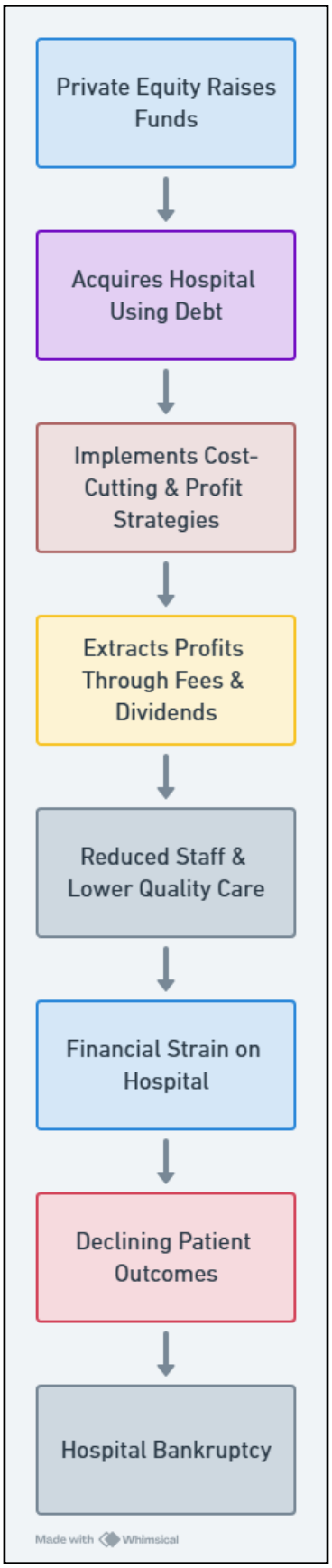

Private Equity in Health Care:

Selected references

LD 985 - An Act to Impose a Moratorium on the Ownership or Operation of Maine Hospitals by Private Equity Insurers.

March 2025

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Presented by Senator TIPPING of Penobscot March 2025

LD #985 132nd Maine

An Act to Impose a Moratorium on the Ownership or Operation of Maine Hospitals by Private Equity Investors

Overview: LD 985 will impose a five-year moratorium on Private Equity hospital investments, allowing time to develop appropriate laws to protect Maine Hospitals.

- With nearly 70% of health care financed by the public (1), the public must have a say if hospitals are to be acquired by for-profit businesses. Over 450 U.S. hospitals are owned by private equity — a rapidly growing trend. (2)
- The idea that private equity (PE) will make hospitals more efficient and provide better patient care is wrong. **A growing body of research shows that PE-backed hospitals have poorer care at higher costs (2).** The reason for this is simple: PE rewards its shareholders by syphoning off well-paid hospital services (e.g., labs) and leaves unprofitable services (e.g., birthing centers) to sink.
- Currently, all Maine acute care hospitals are owned and operated by non-profit entities. **PE ownership or operation of one or more Maine hospitals would worsen existing staffing, quality, and cost challenges.**

Case Study

The Steward Health Care saga demonstrates how private equity can destabilize healthcare systems: Cerberus Capital purchased the non-profit Caritas Christi hospitals in 2010, rebranded as Steward, sold off their real estate, purchased more hospitals across the country, and exited with $800 million in profits. Under subsequent management, Steward continued cutting costs and neglecting bills in order to keep up with its rent payments, resulting in care and safety concerns, including patient deaths. Steward filed for bankruptcy in 2024, with hospital closures that disproportionately impacted vulnerable communities, patients, and providers. (2)

The Way Forward:

- The regulation of Private Equity acquisitions must be carefully considered. There are many options including, among others, outright prohibition, increased financial transparency, rate regulation, and different insurance reimbursement requirements. It will take time for the Maine Legislature to determine the best course of action.
- **A moratorium will insure the best outcome for the Maine people.**

Definitions:

- **Private Equity (PE):** PE is a way of investing in private companies or institutions that are not listed on the stock exchange. PE firms invest in these companies "with the aim of restructuring, streamlining, or expanding operations to generate high returns for investors in short periods." (3) Unlike the U.S., other countries have enacted protective regulations.
- **Real Estate Investment Trusts (REITs)**: REITs allow investors to invest in real esate without having the responsiblity of taking care of the property itself.

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PRIVATE WEALTH SOLUTIONS

The Life Cycle of Private Equity

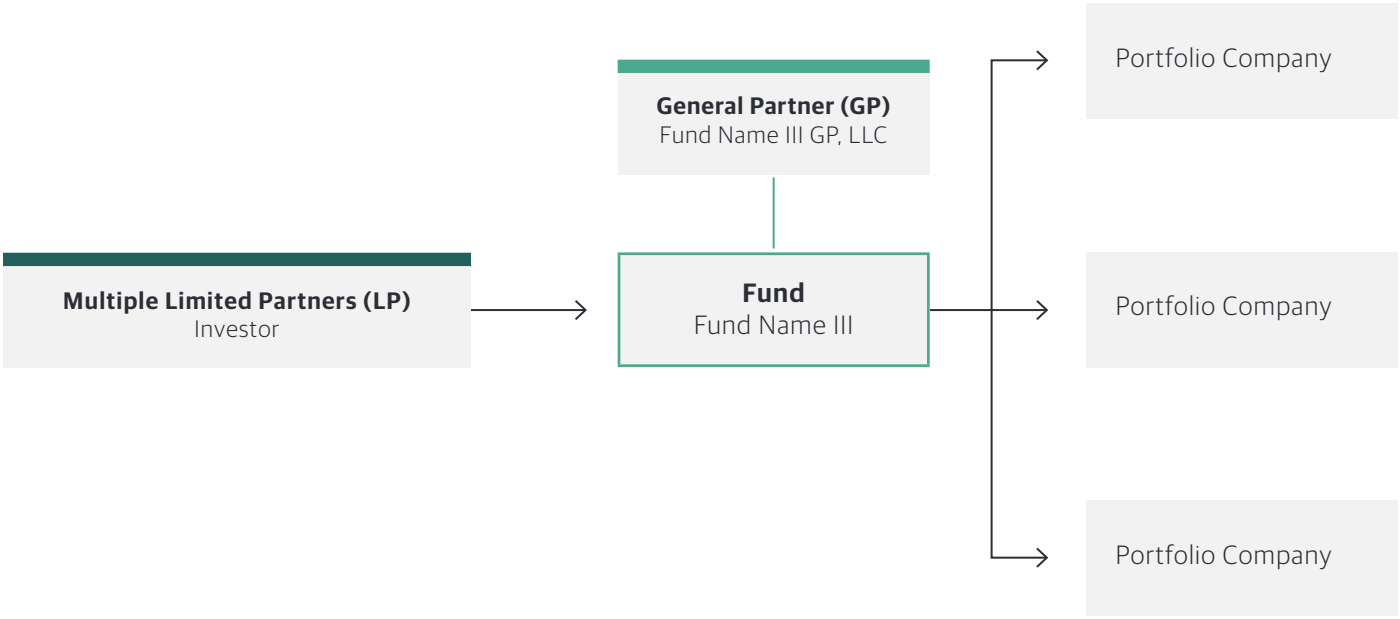
Private Equity managers aim to create value by providing investment capital to a wide range of businesses.

