino Act (1976) created minimum dollar thresholds ($119.5 million in 2024), above which all transactions must be reported for pre-merger review.[98] A common private equity tactic is to use a platform company to acquire smaller companies, also known as a "roll-up." Often the values of these smaller transactions fall below the Hart-Scott-Rodino threshold, allowing the private equity-owned company to fall under the radar of antitrust enforcers. While this has been a well-known consolidation strategy for years, the Biden Harris administration is taking the first steps to explicitly address it.

PESP submitted a **comment letter** in response to the RFI on September 18, 2024.

FEDERAL RULEMAKING

Various federal agencies that regulate healthcare finalized a number of rules in 2023 and 2024 that would have implications for private equity-owned healthcare businesses. However, as mentioned in the introduction to this report, the effectiveness of federal rulemaking to regulate industries has been blunted after the Supreme Court overturned Chevron.

Minimum Staffing Standards for Long-Term Care (LTC) Facilities and Medicaid Institutional Payment Transparency Reporting final rule

On April 22, 2024, the Centers for Medicare & Medicaid Services (CMS) issued a final rule, titled "Minimum Staffing Standards for Long-Term Care (LTC) Facilities and Medicaid Institutional Payment Transparency Reporting."[99]

A central component of the final rule are new minimum nurse staffing requirements. The new standards are 3.48 hours per resident day (HPRD), which must include at least 0.55 HPRD of direct registered nurse (RN) care and 2.45 HPRD of direct nurse aide care.

CMS also created a requirement to have an RN onsite 24 hours a day, seven days a week, to provide skilled nursing care.

The minimum nurse staffing standards and 24/7 RN requirements in this final rule are subject to a staggered timeline for implementation, which is based on geographic location and possible exemptions for qualifying facilities. The first phase began in July 2024; facilities will not be required to meet the 3.48 HPRD nurse staffing requirement and 24/7 RN requirement until Phase 2 in April 2026.[100]

Additionally, CMS will also require states to collect and report on the percent of Medicaid payments attributable to compensation for direct care workers and support staff that deliver care in nursing facilities and intermediate care facilities for individuals with intellectual disabilities. This requirement seeks to increase transparency related to compensation for workers.[101]

Implementation of the rule could make it challenging for private equity-owned facilities to use their typical cost-cutting strategy of reducing staffing, which has major impacts on patient care. Academic studies and investigative reporting have found higher patient mortality rates, reduced staffing, overreliance on psychiatric medications, and reduced quality of care at private equity-owned nursing homes.[102]

Although this rule was a step in the right direction, healthcare advocates have voiced concerns that CMS' ratios were insufficient to meet the needs of nursing home patients.[103]

The Long Term Care Community Coalition (LTCCC) wrote in a November 2023 comment letter that, "The proposed 3.0 minimum sets a bar far too low for the over 15,000 US nursing homes. Accepting this standard is accepting a status quo that means continued abuse, neglect, pain, and suffering for the nation's 1.2-million nursing home residents. LTCCC urges CMS to carefully consider the limitations of the current proposed standard of 3.0 HPRD and the need for a meaningful safe staffing minimum of 4.1 HPRD to improve the lives of nursing home residents."[104]

The final rule settled on a minimum of 3.48 HPRD, an increase from the original proposal of 3.0[105] but still below the 4.1 HPRD advocated by LTCCC.

In October 2024, 20 Republican state attorneys general[106] sued CMS in an effort to strike down the final rule. They argued the rule would cause irreparable harm to nursing home operators. Led by Iowa, Kansas, and South Carolina, the other 17 states joining are Alabama, Alaska, Arkansas, Florida, Georgia, Idaho, Indiana, Kentucky, Missouri, Montana, Nebraska, North Dakota, Oklahoma, South Dakota, Utah, Virginia, and West Virginia.[107] The 20 AGs have called for implementation of the rule to be paused while the court considers oral and written arguments.[108]

The American Hospital Association has also challenged the rule, including by urging federal legislators to halt its enforcement.[109]

