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Policy Options to Address the Growth of Private Equity Among U.S. Physician Practices

Policy Brief

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Summary of the Issue

Health care spending per capita in the U.S. has increased from $8,877 to $13,493 between 2012 and 2022.[1] The U.S. leads global health care spending, both in terms of per-capita expenditures and as a percentage of GDP, nearly doubling that of similar nations as of 2021.[2] Higher prices for private insurance and increased Medicare spending driven by changing referral patterns.[3,4], can be largely attributed to health care consolidation,[5] which contributes significantly to the growth in health care expenditure.

Private equity (PE) has rapidly entered into health care markets over the past two decades, accelerating the consolidation of key sectors of the health care market, including a range of health care providers.[6] Over the past decade (2010-2020), PE firms have invested in a total of $750 billion in the healthcare industry[7] to acquire physician practices, hospitals, nursing facilities, and other health care providers. The entry of PE into health care markets has become a cause of concern, as research has shown that PE acquisitions significantly drive up health care prices and spending, alter workforce composition[8] and morale,[9] and can adversely affect patient access to care and safety in some settings.[10]

Policy Options Overview

1. Enhance antitrust review and enforcement of below-the-threshold PE acquisitions in healthcare
2. Close Medicare payment loopholes
3. Strengthen laws to protect physicians' clinical and professional autonomy
4. Enhance ownership transparency: an essential piece of health care transparency
5. Strengthen existing fraud and abuse laws
6. Strengthen the No Surprises Act

Background and Overview

PE investment in healthcare has witnessed rapid growth, with the volume of PE investment deals escalating six-fold between 2012 and 2021.[11] Notably, investments have surged by 2000%, from $5 billion to $100 billion between 2000 and 2018, culminating in a total of $750 billion in investment activity over the past decade (2010-2020).[7] At the same time, there has been a noticeable shift of investments from hospitals and nursing facilities to physician practices in certain specialties and primary care.[12]

While PE investment can provide capital and alleviate physicians' administrative responsibilities, it also may accelerate consolidation,[11,13] increase costs,[14,15] while also heightening concerns over the corporatization of medicine[16] and the loss of professional autonomy.[17] In a PE investment model, 70% of the deal is financed by debt, and 30% is financed by limited partners firms (only 2% of the deal is financed by the PE firm). However, this significant burden of debt falls on the acquired practice and not the PE firm.[18] In order to seek a return on their investment (>20%),[18] PE firms typically exit their investment within 3-7 years, generating policy debate over whether PE prioritizes short-term gains over long-term stability of acquired practices and patient-centered care.[19,20,21]

Where do Private Equity Firms Invest?

Initial PE investments in physician practices targeted hospital-based physician specialties including emergency medicine, anesthesiology, radiology.[13] Since 2015, PE investments have targeted high-margin procedural specialties like dermatology, gastroenterology, urology, and ophthalmology, which mainly operate on a fee-for-service model and offer consistent returns from commercial insurers and Medicare, along with added cash revenue streams.[12]

Recent research [8] analyzed 97,094 U.S. physicians across six specialties (dermatology, gastroenterology, ophthalmology, obstetrics/gynecology, orthopedics, and urology). It found that:

- ➔ 5% of the physicians worked in PE-acquired practices, with dermatology having the highest proportion of PE involvement at 7.5%, closely followed by gastroenterology and urology.
- ➔ Geographically, PE acquisitions are not evenly distributed throughout the US, and show heterogeneity within specialties.
- ➔ The Northeast region has the highest PE penetration at 6.8%, while the Midwest has the lowest at 3.8%.
- ➔ Washington DC (18.2%), Arizona (17.5%), New Jersey (13.6%), Maryland (13.1%), Connecticut (12.6%), and Florida (10.8%) have the highest PE penetration, with Arizona standing out for its widespread PE presence across all six examined specialties.

The current wave of PE investments in physician practices focuses on value-based specialties, including primary care and cardiology, settings with a large number of patients enrolled in Medicare Advantage and other risk-based payment models.[11]

Private Equity and Changes in Workforce Composition

PE ownership influences the staffing dynamics of acquired physician practices, leading to a notable shift in workforce composition.

- ➔ The rate at which physicians enter and exit (turnover) is higher at PE-acquired practices, suggesting potential physician dissatisfaction due to financial pressures, reduced clinical autonomy, and burnout.
- ➔ There's a marked increase in the employment of advanced practice providers (APPs), such as nurse practitioners and physician assistants among PE-acquired practices. This suggests that PE-acquired practices may replace higher-cost physicians with lower-cost APPs to reduce payroll expenses at acquired practices.[8,22] Alternately, PE-acquired practices may increase hiring of APPs to increase the overall size and staffing of acquired practices.

While the impact of these changes in workforce composition has yet to be studied among physician practices, similar staffing changes in PE-owned nursing homes and hospitals have been associated with diminished care quality and poorer patient outcomes.[10,23]

Private Equity Accelerates Horizontal Consolidation

PE firms make several changes to the acquired entity to increase profitability and revenues through service and diagnostic up-coding, staffing reductions, capturing referrals for ancillary services, and discontinuing less profitable services.[12] However, the most commonly used revenue playbook by PEin physician practices is pursuing horizontal market consolidation through the "platform and roll-up" model to amass market share, which can have the effect of reducing competition and increasing prices, as alleged in the Federal Trade Commission's (FTC) antitrust lawsuit against U.S. Anesthesia Partners and its PE-investor, Welsh Carson. [24]

Under the "platform and roll-up model," a PE firm acquires a well-established practice with strong management, operations, and market presence known as a "platform" practice. This platform is a foundation for future acquisitions of smaller practices (add-ons) to consolidate the market, enhance the platform's value, and create a larger, more powerful entity.[25] While these add-on entities take up the valuation of the larger platform, approximately 90% of these transactions fall below the federally mandated reporting threshold, leading to significant market consolidation and potentially anticompetitive behavior by PE firms without substantial regulatory scrutiny.[26,27,28]

Potential Policy Options to Address Private Equity in Health Care

1.Enhance antitrust scrutiny of smaller transactions that fall below the Hart-Scott-Rodino (HSR) reporting threshold ($119.5 million as of 2024)[29] as well as vertical and cross-market consolidation.