Private equity differs from public equity investing in several important ways. Here we explain the life cycle and key features of a private equity investment. In the three sections below, we examine private equity's (1) structure, (2) time horizon, and (3) differentiated performance measurements, each of which are critical to understanding the life cycle of private equity funds.

I. Building a Private Equity Fund: Structure Matters

Generally when a private equity fund is launched, the General Partner (GP) assumes responsibility for managing the fund and identifying investments. Limited Partners (LPs) are investors who contribute capital, but do not necessarily have discretion over the choice of investments. Performance incentives give the GP motivation to aim for strong performance, which, if successful, benefits both the GP and LPs. The alignment of interests to a certain extent between the two parties differentiates private equity from traditional investing. In their pursuit of returns, private equity managers typically aim to provide various resources to a portfolio company and work closely with them to foster operational improvements.

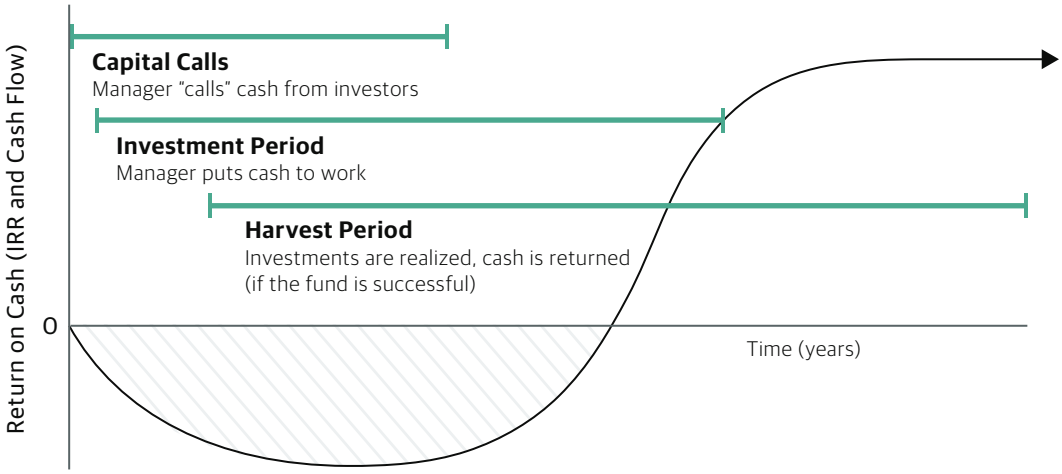
Figure 1: The Structure of Private Equity Funds



II. Staging the Time Horizon: Capital Calls, Investment Period and Harvest Period

The term of private equity funds can be upwards of 7-10 years. One way of thinking about the term is by dividing it into three stages: the fundraising period, the investment period, and the harvest period. After investors have committed capital during the fundraising cycle, the fund will begin to incrementally call this capital during the early stages of the investment period. This stage may span the first few years of the fund. Simultaneously, capital will begin to be deployed by investing in opportunities selected by the GP in the first 3-5 years. The final 3-7 years, the harvest period, is generally when most investments are realized, and the fund, if successful, returns any cash to investors.[1]

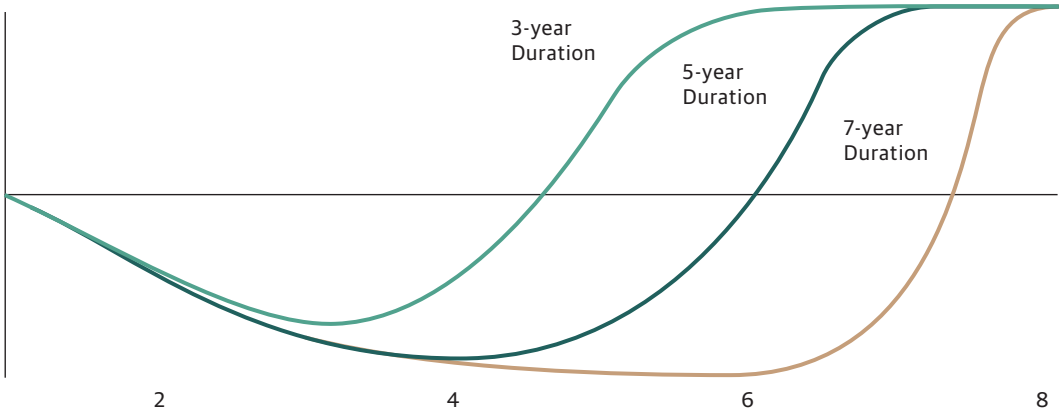
Figure 2: Illustrative Example of the Timeline of Private Equity Funds



III. Analyzing Performance: The J Curve Effect

The J-Curve characterizes an investor's potential performance experience through the life cycle of a fund. In the first few years, investors are providing capital while also paying management fees. As the fund deploys the capital, returns are not high enough to overcome fees, which results in a negative return. As time passes and if investments are successful, returns can improve. When this process is mapped out, it creates a "J" shaped curve as illustrated in Figure 3.

Figure 3: Illustrative Example of the J-Curve



1. The amount and priority of distributions will vary depending upon the terms of the specific fund.

For informational purposes only. A fund's offering materials provide specifics around terms and expenses. A fund's expenses may offset or exceed its profits. This information is not meant to be predictive of the performance of any particular fund, nor are they meant to suggest that all private funds result in positive returns or may avoid loss of principal. Private equity investments involve significant risk and typically high levels of leverage. Hypothetical performance results have many inherent limitations and no representation is made that any investor will, or is likely to achieve, results similar to those shown. Each investor's cash flows and returns will differ and may result in a total loss of principal. There can be no assurance that an allocation to alternatives would yield returns or protect capital. **Past performance does not guarantee future results.**

Key Risk Factors

Certain countries have been susceptible to epidemics which may be designated as pandemics by world health authorities, most recently COVID-19. The outbreak of such epidemics, together with any resulting restrictions on travel or quarantines imposed, has had and will continue to have a negative impact on the economy and business activity globally (including in the countries in which funds invest), and thereby is expected to adversely affect the performance of a fund's investments. Furthermore, the rapid development of epidemics could preclude prediction as to their ultimate adverse impact on economic and market conditions, and, as a result, presents material uncertainty and risk with respect to funds and the performance of their investments.