Medicaid Spending Requirements

On April 22, 2024, CMS **finalized a rule** entitled *Ensuring Access to Medicaid Services* (CMS 2442-F).[110] The changes were made to advance CMS' efforts to improve access to care, quality, and health outcomes, and better promote health equity for Medicaid beneficiaries across fee-for-service (FFS) and managed care delivery systems, including for home and community-based services (HCBS) provided through those delivery systems.[111]

Among other changes, this rule requires that "at least 80% of Medicaid payments for personal care, homemaker, and home health aide services be spent on compensation for the direct care workforce (as opposed to administrative overhead or profit)."[112]

PESP supported this rule when it was proposed in our July 3, 2023 **comment letter** to the agencies, as it may help curb exploitative practices in the home health industry, including by private equity firms.

A study by the LeadingAge LTSS Center found that increasing the pay of caregivers greatly enhances their financial security, thereby improving productivity and increasing the quality of care afforded to patients.[113] Additionally, higher wages can alleviate staffing shortages by attracting more people into direct care work, improving consistency of care, and leading to workers working

more hours.[114] A study by the Washington Center for Equitable Growth showed that increased pay for caregivers prevented deaths, reduced health violations, and lowered the cost of preventative care.[115]

As such, the Medicaid Spending Requirements rule has the potential to limit common labor-related cost-cutting strategies used by private equity-owned home health companies, such as underpaying workers or reducing staffing. This is especially important considering the presence of private equity in home healthcare.[116]

Nursing Home Ownership Transparency

On November 15, 2023, CMS finalized a rule that implements portions of section 6101 of the Affordable Care Act, which require the disclosure of certain ownership, managerial, and other information regarding Medicare skilled nursing facilities (SNFs) and Medicaid nursing facilities.[117]

In September 2022, Public Citizen published a report highlighting how determining ownership of nursing homes is especially challenging, despite legislative requirements stemming from the 2010 Affordable Care Act for HHS to maintain a database with this information. Through the use of various holding companies and special purpose entities, private equity firms have been able to evade transparency. Public Citizen found that "Of 13 private equity firms ...to have holdings in nursing homes, only seven appear in the federal ownership database."[118]

Robust ownership disclosures are an important tool for regulators and healthcare advocates. The lack of transparency within the private equity industry, due to minimal disclosure requirements, has made it challenging to measure the extent of private equity's footprint in nursing homes, as well as the larger healthcare industry, and has posed challenges for advocates seeking accountability for problems within private equity-owned companies.

PESP and Public Citizen submitted a **joint comment letter** in support of the rule when it was proposed, which was endorsed by another 13 organizations[119].

This rule became effective in December 2023.

CONGRESSIONAL INVESTIGATIONS & HEARINGS

Private equity investment in healthcare has received scrutiny from multiple bipartisan Congressional investigations in the last year, including investigations into private equity's impacts on hospitals, emergency departments, and methadone treatment programs.

Senate investigation into hospitals

In December 2023, the Senate Budget Committee opened a bipartisan investigation into effects of private equity ownership on hospitals. In a press release announcing the investigation, the committee noted that many private equity-acquired hospitals experienced "significant staffing reductions and substandard healthcare and have been stripped of valuable assets, including their real estate, leaving them saddled with debt."[120]

As part of the investigation, budget committee members sent letters to the chief executive officers of Leonard Green & Partners, Prospect Medical Holdings, Medical Properties Trust, Apollo Global Management, Lifepoint Health, and Ottumwa Regional Health Center, which demanded answers regarding questionable financial transactions that may have impacted care quality for patients at private equity-owned hospitals.[121]

The investigation builds on a previous effort in March 2023 by committee Ranking Member Grassley seeking information on an Iowa hospital under private equity ownership which contributed to "a series of horrific events involving alarmingly mismanaged care."[122]

Senate investigation into Steward Health

Multiple U.S. senators and the Senate Committee on Health, Education, Labor, and Pensions (HELP) have

put considerable scrutiny on Steward Health Care, which declared bankruptcy in May 2024 after private equity firm Cerberus Capital Management, aided by hospital landlord Medical Properties Trust (MPT), extracted significant profits from the financially struggling health system.[123]