This proposed policy aims to improve antitrust monitoring by reviewing below-the-radar physician practice acquisitions by PE firms, especially those of add-on acquisitions. Many states, including Connecticut, Illinois, Massachusetts, New York, Oregon, and Washington, have passed laws to increase scrutiny of health care transactions that fall below reporting thresholds and improve antitrust monitoring.[30] However, this policy should be accompanied by enhanced funding for antitrust agencies to ensure appropriate allocation of resources for oversight of acquisitions most likely to reduce competition.[31]

2.Strengthen legislative & regulatory frameworks to close existing payment loopholes exploited by PE, particularly in Medicare.

Reforming Medicare's Part B payment formula for physician-administered drugs is necessary to reduce incentives for overuse of and unnecessary spending on expensive medications. Furthermore, reforms to risk-adjustment systems and increased auditing in Medicare Advantage and Accountable Care Organization (ACO) programs can deter corporate investors in primary care from exploiting existing reimbursement incentives.

3.Strengthen laws to protect physicians' clinical and professional autonomy by enhancing prohibitions on the corporate practice of medicine and restricting physician non-compete clauses.

State and federal policymakers can strengthen prohibitions on the corporate practice of medicine and physician non-compete clauses to protect the clinical and professional autonomy of physicians in PE-acquired practices. These protections would allow physicians to speak out or leave over ethical or professional concerns they encounter in practice, including those driven by revenue-maximization strategies of PE investors.

The "corporate practice of medicine" prohibition bars nonprofessionals like PE investors from owning or controlling medical practices. Yet, PE investors have figured out how to contractually circumvent the corporate practice prohibition through the use of management services organizations and so-called "friendly-PC" arrangements to control the physician practice, even without formal ownership. States can strengthen the corporate practice of medicine to allow professional practices to maintain ultimate control over key business as well as clinical decisions.[17]

Further, policymakers could prohibit non-compete terms for employed physicians that preclude group members from practicing in the areas where the firm operates for a prescribed length of time. The large geographic scope of PE roll-ups increases the restrictions on physician mobility. The FTC (and several states) have proposed or passed laws to restrict non-compete clauses in

physician employment contracts.[32]

4.Enhance ownership transparency: an essential piece of healthcare transparency.

Policymakers, researchers, and the public currently lack comprehensive data on who owns or controls physician practices, often acquired or controlled through complex corporate and contractual structures that obscure the identity of PE or corporate investors.[33] Providing a centralized national database to enhance transparency on practice ownership and control can allow patients, policymakers, researchers, and other stakeholders to understand the extent and effects of PE involvement in healthcare, including changes in prices, utilization, and quality of care while holding acquired practices accountable. While steps have been taken to improve ownership transparency in certain settings like nursing homes, significant gaps regarding lack of comprehensive data on ownership structures, and financial details of ownership, currently hinder effective oversight and accountability measures.[34]

5.Strengthen enforcement of existing fraud and abuse laws.

PE firms' incentives to increase the profits of acquired practices may increase risks of overutilization, overbilling or upcoding, and self-referrals for ancillary services and also lead to stinting, reduced staffing levels, or inadequate supervision. To penalize PE-acquired practices from engaging in fraudulent billing, upcoding, self-referrals, and kickback schemes, federal enforcement of the False Claims Act (FCA), Stark Law, and Anti-Kickback Statute (AKS) could be more strictly enforced. Moreover, whistleblowers and government enforcers should attempt to hold PE-management companies liable, because their active management control of portfolio practices suggests they knowingly participated in the improper conduct.

6.Strengthen the No Surprises Act.

The No Surprises Act (NSA) bans surprise out-of-network (OON) billing used as a revenue strategy by PE-backed physician staffing firms. Yet, there's room for enhancement to curtail the potential abuse of the Act's independent dispute resolution (IDR) mechanism aimed at inflating OON reimbursements.

Recent data[35] showed that nearly 80% of the disputes were won by health care providers at rates above the median in-network rate with the majority of these disputes being initiated by providers or management companies that are PE-backed.[36] Hence, the current IDR process has been overloaded and weakened, where provider groups (including those who are PE-backed) are still leveraging loopholes to profit from the IDR methodology created by the NSA.

Stakeholder List by Policy Option Number: Federal Trade Commission (FTC)[1,3], Department of Justice (DOJ)[1,5], The Medicare Payment Advisory Commission [2,5], Centers for Medicare & Medicaid (CMS)[2,4,5,6], Department of Health and Human Services (HHS) [2,5,6] , State Legislatures and Attorney General[1,3,4,5]

Other Related Materials:

- ➔ Remarks to the FTC on Private Equity Investments in Physician Practices by Erin Fuse Brown
- ➔ Panel discussion on Private Equity and the Future of U.S. Health Care at Brown University
- ➔ Dr. Yashaswini Singh and colleagues (Drs. Ehsan Rahimy and Jane Zhu) explore the correlation between PE acquisition of ophthalmology practices and a rise in healthcare expenditures in this podcast by *Straight from the Cutter's Mouth*.

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