Certain information contained in these materials constitutes "forward-looking statements," which can be identified by the use of forward-looking terminology or the negatives thereof. These may include financial estimates and their underlying assumptions, statements about plans, objectives and expectations with respect to future operations, and statements regarding future performance. Such forward-looking statements are inherently uncertain and there are or may be important factors that could cause actual outcomes or results to differ materially from those indicated in such statements. Blackstone believes these factors include but are not limited to those described under the section entitled "Risk Factors" in its Annual Report on Form 10-K for the fiscal year ended December 31, 2020, and any such updated factors included in its periodic filings with the Securities and Exchange Commission, which are accessible on the SEC's website at www.sec.gov. These factors should not be construed as exhaustive and should be read in conjunction with the other cautionary statements that are included in these materials and in the filings. Blackstone undertakes no obligation to publicly update or review any forward-looking statement, whether as a result of new information, future developments or otherwise.

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✉ Email: privatewealthEMEA@blackstone.com

BX202103313S

PRIVATE EQUITY
RISK INDEX

MAINE

PRIVATE EQUITY RISK SCORE

39/100

MEDIUM RISK

KEY TAKEAWAYS:

- Maine is among the 10 states with the smallest share of its private sector workforce employed by private equity-controlled companies.
- Maine is among the bottom 10 states for the share of hospitals controlled by private equity.
- Maine is among the bottom 10 states for the share of single-family homes purchased by corporate investors over a five-year period.

PRIVATE EQUITY RISK

Higher Score = Greater Risk
Risk score from 0 to 100

Workers and Jobs	16/100
Share of private sector workforce at private equity-controlled companies (Average 2018-2022)	7.8%
Change in the share of workforce controlled by private equity from 2018 to 2022	29.7%
Layoffs at private equity-controlled companies (2015-2022)	631
Employee deaths and hospitalizations at private equity-controlled companies (2018-2022)	1

Health Care	45/100
Share of hospitals that are private equity-controlled	0.0%
Average Medicare patient survey rating of private equity-controlled acute care hospitals (1 = lowest, 5 = highest)	NA
Rate of readmission after discharge from private equity-controlled acute care hospitals	NA
Share of nursing homes that are private equity-controlled	12.6%
Average Medicare quality rating of private equity-controlled nursing homes (1 = lowest, 5 = highest)	2.6
Substantiated complaints per private equity-controlled nursing home (2019-2022)	3.6
Share of population in a metro area where a single private equity firm controls over 30% market share of one or more physician specialties	0.0%

Housing	24/100
Percentage of homes purchased by medium, large and mega investors (2018-2022)	4.3%
Change in share of homes purchased by medium, large and mega investors from 2018 to 2022	31.7%

Public Pensions	86/100
Share of state pension assets invested in private equity	19.2%
Share of state pension assets covered by private equity fee disclosure (including carried interest)	0.0%
Share of state pension assets covered by responsible contractor policy	0.0%

PRIVATE EQUITY RISK INDEX

M INE

ST TE POLICY SOLUTIONS TO DDRESS PRIV TE EQUITY RISKS

Workers and Jobs	dopted?
Severance for mass layoffs: For mass layoffs, require 90 days advance notice and require employers to pay one week of severance pay for each year of employment	
Bonding for unemployment insurance: Require private equity-controlled companies with high debt ratios to post a bond to the unemployment insurance system to cover unemployment insurance taxes in the event of a bankruptcy	

Health Care	dopted?
Review of health care mergers: Require notice, public review or approval process for hospital and other health care mergers	✔
Medical debt collection: Regulate medical debt collection	
Nursing home staffing: Require specific percentage of Medicaid or overall revenues in nursing homes to be spent on staffing costs for patient care	
Hospital fees: Limit hospital facilities fees	

Housing	dopted?
Good cause evictions: Prohibit evictions of tenants for reasons other than specified causes, such as non-payment of rent	
Rental cost caps: Cap annual rent increases statewide at inflation plus a small percentage or allow local jurisdictions to cap rent increases	✔
Tenants' right to purchase: Give tenants of mobile home parks and multi-family housing advance notice of sales and first right of refusal to purchase	✔
Landlord registry: Create a mandatory registry to identify beneficial ownership of all corporate landlords with multiple holdings	

State Pension Funds	dopted?
Fee disclosure: Require disclosure of all fees paid to each private equity fund by state pension funds	
Compliance with all state laws: Require signed affirmation from private equity fund managers that all of their portfolio companies comply with state labor laws, environmental laws and health codes	

Private equity behind 7 of 8 largest healthcare bankruptcies in 2024

Feb 12, 2025, 6:00 AM ET

New tracker shows private equity-backed bankruptcies in healthcare not slowing down

NEW YORK, NY, UNITED STATES, February 12, 2025 — https://www.einpresswire.com/

New research released by the Private Equity Stakeholder Project (PESP) shows that private equity played a disproportionately large role in large U.S. bankruptcies in 2024: 56% of large corporate bankruptcies (those with liabilities exceeding $500 million) had a history of private equity ownership. Private equity bankruptcies in 2024 resulted in at least 65,850 layoffs across the country. Specifically in healthcare, the percentage of private equity bankruptcies did not decrease between 2023 and 2024, despite reporting that all healthcare bankruptcies were down in 2024.

In 2023, 21% of healthcare bankruptcies involved private equity-owned companies. This number stayed the same in 2024, with 21% of healthcare bankruptcies being private equity backed. More importantly, however, was that 7 out of 8 (88%) of the largest (liabilities over $500 million) bankruptcies in the healthcare industry in 2024 had a history of private equity ownership.

In fact, more private equity bankruptcies have already been announced in 2025. Safety net hospital chain Prospect Medical Holdings filed for bankruptcy on January 11 with debts of more than $400 million. Its former private equity owner, Leonard Green & Partners had siphoned hundreds of millions of dollars in debt-funded dividends throughout its ownership, leaving the hospitals and the communities they serve holding the bag.