Beginning in January, the Massachusetts congressional delegation began to publicly scrutinize Steward, including sending a letter to Cerberus seeking answers about its role in creating financial difficulties at Steward; and three letters sent through March to Steward CEO Ralph de la Torre which sought information about Steward's finances, criticized de la Torre for years of mismanagement, and called on the executive to testify at a congressional hearing in Boston the following month.[124]

In early April, a subcommittee of the Senate Committee on Health, Education, Labor, and Pensions

(HELP) held a hearing in Boston, titled "When Health Care Becomes Wealth Care: How Corporate Greed Puts Patient Care and Health Workers at Risk," focusing on Steward's hospitals in Massachusetts, and including in-person testimony from PESP.[125]

A few days after the hearing, the Massachusetts congressional delegation urged the FTC and DOJ to scrutinize UnitedHealth's proposed acquisition of Steward's physician group.[126]

Later in April, Senators Warren and Markey called out Medical Properties Trust and Macquarie Infrastructure Partners for exploiting Steward hospitals in Massachusetts and urged them to keep the locations open.[127] The senators sent a letter questioning six private credit funds holding Steward debt, and called on them to offer loan modifications that could potentially help keep the hospitals open.[128]

In September, another HELP Committee hearing was held, titled "Examining the Bankruptcy of Steward Health Care: How Management Decisions Have Impacted Patient Care."[129] PESP submitted written testimony to the committee and spoke at a press conference hosted by Senator Markey following the hearing.[130]

Steward chief executive Ralph de la Torre – whose lawyer said he could not testify without violating his Fifth Amendment right against self-incrimination and interfering with the company's bankruptcy reorganization – ignored a congressional subpoena demanding his presence at the September hearing. In response, the U.S. Senate unanimously moved to refer a contempt charge to the Justice Department. If found guilty, de la Torre could serve up to 12 months in prison.[131]

Senate investigation into emergency departments

In April 2024, the chair of the Senate Homeland Security and Government Affairs Committee started an inquiry requesting information about private equity-run emergency departments and impacts on patient care.[132]

"I am pressing these companies and their private equity owners for needed transparency so that we better understand how their business practices could be affecting patient safety, quality care, and physicians' abilities to exercise independent judgment in providing patient care," said U.S. Senator Gary Peters.[133]

Peters requested information about business operations, staffing decisions, and patient care and safety at several emergency departments across the country, in letters addressed to private equity firms Apollo Global Management, Blackstone, and KKR; and physician staffing companies US Acute Care Solutions, Lifepoint Health, and TeamHealth.[134]

Senate investigation into opioid treatment programs (OTPs)

In March 2024, the HELP Subcommittee on Primary Health and Retirement Security sent letters to investigate the role of private equity in opioid treatment programs (OTPs) and how it is impacting access to methadone for opioid use disorder (OUD).[135]

Methadone is a "gold standard treatment" for OUD, but many individuals who need methadone cannot receive it due to stringent restrictions placed on access.[136] In recent years, private equity firms have acquired stakes in nearly a third of U.S. opioid treatment programs (OTPs), according to *STAT*.[137]

In letters sent letters to seven OTP companies, the senators asked the companies to provide a comprehensive review of any private equity investments in OTPs, and wrote: "We are concerned that there is incompatibility manifesting itself in private-equity-backed OTPs seeking to maintain their monopoly on methadone access, not because it is good for the patient, but because it is good for the bottom line. Any interference with policies that would save lives for the sake of profit is unacceptable."[138]

FEDERAL AND STATE ENFORCEMENT ACTIONS

Both federal and state regulators have recently engaged in enforcement actions against private equity-owned healthcare companies around Medicaid/Medicare fraud and antitrust issues.
Medicare/Medicaid fraud enforcement
The False Claims Act (FCA) is a federal law that establishes liability for individuals or companies that defraud government programs in the US. It is often used alongside the Stark Law, Anti-Kickback Statute, and state-specific laws against healthcare companies that defraud Medicaid, Medicare, and related programs.[139]

Government agencies, including the Department of Justice, the Department of Health & Human Services Office of Inspector General (OIG), and the Centers for Medicare & Medicaid Services (CMS), are charged with enforcing these laws[140] in conjunction with state attorneys general, where relevant.[141]

There is substantial overlap between the risks associated with private equity ownership of healthcare companies and the activities targeted by the False Claims Act (FCA). Efforts to increase cash flow can sometimes cross the line into illegal behaviors that defraud Medicare and Medicaid programs.

