Private Equity in Health Care: Three Takeaways Going Forward

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Federal agencies are turning up the volume on their warnings to private equity (PE) investors to stop putting profit motives before patient health. The Federal Trade Commission (FTC), the Department of Health and Human Services (HHS), and the Department of Justice (DOJ) announced on March 5, 2024, the launch of a cross-government inquiry ("Inquiry") on the impact of corporate control in health care.

The Inquiry was preceded in late February by a Request for Information (RFI) seeking data from the public about health care transactions, particularly those that are below the threshold for DOJ or FTC antitrust review under the Hart-Scott-Rodino Antitrust Improvements Act. According to the press release announcing the Inquiry, information submitted in response to the RFI would inform the agencies' "enforcement priorities and future action, including potential regulations aimed at promoting and protecting competition in health care markets and ensuring appropriate access to quality, affordable health care items and services."

These same agencies also held a Private Capital, Public Impact Workshop on Private Equity in Healthcare ("Workshop"), also on March 5, 2024, detailing many examples of significant harm resulting from private equity and other investments in health care entities. The Workshop provided specific examples of failed hospitals, depleted health care professionals, and increased patient mortality that were attributed to the profit motives of private equity and similar investors seeking short-term returns and exits. Speakers discussed studies that show a clear trend that levels of care decline and that patients and providers suffer following PE investment. FTC Chair Khan referenced the Welsh Carson case (FTC v. U.S. Anesthesia Partners, et al.) and the revised Merger Guidelines that make it clear that DOJ and FTC will look at the cumulative effect of smaller deals that together eliminate competition and increase

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prices.

The FTC's Complaint, filed in September 2023 in the Southern District of Texas, asserts that through sequential roll-up acquisitions in multiple markets, Welsh Carson's portfolio company U.S. Anesthesia Partners (USAP) acquired large swathes of the Texas anesthesia market, thereafter using its market share as well as price-setting agreements with competitors to markedly increase rates. In Austin, for example, USAP's market share after its initial acquisition was just 3.5%; market share increased to 50% after a series of smaller acquisitions spanning just seven years. The FTC alleges that USAP's cumulative acquisitions—none of which, standing alone, might have been problematic—and subsequent actions have "cost Texans tens of millions of dollars more each year than they did before USAP was created" and that, "by 2020, USAP's rates were 'nearly 40% more expensive than the average cost of all other anesthesia providers in Texas . . . ,'" with no concurrent improvement in services. The case is still in its early stages, and USAP and Welsh Carson have filed motions to dismiss arguing, among other things, that the FTC's attempted "hindsight enforcement over long-completed investments . . . is well beyond the authority of the FTC." A hearing was held on the motions to dismiss on April 8, 2024, but the court has not yet issued a ruling.

The Workshop ended with a fireside chat featuring Rhode Island Attorney General (AG) Peter Nerohna, who discussed his use of the RI Hospital Conversions Act that requires the approval of the AG and the Department of Health before the transfer of more than 20% of ownership or control in hospitals in RI. This requirement of a government review before an investor can sell its interests in a hospital provides regulators with the opportunity to examine the financial health of the hospital and determine whether to allow the investor to finalize a sale. In one case, AG Nerohna required that an equity investment firm place millions in escrow before approving its sale of two hospitals that were in substantial debt.

Analysis of the Welsh Carson case and the recent government agency scrutiny highlights a fundamental disconnect between private equity investors and many health care businesses. Health care provider services are almost entirely paid for by Medicare,

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Medicaid and other third-party payors. The simple truth is that health care reimbursement is capped, which means that revenues are capped. In the late 1980s and 1990s, physician practice management (PPM) investors discovered that simple truth—health care reimbursement is not sufficient to pay for the cost of quality health care and still generate an extra layer of increasing profits. The short-term profit goal of many investors thus requires the very strategies that result in antitrust and other regulatory scrutiny: increasing prices and decreasing care quality by cutting costs and requiring providers to squeeze in more patients.

Those strategies did not work twenty years ago (except for the companies that got in and out early on) and are not likely to work long-term now. It seems clear that the current window is closing for buying providers with debt, stripping assets and cutting costs to increase short-term profits, then reselling the debt-burdened providers. FTC Chair Lena Khan stated at the Workshop that "[t]hese short-term profit-extracting strategies can undercut long-term value, and, in the context of health care, have life-or-death consequences."

Investors in health care businesses can learn (or relearn) from the current state of affairs. Three takeaways are:

- Health care reimbursement is finite. The goal of short-term investments in providers that depend on third party reimbursement is a hard nut to crack and will be watched carefully by enforcement authorities. Technology or health and wellness companies that do not depend solely on third-party reimbursement, but are largely self-pay, may be a more successful play.
- The Government has your number if you are planning to generate profits by roll-ups, or buying up small practices, resulting in market consolidation, increased prices, and decreased care. Watch out for requirements like the RI law that limit the ability of an investor to buy with debt and exit with capital. The RI law and similar statutes will increase the risk of investment because the ability to exit quickly may be blocked by regulators.

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- Investment in health care can work, but it takes real investment on the front end and a long-term view with a shared vision. New technology or value-based care arrangements may be able to create savings without compromising care—but to do those right requires investments up front and having goals that mesh with those of the acquired providers and applicable laws. A long-term view means holding onto the assets and improving them over time, thus increasing their inherent value.

The message is clear that the federal and state governments will use their competition and other authority to exercise more oversight of health care transactions that individually may not meet the threshold for antitrust scrutiny. Regulators also will use other arrows in their quivers to disrupt investments they see as harmful to the health care delivery system, patients and providers. For more information, contact the authors or any member of Frost Brown Todd's Private Equity and Venture or Health Care Innovation teams.

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