The healthcare analysis was published as part of a new tracker of U.S. bankruptcies involving companies where a private equity firm had a controlling stake in a company at the time of bankruptcy or since 2020. Private equity firms have demonstrated overreliance on cost-cutting measures and aggressive financial policies that have limited long-term prospects as they pursue short-term profits. Focusing on immediate financial gains can lead to significant mismanagement and economic instability, contributing to higher bankruptcy rates among private equity-owned companies.

Compiled using S&P Global Intelligence data and news searches, key findings of the tracker include:

- Although private equity accounts for 6.5% of the U.S. economy according to the primary lobby group for the industry, it was responsible for 11% of all corporate bankruptcies in 2024.

- Private equity-backed companies accounted for 56% of large corporate bankruptcies (companies with liabilities over $500 million) in 2024.

- Private equity-backed companies accounted for 7 of the 8 largest healthcare bankruptcies in 2024.

- Private equity-backed companies accounted for 21% of all healthcare bankruptcies

in 2024.

- Private equity-related bankruptcies in 2024 have resulted in at least 65,850 layoffs across the country.

The tracker includes several large high-profile bankruptcies with links to private equity, including that of multi-state hospital system Steward Health Care. Owned by private equity firm Cerberus Capital Management from 2010 to 2020, Steward filed for Chapter 11 bankruptcy in May 2024 with over $9 billion in liabilities. Since 2018, Steward has closed six hospitals in the US, resulting in the layoffs of at least 2,650 workers and reduced access to care for the communities they served. Steward has also cut important service lines, such as obstetrics, behavioral health, and cancer care, among others.

“As private equity’s footprint continues to grow in nearly every sector of the economy, the industry’s role in over half of large bankruptcies raises pressing questions for policymakers, investors, and consumers,” said Valentina Dabos, Senior Campaign and Research Coordinator at PESP and lead author of the tracker. “In healthcare, the consequences can be life-altering. Bankruptcy-driven closures or cost-cutting measures leave patients without reliable access to care, disrupting treatment plans and jeopardizing lives.”

Sam Garin
Private Equity Stakeholder Project
+1 248-303-7020
email us here

01.07.2025

Private Equity In Health Care Shown To Harm Patients, Degrade Care And Drive Hospital Closures

Bipartisan Senate Budget Committee investigation exposes how private equity firms prioritize profits over patients, jeopardizing care and eroding hospitals' financial health

WASHINGTON – Today, Sens. Chuck Grassley (R-Iowa) and Sheldon Whitehouse (D-R.I.), in their respective capacities as Ranking Member and Chairman of the Senate Budget Committee during the 118th Congress, **released** a bipartisan staff report on the findings of their investigation into the ways in which private equity investment in health care has negative consequences for patients and providers.

The Committee focused on two private equity firms—including the single-largest private equity investor in health care—that currently or previously invested in two prominent hospital operators. Throughout the course of its investigation, the Committee reviewed more than one million pages of documents from Leonard Green & Partners, Prospect Medical Holdings, Medical Properties Trust, Apollo Global Management (Apollo), Lifepoint Health and Ottumwa Regional Health Center, a for-profit Iowa hospital, that revealed new information about the business dealings of private equity-owned hospital operators. Documents obtained by the Committee detailed how private equity's ownership of hospitals earned investors millions, while patients suffered and hospitals experienced health and safety violations, understaffing, reduced quality of patient care and closures.

> "The Ottumwa community has personally felt the impact of private equity on its health care system. Under private equity ownership, wait times at Ottumwa Regional Health Center have gone up as patient experience has gone down. The diminishing quality of care, service availability and care capacity at the hospital is forcing Ottumwa residents to travel significant distances in order to receive appropriate treatment. Iowans deserve better," **Grassley said**. "A dependable health care system is essential to the vitality of a community. As always, sunshine is the best disinfectant. This report is a step toward ensuring accountability, so that hospitals' financial structures can best serve patients' medical needs."

> "Private equity has infected our health care system, putting patients, communities, and providers at risk," **Whitehouse said**. "As our investigation revealed, these financial entities are putting their own profits over patients, leading to health and safety violations, chronic understaffing, and hospital closures. Take private equity firm Leonard Green and hospital operator Prospect Medical Holdings: documents we obtained show they spent board meetings discussing profit maximization tactics—cost cutting, increasing patient volume, and managing labor expenses—with little to no discussion of patient outcomes or quality of care at their hospitals. And while Prospect Medical Holdings paid out $645 million in dividends and preferred stock redemption to its investors—$424 million of which went to Leonard Green shareholders—it took out hundreds of millions in loans that it eventually defaulted on. Private equity investors have pocketed millions while driving hospitals into the ground and then selling them off, leaving towns and communities to pick up the pieces."

Read the full report **HERE**, and view the documents released by the Committee **HERE** and **HERE**.

Key Findings:

Apollo-Owned Lifepoint Health and Ottumwa Regional Health Center (ORHC)

- **ORHC has been repeatedly failed by its private equity-owned operators, including current operator Lifepoint Health, which is owned by funds affiliated with Apollo. ORHC's private equity-owned operators failed to fulfill seven promises—including legally binding ones—made to ORHC when it was first acquired by a private equity-owned operator in 2010.** These failures are related to hospital growth, physician recruitment, routine capital expenditures, charity care, patient satisfaction and continuation of services.
- **The failed leadership of ORHC's private equity-owned operators has decreased patients' quality of care and caused the hospital financial harm**. Worsening conditions at the hospital, such as inadequate staffing, have resulted in significant negative consequences, such as a nurse practitioner's assault of female patients in 2021 and 2022.
- **Apollo has made millions in profits as a result of its investment into Lifepoint Health and ORHC's previous private equity owners, even as the hospital's operations have suffered.** According to the Committee's findings, Lifepoint Health pays Apollo $9.2 million annually just to cover management fees.

Leonard Green & Partners (LGP) and Prospect Medical Holdings (PMH)

- **LGP wielded substantial influence over PMH's financial decisions and incentivized PMH management to satisfy LGP's financial goals regardless of patient outcomes.** For example, LGP granted stock options to PMH employees based on reaching earnings goals, but similar incentives for improving patient safety and care at PMH's hospitals were nonexistent.
- **LGP and PMH's primary focus was on financial goals rather than quality of care at their hospitals, leading to multiple health and safety violations as well as understaffing and the closure of several hospitals.** During LGP's majority ownership, several PMH hospitals suffered from the effects of labor cuts, decreased patient capacity, inadequate and unsafe building maintenance, and financial distress.
- **Despite gross financial and operational mismanagement of its hospitals, LGP took home $424 million of the $645 million that PMH paid out in dividends and preferred stock redemption during LGP's majority ownership—in addition to over $13 million in fees—that left PMH in severe financial distress.** In order to pay out these distributions, PMH was forced to take on hundreds of millions of dollars in debt, eventually leading to PMH running out of cash and defaulting on its loans.