The Private Equity Stakeholder Project tracked seven Medicaid/Medicare fraud settlements, also known as FCA settlements, between the DOJ, state attorneys general offices, and private equity-owned healthcare companies in the past year.

COMPANY	TYPE	SETTLEMENT ANNOUNCEMENT	SETTLEMENT AMOUNT	RELEVANT PE FIRMS
Precision Toxicology	Drug testing	October 2024	$27 million	Owned by BelHealth Investment Partners since 2014.[142]
Intrepid USA	Home health & hospice	August 2024	$3.85 million	Acquired by Patriarch Partners in 2006.[143]
Crossroads Treatment Centers	Substance use disorder treatment	July 2024	$863,934	Owned by Revelstoke Capital Partners since 2014.[144]
Gentiva	Home health & hospice	July 2024	$19.4 million	Currently owned by Clayton, Dubilier, & Rice.[145]
Avertest (dba Averhealth)	Drug testing	June 2024	$1.3 million	Owned since July 2019 by Five Arrows.[146]
Elara Caring	Home health & hospice	May 2024	$4.2 million	Blue Wolf Capital and Kelso & Company; Palladium Equity Partners. See here for a timeline of PE ownership.[147]
TeamHealth	Physician staffing	October 2023	$4.4 million	Owned by Blackstone since 2017.[148]

For more information about each settlement, click on the company name.

The DOJ has identified private equity as a recent FCA enforcement priority. In remarks prepared for the Federal Bar Association in February 2024, one high-level official, speaking of investors such as private equity firms or venture capital firms, said:

> "These entities may influence patient care by providing express direction for how a provider should conduct their business, or more indirectly by providing revenue targets or other indirect benchmarks intended to prioritize reimbursement."[149]

The DOJ also signaled in 2020 that it planned to hold private equity firms accountable for their portfolio companies' actions.[150] Between 2019 and 2021 there were at least four False Claims Act cases that named private equity firms as defendants.[151] However, in all of the cases listed above, the private equity owners were not named as defendants.

Antitrust enforcement

The Federal Trade Commission (FTC) and Colorado Attorney General separately engaged in enforcement actions against U.S. Anesthesia Partners (USAP), an anesthesiology provider that private equity firm Welsh Carson Anderson & Stowe (WCAS) created as a platform for a provider consolidation strategy in 2012.[152]

Colorado AG requires U.S. Anesthesia Partners to make divestments

The Colorado Attorney General's office reached an agreement with USAP of Colorado, Inc. in February 2024 following a Colorado Department of Law investigation into the company's anticompetitive business practices. The agreement required USAP to divest its exclusive contracts at five Colorado hospitals, change certain business practices, and pay $200,000 in monetary relief.[153]

According to the AG's press release, USAP began purchasing anesthesia practices in the Denver Metro Area in 2015,

> "modeling their plan on a similar approach the company took in Texas earlier in the decade. By 2021, USAP bought out all its major competitors and established control of surgical anesthesia at the two largest hospital systems in the Denver area, accounting for more than 70% of health plan reimbursements."

> "The result of USAP's successful cornering of the Denver-area surgical anesthesia market was higher costs for consumers and their employer-provided health insurance plans, onerous non-compete restrictions on health care professionals, and patients often facing delays or outright cancellation of their surgeries. At the

same time, USAP charged reimbursement rates at 30-40% higher than competing groups in the Denver Metro Area, creating a financial windfall for USAP and its private equity ownership."[154]

FTC lawsuit against USAP and Welsh, Carson, Anderson & Stowe

In September 2023, the FTC sued private equity firm WCAS and USAP, alleging a coordinated monopoly scheme at Texas patients' expense. According to the complaint, WCAS and USAP engaged in a decade-long strategy to consolidate Texas anesthesiology practices, drive up prices for services, and increase company profits.[155]