Background:

In March 2023, Grassley **wrote** to four companies with ownership interests in Ottumwa Regional Health Center in Ottumwa, Iowa—a formerly nonprofit hospital sold to a private equity firm in 2010—with concerns following a nurse practitioner's disturbing assault on nine sedated female patients. Grassley sought information on Ottumwa Regional Health Center's financial arrangements in an effort to determine the extent to which private equity ownership contributed to the alarming events. The companies failed to provide full and complete responses to Grassley's questions, prompting additional oversight.

In December 2023, in recognition of their bipartisan concern about the growth of private equity in health care, Grassley and Whitehouse **expanded** upon that investigation. The senators sent letters to the chief executive officers of Apollo Global Management, Lifepoint Health, Medical Properties Trust, Leonard Green & Partners, Prospect Medical Holdings and Ottumwa Regional Health Center, a for-profit Iowa hospital. The senators demanded answers regarding questionable financial transactions and business strategy that may have impacted quality of care for patients in hospitals under private equity ownership.

Today's **report** is a result of their inquiry.

Read the senators' full letters to each of the companies:

- **Grassley, Whitehouse Letter to Apollo Global Management Inc.**
- **Grassley, Whitehouse Letter to Medical Properties Trust**
- **Grassley, Whitehouse Letter to Lifepoint Health Inc.**
- **Grassley, Whitehouse Letter to Ottumwa Regional Health Center**
- **Grassley, Whitehouse to Leonard Green & Partners, L.P., Prospect Medical Holdings, Inc. and Medical Properties Trust, Inc.**

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Viewpoint

February 12, 2025

Who Should Own Americans' Health Care?

David U. Himmelstein, MD[1,2]; Robert Kuttner, MA, PhD[3]; Steffie Woolhandler, MD, MPH[1,2]

» Author Affiliations | Article Information

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Health reform debate has long focused on who gets coverage and how to pay practitioners and hospitals. Few have questioned who should own hospitals and other essential health care resources. The collapse of the 31-hospital Steward Health Care system, driven by its investor-owner's financial strategies, highlights the salience of proprietorship.

Steward was the descendant of the Caritas Christi hospital chain owned by the Archdiocese of Boston. In 2010, Cerberus Capital, a private equity firm, purchased Caritas Christi's hospitals for $895 million. Cerberus put up 27% of that amount, $246 million, with the balance financed by debt that the hospitals, not Cerberus, were on the hook to repay. Cerberus promised regulators it would invest in facility upgrades, a promise it met, in part, using borrowed funds that deepened the hospitals' indebtedness to $1.4 billion by 2015. By then, Cerberus had also sold off Steward's laboratory services and 13 of its medical office buildings. In 2016, it sold the hospitals' remaining real estate for more than $1 billion, used some of the proceeds to reward the investors and the hospitals' chief executive officer (CEO), and left the hospitals owing large and escalating lease payments.[1,2]

Four years later, Cerberus sold the hollowed-out hospital chain to a group led by the chain's CEO. He subsequently went on a buying spree, using funds from sale-leaseback transactions similar to Cerberus' Massachusetts deals to assemble a multistate chain of hospitals with 8000 beds, as well as 25 urgent care centers and 42 skilled nursing facilities. But burdened by the unsustainable lease costs, Steward spiraled downward financially (even as it refused regulators' demands for legally required financial reports), leaving the hospitals unable to afford essential supplies, equipment, repairs and staff, reportedly contributing to at least 15 patient deaths. Meanwhile, Steward funded private jets for the CEO's travel, subsidized his pur-

chases of lavish homes in Spain and Costa Rica, and paid millions in management fees to an outside firm he controlled.[1,2]

In May 2024, Steward filed for bankruptcy, owing employees $290 million, vendors and suppliers almost $1 billion, and its landlord $6.6 billion for long-term lease payments. Two of its Massachusetts hospitals were shuttered; the others were rescued by large infusions of state funds, with the initial bolus earmarked to repurchase the hospitals' buildings and land. Most of Steward's non-Massachusetts hospitals remain in operation, many kept alive by the landlord's temporary rent concessions. A private equity-backed firm purchased Steward's 5000-practitioner physician group at a bankruptcy auction.

Other private equity firms have followed a playbook similar to Cerberus'. In the wake of private equity acquisitions nationwide, acquired hospitals' assets have fallen, on average, by 24%.[3] After the Carlyle Group purchased ManorCare's more than 500 nursing homes using $5 billion in loans (which the nursing homes, not Carlyle, were responsible for repaying), it sold off the homes' real estate for $6.1 billion and kept the proceeds. ManorCare, saddled with a $472 million yearly rent bill, laid off staff, incurred mounting citations for quality violations, and went bankrupt.[4]

Private equity firms have used different strategies to profit from the physicians' practices they've purchased. Having cornered the market by "rolling up" a large share of, for instance, dermatology, gastroenterology, or emergency medicine practices in a region, they have used their leverage to boost prices. And they have profited by replacing physicians with cheaper mid-level clinicians and ramping up the delivery of questionable services like repeated skin biopsies on nursing home residents with dementia, performed by physician assistants.[5]

Steward's saga, and other instances of private equity firms' smash-and-grab approach to profit making, are striking for their audacity, reflecting their business model, which calls for jettisoning acquisitions after realizing short-term gains. But they are only extreme cases of a broader malady—the deepening commercialization of US health care. The conflict between financial ambition and clinical mission is also present, if less acute, in other investor-owned health care firms, eg, investor-owned hospitals' greater likelihood of providing profitable services like invasive cardiology and eschewing unprofitable ones like obstetrics.[6] And even among nonprofit hospitals, the need to generate surpluses in order to amass the capital needed for the construction or modernization of facilities often leads them to prioritize lucrative services (eg, elective procedures) over money losers like obstetrical care or care for uninsured people. And among all ownership types, mergers and acquisitions have created sprawling hospital chains with the clout to demand higher prices, led by executives whose distance from the staff they oversee and the communities they serve insulates them from the clinical consequences of their decisions.

While profit-seeking stratagems often raise costs and sometimes undermine care, even those deployed by private equity firms generally comply with the letter of the law. Owners have the right to use their prop-

erty as they see fit, even (as in Steward's and ManorCare's cases) to profit by running it into the ground. But while shuttering restaurants or toy stores—as private equity investors did after eviscerating Red Lobster and Toys "R" Us—may upset customers, closing a hospital or short-staffing a nursing home is more consequential. Moreover, unlike toys or restaurant meals, government funds 69% of health expenditures.[7]

Regulations can curtail owners' prerogatives—often to good effect—but they can't change owners' goals. Absent policy changes that disconnect care from commerce, health care CEOs are unlikely to heed their better angels.

The incremental reforms that some have proposed applying to private equity in health care[8]—improved oversight of acquisitions, increased financial transparency, minimum staffing ratios and spending floors, and limiting the amounts of debt and lease costs imposed on acquired facilities—might yield benefits. Enforcing the spirit and not just the letter of the many state laws prohibiting nonphysician ownership of physicians' practices could restrain private equity and insurance firms' incursions in care.[9] Additional targeted policies could sharply curtail private equity involvement in health care delivery; for example, a proscription on Medicare and Medicaid payments to private equity–owned health care facilities and practitioners. Prohibiting investor-owned practices, hospitals, and other facilities from participating in Medicare and Medicaid—mirroring Medicare's pre-1980 exclusion of for-profit home care agencies and New York State's ban on for-profit hospitals—would have even wider effects.

Addressing the financial incentives that skew priorities at nonprofits would require even more fundamental and difficult reforms. Universal coverage with uniform reimbursement rates applied to all patients could obviate preferences for patients with better-paying coverage. Freeing hospitals from the imperative (and license) to accumulate surpluses in order to fund their capital needs would vitiate incentives to prioritize lucrative services. That might be accomplished by adopting the grant-based capital funding approach used by governments in Canada, some European nations, and even in the past in the US (under the Hill-Burton program), together with precluding the diversion of patient care revenues to profit/surplus or excessive compensation for executives.

For Steward's owners, and a growing share of health care proprietors, money has become the mission. Refashioning ownership to vest governance in locally accountable public agencies or tightly regulated nonprofit boards could help make health care institutions answerable to the communities they serve. Dominion over medical resources should reside with them, not with the highest bidder.

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Corresponding Author: David U. Himmelstein, MD, Hunter College, 255 W 90th St, 12A, New York, NY 10024 (david_himmelstein@hms.harvard.edu).

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Private equity's appetite for hospitals may put patients at risk

By Maya Brownstein December 16, 2024
https://hsph.harvard.edu/news/private-equitys-appetite-for-hospitals-may-put-patients-at-risk/

In the wake of the Steward Health Care crisis, corporate and private equity ownership of health care has come under new scrutiny. Here, Harvard health policy experts weigh in on the growing corporatization of the U.S. health care system and what it means for patients, practitioners, and public health.

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Throughout 2024, eye-opening news headlines from around the country trained a spotlight on the collapse of Steward Health Care:

As Steward hospitals teeter, CEO's $40 million yacht is docked in the Galapagos Islands

Sick patients collapsed waiting for care in overwhelmed Steward hospital's emergency department

Steward Health Care files for Chapter 11 bankruptcy

Steward owned more than 30 hospitals across Arizona, Arkansas, Florida, Louisiana, Massachusetts, Ohio, Pennsylvania, and Texas. Its volatility and eventual crash jeopardized access to health care for millions of patients.

How did Steward, at one point the largest private for-profit health system in the U.S., go belly up?

The long and short: In 2010, private equity firm Cerberus Capital Management purchased Caritas Christi Health Care, a struggling eastern Massachusetts hospital system, from the Archdiocese of Boston, converting it from non-profit to for-profit and rebranding it as Steward Health Care. In 2016, after years of continued financial instability, Steward signed a sale-leaseback agreement with Medical Properties Trust (MPT), selling the land and buildings occupied by its hospitals to the real estate investment trust then leasing them back. Steward made $1.25 billion from the agreement—enough to steady its financial footing, pay off Cerberus, and fund a growth spree. The next year, the company purchased 26 more hospitals across the country. But with the agreement came what many viewed as inflated rents.

By 2020, Cerberus, having made $800 million in profit on its initial investment, decided to sell Steward hospitals to a group of its physicians, essentially transferring ownership back to Steward's management team, led by CEO Ralph de la Torre. Over the next several years, concerns about patient care and safety at Steward hospitals mounted as the company opted to cut

costs and neglect bills in order to keep up with its rent payments to MPT. In January 2024, MPT announced that Steward was $50 million behind on those payments. By May, the company filed for bankruptcy. Financial documents made clear that the company had paid hundreds of millions to investors and leadership, including de la Torre, who enjoyed a lavish lifestyle while patients at Steward hospitals faced increasingly unsafe conditions. De la Torre was subpoenaed by Congress in July; he failed to appear.

After months of tense negotiations between state governments, Steward, MPT, and potential buyers, by November, most Steward hospitals had found new owners, a mix of non- and for-profit hospital systems and private equity firms. But two hospitals didn't survive: Carney Hospital, which served Boston's low-income, majority Black and Hispanic southern neighborhoods, and Nashoba Valley Medical Center, which served 17 suburban and rural communities across central Massachusetts. Thousands of patients and hundreds of staff have been left to find health care and jobs with new providers farther away.

The Steward meltdown has captured the attention of the public and policymakers not as an outlier, but as an object lesson. Its story shines a light on the growing role of private equity in the U.S. health system, helps explain rising discontent among patients and clinicians, and lays bare the dangers of prioritizing profits over people in health care.

A 'core contradiction'

John McDonough, professor of the practice of public health at Harvard Chan School, calls private equity "the sharp end of capitalism."

"It's otherwise often described as 'capitalism on steroids,'" McDonough said. "It's for-profit business in its most aggressive form. [Private equity firms] seek returns on their investment as high as possible as quickly as possible, then rush to sell off that investment and go on to their next conquest."

After decades establishing a presence everywhere from manufacturing, to telecommunications, to grocery stores, in the mid 2000s private equity firms began targeting health care. It was a natural next step: The industry is worth nearly $5 trillion in the U.S., offering significant, dependable cash flow. Firms saw the potential for profits and began buying up physician practices and health facilities, from hospitals to nursing homes to fertility clinics, looking to at least double their initial investment and then sell within a short time, often three to seven years.