The FTC had originally alleged that US Anesthesia Partners' strategy and decisions had been actively directed by WCAS, particularly in Texas. WCAS maintains influence over USAP's directors, and including two guaranteed seats on US Anesthesia Partners' board.[156] According to the FTC complaint, internal WCAS communications describe the firm as US Anesthesia Partners' "primary architect."[157]

The complaint alleged that WCAS has maintained influence over USAP's management and directors despite a reduced ownership stake. When USAP was founded in 2012, WCAS owned 50.2% of the company. In September 2023, it owned approximately 23% of USAP.[158]

However, in May 2024, a federal district court granted WCAS's motion to dismiss it from the FTC lawsuit. The court determined that FTC had not adequately alleged that WCAS "is violating" antitrust law. In other words, the court determined there was insufficient evidence to determine that WCAS "is" committing or "is about to" commit a violation the FTC Act. The lawsuit against USAP is ongoing, but WCAS is no longer a defendant.[159]

WCAS and other owners have collected multiple debt-funded dividends from USAP. In 2018, USAP took on debt to fund $369 million in payments to its owners.[160] The company increased its debt again in 2021, in part to pay $400 million to WCAS and other owners.[161]

USAP and WCAS have profited through the company's growth. USAP increased the prices for each provider it acquired, according to the FTC, bringing in millions of additional dollars at the expense of patients and other payors.[162]

USAP had other ways to keep prices high: The company allegedly made price-setting arrangements with other anesthesia groups in Houston and Dallas and entered into a territorial agreement not to compete with another large competitor.[163]

The intended effect, claims the FTC, was higher prices for anesthesia services. The agency estimates that the same services cost Texans millions more than before USAP existed.[164]

The strategy has done well enough for WCAS that the private equity firm has "deploy[ed] a similar strategy to consolidate" other practice specialties including emergency medicine and radiology.[165] In 2015, WCAS established US Acute Care Solutions, an emergency medicine provider.[166] That year, it provided services in 64 hospitals; six years later in 2021, the company was at over 220 sites.[167] WCAS sold its stake in US Acute Care Solutions in February 2021.[168]

The private equity industry's lead lobbyist describes FTC as having a "radical new antitrust theory," and its recent actions constitute a "power grab" authored by a federal administration that is "threatening this system"—under which private equity is imagined to play a vital productive role.[169]

The dismissal of WCAS from FTC's lawsuit represents a setback for antitrust enforcers in the Biden-Harris administration who have taken bold moves to attempt to hold private equity firms accountable for their portfolio companies' actions.

FEDERAL NO SURPRISES ACT

The No Surprises Act is a piece of federal legislation that went into effect on January 1, 2022 to address the problem of surprise medical bills.

Private equity-owned healthcare companies have been at the center of controversies around surprise billing. In recent years, private equity-owned physician staffing companies Envision Healthcare (formerly owned by KKR until its 2023 bankruptcy) and TeamHealth (Blackstone) have attracted public scrutiny for the profits they generated from surprise medical bills.

Surprise medical bills arise when patients go to a seemingly in-network provider for emergency care only to learn after-the-fact that they were treated by out-of-network clinicians. These out-of-network bills can be devastatingly high for many individuals.[170]

Ultimately, and despite a dark money campaign funded by private equity-backed companies,[171] surprise billing drew enough scrutiny from various stakeholder groups to result in federal legislation to limit the practice. This legislation, dubbed the No Surprises Act, went into effect in January 2022.[172]

The No Surprises Act was an effort to protect patients from outsized and unexpected bills when they seek emergency (and even scheduled) care and help address rising costs in the healthcare system. However, since its implementation the Act has fallen short of its potential.

Part of the act includes an Independent Dispute Resolution (IDR) process. This process is supposed to determine out-of-network payment amounts when providers/facilities and health plans cannot reach agreement.