Private equity's foothold in health care has continued to grow. In 2021, according to researchers at UC Berkeley, 5,779 physician practices, specializing in everything from primary care to oncology, were owned by private equity firms—up from 816 in 2012. Nonprofit watchdog the Private Equity Stakeholder Project (PESP) reported that, as of February 2024, nearly 460 U.S. hospitals were owned by private equity firms. These hospitals—which include non-specialty acute care hospitals, rehabilitation hospitals, psychiatric facilities, and long-term acute care facilities—represent 8% of all private (not owned by the government) hospitals and 22% of for-profit hospitals.

5,779 physician practices were owned by private equity in 2021—up from 816 in 2012

22% of for-profit hospitals—460 in total—are currently owned by private equity

80%of physicians are employed by a hospital system or corporation—up from 60% in 2019

But ownership by private equity is just the latest version of capitalism's creep into health care. Its way was paved by corporations entering the industry in the 1980s as an era of free market fundamentalism emerged and the "maximizing shareholder value" movement began to boom. Publicly traded companies began buying up hospitals and health facilities, as well as physicians and physician practices, to establish their own health systems. Today, nearly a quarter of U.S. hospitals are run by for-profit entities that promise to bring business smarts and a flow of capital to health care delivery.

"The pitch is that corporations can raise capital and invest in improving the business—quality of care, operations, professional management—in a way non-profits can't," said Meredith Rosenthal, C. Boyden Gray Professor of Health Economics and Policy. "But the challenge is that because health care is so important, the public expects these corporations to prioritize public interest over profits. And that's not what they're built to do."

"But the challenge is that because health care is so important, the public expects these corporations to prioritize public interest over profits. And that's not what they're built to do."
Meredith Rosenthal, C. Boyden Gray Professor of Health Economics and Policy

"Medical care has always had a for-profit element. Physicians were mostly small businesspeople," McDonough said. "But there's a difference between a sole proprietor or small business and a mega-corporation that believes its only purpose in the world is return on equity to shareholders. Hold that belief up against a medical provider's belief that patients come first, and right away there's conflict. It's this core contradiction that I think American society has never sufficiently grappled with."

Non-profits like profits, too

It's not just corporate health care providers producing this dilemma. Non-profits, which remain the majority of U.S. hospitals and health care facilities, sometimes prioritize profits over their social missions—and community benefit requirement cementing their tax-exempt status—in order to grow, and even just survive, in a tight economy and increasingly competitive health care market.

“Economists have studied whether non-profits behave differently than for-profits. Do they provide more charity care [free or discounted medical services for poor patients]? Do they invest more in community well-being? The answer generally has been no,” Rosenthal said.

One study, conducted in 2020 by Joseph Bruch, PhD ‘21 and David Bellamy, PhD ’23, indeed found no significant difference between what non-profit and for-profit hospitals spend on charity care as a percent of their total expenses.

“It’s getting harder and harder to tell the difference between a non-profit and for-profit board of directors,” McDonough said. “It’s this for-profit ethos that has swarmed and swamped the U.S. medical space. Many people think the system can prioritize patients and profits at the same time and that it will be okay. But then we look at calamities like Steward, and we think to ourselves, maybe it can’t. And maybe it won’t be okay.”

Consequences of cost-cutting

For Steward patients, it wasn’t okay. Reports of poor-quality care and compromised patient safety ran the gamut: from understaffed emergency rooms and ill-equipped maternity wards, to stairwells infested with bats, to cancelled surgeries and suspended trash service due to unpaid invoices. These extreme examples represent what a growing body of research suggests: Health care quality declines when private equity and its extreme for-profit approach take over.

A 2023 study found that Medicare patients at private equity-owned hospitals suffered a 25% increase in hospital-acquired complications compared to Medicare patients at hospitals not owned by private equity. These complications included a 38% increase in bloodstream infections from central lines—longer-term, surgically inserted ports through which patients can intravenously receive fluids, medications, and blood—despite 16% fewer central lines placed. Similarly, the rate of surgical site infections doubled at private equity-owned hospitals while those at the control hospitals decreased. And while falls at hospitals not owned by private equity have been trending downward—a product of a nationwide, decades-long hospital safety movement—falls at private equity-owned hospitals have remained steady, amounting to a 27% relative increase.

“We believe [these findings are] largely explained by staffing cuts,” said the study’s senior author Zirui Song, PhD ’12, associate professor at Harvard Medical School and Massachusetts General Hospital. “The unique financial pressures private equity-owned hospitals face, such as new debt placed on them from the acquisition and expectations of profitability in the short run, may lead to cutting the costs of delivering care—such as through reducing staffing. But while you may be able to substitute people with machines in other industries, health care remains human-labor intensive, especially inpatient care. Cutting staff can have salient consequences for quality of care and patient outcomes.”

Another study by Song and colleagues found that private equity-owned hospitals earned 27% more income after acquisition than hospitals not owned by private equity. That financial gain was fueled by increasing charges—the asking prices for hospital services—by between 7% and 16%,

depending on the department, as well as by issuing more charges per day and seeing fewer patients enrolled in Medicare, which provides lower reimbursements than commercial insurers.

Exacerbating disparities

What type of hospitals does private equity tend to target?

New evidence from Song and colleagues suggests that firms typically set their sights on financially healthier—rather than struggling—hospitals, compared to similar peer hospitals that were not acquired. That's because private equity firms tend to place new debt onto acquired hospitals, and those on stronger financial footing are better able to take on that debt.

There are examples, however, of hospitals serving mostly uninsured or publicly insured patients being taken over by private equity firms. These takeovers may exacerbate health disparities, as many of these disadvantaged patients belong to racial or ethnic minorities and already suffer worse health outcomes, said Song. When discontinuation of hospital services—or total closure—occurs, it has an outsize impact in communities where access to health care is already limited. Carney Hospital is one such example; in an op-ed, Harvard Chan School's Alecia McGregor, assistant professor of health policy and politics, called its closure "a matter of life and death" that threatens to deepen Boston's already extreme racial disparities in health.

"I don't think there is enough evidence to definitively say that private equity targets hospitals that mostly serve people of color. But in some cases, these financially vulnerable facilities may fit their business model," McGregor said. "And when private equity backed acquisitions lead to closures, this is when marginalized communities often hurt the most. Take Hahnemann University Hospital, for instance—a historic facility serving mostly low-income Black and Hispanic Philadelphians that was closed by its private equity owner after less than two years. Many viewed the closure as a maneuver for the hospital's prime city real estate."