Private equity-owned companies have overwhelmed the IDR process,[173] and the number of claims through the first half of 2023 had far exceeded initial federal estimates that there would be 17,333 IDR claims per year.[174] CMS data covering the first half of 2023 revealed that the highest numbers of disputes were separately initiated by four companies, all of which are owned by private equity firms. Together they initiated 191,785 disputes, representing 70% of the 274,432 total claims (excluding air ambulances) filed in the first half of 2023.[175]

According to a December 2023 GAO report titled "Roll Out of Independent Dispute Resolution Process for Out-of-Network Claims Has Been Challenging," IDR entities report dispute backlogs, as well as long delays in the determination and payment process.[176]

In order to understand the issue in full — and resolve it — deeper examination and possible revisions to the IDR process may be worth pursuing. Data on its implementation suggest that private equity-owned companies have continued to do business based on a model that exploits out-of-network payments.

The burdens of the surprise billing have fallen in different ways onto regulators and patients, as outsized resources go towards resolving payment disputes from primarily private equity-backed companies. The unimaginable scale (i.e., exceeding official estimates) of claims demonstrates the challenges for the No Surprises Act to protect patients and payers from rising medical costs.

POLICY RECOMMENDATIONS

The financialization of healthcare in the United States is a multi-faceted issue that cannot be pinned on private equity alone. However, private equity business strategies are an amplification of the typical profit-seeking strategies seen in healthcare, and are having outsized impacts on the healthcare system.

Much of PESP's proposed policy solutions to address private equity in healthcare would go above and beyond regulating private equity investments in healthcare to address broader financialization of healthcare issues that show up in nonprofit and for-profit business models alike. However, it is important to point out that private equity does depart from other types of for-profit healthcare ownership in three key ways, and these have implications for how regulations need to be designed to ensure that private equity investment strategies are captured alongside other profit-seeking strategies that can harm patients and workers.

1 Lack of transparency:

Private equity-owned companies are less regulated than publicly traded companies. They do not need to make the same disclosures to the Securities and Exchange Commission (SEC) or to their investors. As such, critical financial information about private equity investments often remains in the shadows.

2 Use of debt:

Private equity investment strategies involve using much more debt than is typical in other types of investments. Firms use debt to buy companies in leveraged buyouts, and the company – not the PE firm and its investors – will be on the hook for the debt. Portfolio companies can also be directed by their PE owners to take on more debt during the ownership period in order to finance add-on acquisitions or pay dividends to investors.

3 The moral hazard of limited liability:

A private equity firm can generate returns on an investment even if the company ends up in financial distress or bankruptcy. This is because private equity firms are not liable for the debt secured by their portfolio companies, and so they cannot lose more money than the amount they invested, which is often not much. In other words, private equity firms take on little risk but get to make outsized returns.[177]

For the reasons above, updated healthcare regulations must take these factors into account. Regulations that require increased transparency and financial disclosures, regulations on use of debt, and requirements for private equity firms and other investors to have more liability for their healthcare investments are all ways to put guardrails in place to protect patients and workers. These regulations should be bare minimums, and policymakers and regulators can and should go much farther to protect patients from the increasing financialization of healthcare that is seen in both "nonprofit" and for-profit healthcare.

The current federal policymaking landscape has become an increasingly challenging place to pass meaningful legislation given partisan gridlock. Additionally, the election of Donald Trump and Republicans' victory in both chambers of Congress,[178] along with the recent limits placed by the judiciary on federal agencies' regulatory powers, have effectively stymied opportunities to address private equity at the federal level. Given this current political context, PESP believes state legislatures may prove the most likely avenues to win legislation necessary to protect patients, workers, and communities from private equity's harms. That said, Congress and federal agencies can and should continue to do what is in their power to update laws and regulations to regulate private equity in healthcare and hold private equity firms accountable.

The Private Equity Stakeholder Project advocates for state and federal policymakers to pass laws that would do the following:

Merger Review

- On the state and federal levels, create a robust set of change-of-ownership regulations for healthcare facilities that give states and federal agencies the authority to approve or deny transactions based on multiple factors, including cost and market share, long term access to quality healthcare for the community, and preservation of jobs and collective bargaining rights. In July 2024, the National Academy for State Health Policy (NASHP), a nonpartisan organization committed to developing and advancing state health policy innovations and solutions, published an updated version of its Comprehensive Consolidation Model Addressing Transaction Oversight, Corporate Practice of Medicine and Transparency.[179] NASHP's model legislation is a valuable resource for state policymakers seeking to curb anti-competitive investment practices in healthcare. Additionally, Rhode Island's Hospital Conversions Act presents an effective model of enacted legislation in this area.