PESP also reports that a quarter of private equity-owned hospitals serve rural populations, whose health care alternatives are sparse if they're unsatisfied with quality or costs and whose outcomes are jeopardized if the only hospital in town closes. Since Nashoba Valley Medical Center was closed, first responders travel around 15 miles to transport patients to emergency care, according to a local fire chief. They used to travel three.

Policy potential

"Theoretically, there could be benefits to private equity investments in health care. They could provide facilities and clinicians with an infusion of capital, but also with managerial know-how and business acumen that might improve health care, such as through making care more 'efficient,'" Song said. "Unfortunately, however, the current evidence base does not support that. Rather, evidence seems to suggest that by cutting the human labor and other inputs that make care delivery possible—also seen in private equity acquisitions of physician practices and nursing homes—the care might just become less safe."

Song published a series of policy recommendations for officials looking to reduce corporate influence, specifically that of private equity, over health care delivery and outcomes. His recommendations for state policy included reviving or enforcing corporate practice of medicine laws, which, in their aim to protect physicians as independent practitioners, can go as far as prohibiting corporations from hiring physicians or influencing medical decisions. His recommendations for federal policy included:

- Strengthening fraud and abuse protections
- Improving Federal Trade Commission staffing and bandwidth, in order to improve oversight over health care acquisitions and mergers
- Discouraging risk-taking behavior by corporate owners (sometimes referred to as moral hazard), through measures like legally affiliating private equity firms with their rolled-up set of acquired entities, limiting the percent debt a firm can use to make an acquisition, and reforming the tax benefit that allows private equity proceeds to be taxed at 20% (rather than the regular corporate business rate, which is higher)
- Regulating health care prices and prohibiting surprise billing
- Increasing public transparency into private equity acquisitions

Some policymakers have already begun efforts to enact these recommendations. In June, Massachusetts senators Elizabeth Warren and Edward Markey introduced the Corporate Crimes Against Health Care Act, which would penalize private equity firms if a health facility they own closes or has poor finances resulting in injury or death to a patient. A month later, Markey proposed another bill, the Health Over Wealth Act, which would require greater transparency for private equity firms and for-profit companies that own health care entities.

Meanwhile, in the last year, several congressional committees—including the Senate Budget Committee, the Senate Committee on Homeland Security and Governmental Affairs, and the House Committee on Ways & Means—have launched investigations into and held hearings on the role of private equity in health care. On a state level, legislation to regulate private equity in health care is pending in Massachusetts, New Jersey, New York, and Pennsylvania. California, Indiana, Minnesota, New Mexico, and Oregon already have programs that do so. (In September, California Governor Gavin Newsom vetoed a bill that would further intensify regulations.)

Deeper changes

These regulations—if passed—could help protect physicians as well as patients. One of the significant changes from the corporatization of health care is that, increasingly, physicians are no longer working for themselves. In the 1980s, most doctors owned their own small clinics. Today, nearly 80% are employed by a hospital system or corporation—up from just over 60% in 2019, according to Avalere Health.

“If you’re a physician working in a hospital, chances are you don’t work for the hospital. You work for a corporation,” McDonough said. “And when you sign on with the corporation, you sign a non-compete clause. You can’t criticize anybody or raise your voice even as your workload keeps growing, even when you’re the only physician in the emergency department

with multiple traumas, even when you're seeing patients being put at risk and your colleagues being exploited."

Burnt out, frustrated—and organizing

In November, primary care physicians employed by Massachusetts' largest health system, non-profit Mass General Brigham, cited the "corporatization of medicine" among their reasons for pushing to unionize. Across the country, a small number of doctors—around 70,000, representing 8% of the profession—already belong to a union. But that number has been growing steadily, and will likely continue to do so with the arrival of a new generation of physicians. Currently, 20% of medical residents—more than 32,000—belong to a union, a number that has doubled since 2019.

As this hypothetical proves reality for more and more physicians, many are banding together to advocate for some of the policies Song recommends. A physician advocacy group called Take Medicine Back, for instance, is working to garner support for corporate practice of medicine laws.

But tighter regulations on private equity and corporations in health care can only achieve so much. Many experts believe deeper changes to health policy and investments in public health are equally needed. Examples include:

- Higher reimbursements for public insurance, so that, in McGregor's words, "small community hospitals that serve populations largely on Medicare or Medicaid can better meet their costs and remain in business without the private sector filling in"
- Simplified health insurance systems, like those in the Netherlands and Switzerland, that use private insurance plans that are streamlined, with fewer choices, making them more transparent and easier to understand and regulate
- Funding for non-medical social care, such as housing and food—in Rosenthal's words, "social supports that make a big difference in people's lives and that, when underinvested in, drive up our health care costs"

'One of the biggest lies we've ever been told'

These additional policy levers could help diminish for-profit health care's influence, but by how much is a matter for debate.

"At the end of the day, I think we're always going to have this kind of mixed public and private system," Rosenthal said. "Politically, it would be very challenging for us to go in a more government-focused direction. There's just a lot of distrust. And the one big thing that's quite different about our country is that we don't consider health a right. It's not in our constitution like it is for many of our peers."

But significant change may be on the horizon, driven by public discontent around health care and growing visibility, brought by cases like Steward, into the consequences of a system where profits can come at the expense of patient care.

When health care follows the money, we get sicker and sicker.
Alecia McGregor, assistant professor of health policy and politics

"As a country, we've become desensitized to this notion that health care is the same as any ordinary commodity, and that the provision of health care can be run like any other business," McGregor said. "I think this is one of the biggest lies we've ever been told, because we've seen health care costs skyrocket in a way that's different from any of our wealthy country counterparts, yet our outcomes—life expectancy, maternal health, infant mortality—are abysmal. When health care follows the money, we get sicker and sicker."

"Surrendering our health care system to the for-profit marketplace was a fundamental error that we're paying the debts of right now," McDonough added. "But I see people working on it, reassessing the role and value of for-profits and asking what a post-neoliberal health care system might look like."

In the meantime, the story of Steward, now under new ownership and a new name, continues to unfold. Its physician network, made up of 5,000 doctors, was recently purchased by Rural Healthcare Group and rebranded as Revere Medical. Rural Healthcare Group is owned Kinderhook Industries, a private equity firm.

For concerned patients, Rosenthal offered some concrete advice. "Find a provider you trust and be skeptical. Always ask about the benefits of an intervention. Because more services, more tests, more treatments are not always beneficial—but they're always profitable."

About The Author

Maya Brownstein

Media Relations Manager in the Office of Communications

Harvard T.H. Chan School of Public Health

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