  On the federal level, expand federal pre-merger review authority by amending the Hart-Scott-Rodino Act to capture private equity-backed mergers and acquisitions of a lower dollar threshold. Additionally, healthcare mergers and acquisitions review authority should be expanded to the US Department of Health and Human Services, due to impacts private equity investment may have on quality of and access to patient care. On the state level, require review of all private equity-backed healthcare provider transactions, regardless of dollar value.

Transparency

- Require full financial transparency of licensed hospital operators and other health facilities and their investors, including private equity firms, real estate investment trusts (REITs), and other shareholders. States should have statutory requirements for all hospitals and health facilities to produce annual, audited financial disclosures to the state, including for their parent companies and any subsidiaries.

  Such laws must be enforceable and have real consequences for noncompliance. Businesses

should lose their licenses to operate healthcare facilities and be barred from acquiring or opening new facilities if they demonstrate a pattern of noncompliance.

Anti-Looting

- Require that acute care hospital operators offer a minimum package of services, including emergency care and labor and delivery services, to maintain or be granted a license to operate.

- Give states the authority to put hospitals in receivership in the event of mismanagement by their owners, in order to protect access to healthcare for the communities the hospital serves. States should implement a tax on for-profit providers to fund state receivership.

- Bar hospital investors from paying themselves debt-funded dividends from health systems (also called dividend recapitalizations) or dividends from real estate sales. If dividends are allowed, they should only be paid as a percentage of overall profit and may not be funded by taking on additional debt or lease liabilities. Investors should be able to prove that the dividends can be funded without impacting the short -and long-term financial viability of the hospital/ health system.

- Ban or place limits on sale-leasebacks and similar types of real estate transactions involving hospital real estate, for all hospital types.

  - If sale-leasebacks are permitted, states should have the authority to approve or deny the transaction, and there should be limits or bans on their proceeds being used for investor payments; requirements for the health system and investors to prove that transaction will not negatively impact the short- and long-term sustainability of the system appraisal of the property; and a requirement for a certain percentage of the proceeds to go toward capital improvements in the hospital(s).

  - Triple net leases for hospital real estate, which require the tenant to pay property taxes, property insurance and maintenance, should be prohibited.

- Place limits on the ratio of debt-to-equity used to finance healthcare buyouts.

Joint and Several Liability

- Require joint and several liability for corporate owners and investors of hospital systems (both operations and real estate). This would mean that if the hospital was sued for violations of the False Claims Act, a right of action would automatically exist against the private equity owner(s), landlord, and other investors.

Limit management fees

- Place limits on management fees. Investor owners may not charge arbitrary fees to hospital companies, such as management fees for services not provided. Management fees for services unrendered (or to be rendered in the future - i.e. charging a company management fees for the next five years) should be prohibited. Investors should have to report management fees collected from hospital portfolio companies (and for what services rendered and when) to state regulators.

Minimum Staffing Ratios

- Have federal and state minimum staffing ratios for healthcare facilities that vary, depending on

the type of care being provided and the type of facility. Employers that demonstrate a pattern of noncompliance should face severe financial penalties and lose their licenses to operate.

Corporate Practice of Medicine

- States should update corporate practice of medicine (CPOM) statutes to ensure that private equity-owned physician practice management companies cannot use loopholes to direct clinical care.

In addition to updating regulations, it is imperative that lawmakers ensure that agencies tasked with review and enforcement have ample resources to do so. Furthermore, federal and state agencies and offices tasked with enforcement should ensure all current laws, including corporate practice of medicine laws, are being enforced.

The aforementioned policy recommendations could go far in reigning in the most exploitative business practices of private equity firms, real estate investment trusts, and other for-profit investors in US healthcare. However, in the current for-profit healthcare system, private players—be they for-profit hospitals, insurers, hospital landlords, or medical staffing companies–will continue to dictate access to and quality of healthcare unless our society shifts to treat healthcare as a public good and a human right.

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Contact:
mary.bugbee@pestakeholder.org