OPP/BE Private Equity Healthcare Workshop | March 5, 2024

Tamar Katz:

Good morning and welcome to Private Capital Public Impact, an FTC workshop on private equity in healthcare. My name is Tamar Katz and I'm an attorney advisor in the FTC's Office of Policy Planning. On behalf of the entire FTC Workshop team, we're delighted that you're joining us today via our live webcast. Before we begin our program, I have a few housekeeping details to cover. First, we encourage viewers to participate in this event in real time by joining us on Twitter. Our Twitter handle is @FTC and we'll be tweeting using the hashtag PEHealthcareFTC.

Second, we have another opportunity for public participation and input in these important issues. This morning, the FTC, the Department of Justice and the Department of Health and Human Services launched a joint public inquiry into corporate profiteering and healthcare. We encourage the public and all interested market participants to contribute by submitting their stories and views. You can submit a comment at regulations.gov and we'll also post a link to that opportunity to comment from the webpage for this event.

Third, shortly after the event, a video recording and transcript of this workshop will be available on our workshop webpage. Our intent is to create a lasting resource for everyone who's interested in this important topic. Finally, as with any virtual event, please bear with us if we experience any technical issues with our livestream. And now I have the great pleasure of introducing our first speaker, Chair Khan, to kick off our workshop. Chair Khan?

Chair Khan:

Great. Thanks so much, Tamar. Good afternoon, everybody. It's so great to be here with you all and I'm so excited to learn from the knowledge and expertise on this critical topic. Really just want to start by thanking all of the speakers that you'll hear from today spanning leaders from the Department of Justice and Department of Health and Human Services, respected academics and healthcare workers who have seen firsthand the impact of private equity investments in healthcare. I also want to thank our Office of Public Policy and Bureau of Economics for spearheading today's workshop and bringing together such a terrific group. And lastly, just want to also give a thanks to congressional leaders, particularly Senators Grassley and Whitehouse, who are spearheading a congressional investigation into private equity buyouts of hospital and also providing some much needed light in this opaque area.

So much has changed in the provision of healthcare over the past decades. One area that has been top of mind for the FTC is private equity acquisitions of healthcare service providers such as outpatient clinics, nursing homes, and physician practices. In recent years, these private investments have soared. Private investments can sometimes be an important source of capital, especially for small to mid-size companies that can benefit from the access that this financing provides. Some private equity firms take

a more long-term view and focus on creating real operational improvements to generate value in ways that provide broader benefits, but we've also seen some private equity firms take a different approach. [inaudible 00:03:12] companies with enormous [inaudible 00:03:25] Over the last two years, the FTC has heard an outpouring of concern about the ways that private equity buyouts in healthcare have worsened outcome for workers and patients alike. One physician's assistant told us that the private equity entry into healthcare had led to punishing hours and a sharp decline in patient care, including shortages of basic drugs and supplies. A doctor in Minnesota told us that years of consolidation in her field and the increasing focus on efficiency and profits have resulted in patients having to travel further and further distances for lower quality care. A registered nurse wrote to us about how she has seen mergers and private equity acquisitions in healthcare result in a disenfranchisement in the healthcare system that leads patients to forego care.

A common theme across comments is that growing financialization in the healthcare industry can force medical professionals to subordinate their medical judgment to corporate decision-makers, profit motives at the expense of patient health. A close look at recent deals can bear that out, exposing a number of concerning extractive practices that we've seen adopted in some instances. One practice we've seen is the short-term, high-risk and low-consequence ownership that can encourage a flip-and-strip approach. Often private equity firms can use large amounts of debt to acquire companies with the goal of increasing profits quickly so that they can resell and reap returns a few years later.

Healthcare workers have reported staffing cuts and increased hours that can worsen patient care in a range of ways from longer wait times before a nurse can bring a patient pain medicine or help them get to the bathroom to increased falls and accidents as a consequence of fewer staff available. The short-term profit-extracting strategies can also undercut long-term value and in the context of healthcare, have life-or-death consequences. For example, one study estimated the private equity takeovers of nursing homes and the staffing cuts that followed have led to increased mortality rates, specifically around 21,000 excess deaths among nursing home patients over the course of just 12 years. Later this morning, we'll hear from CMS principal, deputy Administrator John Bloom, and HHS Inspector, General Christi Grimm, about the steps that they are taking to address this and I applaud their efforts.

We've also seen the harms of private equity acquisitions in emergency care. As of June 2022, more than 40% of the country's emergency rooms were overseen by for-profit healthcare staffing companies owned by private equity firms. Under private equity ownership, emergency physicians have reported their experiences of endless cuts to staffing hours that have left doctors with significant patient safety concerns and result in poor patient experiences and outcomes. One ER doctor wrote to us that they felt as if their "medical license was being exploited by private equity to maximize profits to shareholders at the expense of patients."

When extreme cuts have failed to produce the desired profits, private equity owners can also cut and run, leaving patients and healthcare workers in free fall. Just last year, two private equity-owned medical staffing firms declared bankruptcy after they were unable to pay their debt obligations. When one of these groups suddenly closed its doors, thousands of emergency room physicians scrambled and tried to figure out how to continue serving patients, even as hospitals were waiting to sign new contracts with other groups. And a second practice that we've seen PE firms deploy is rolling up markets through serial acquisitions and a buy and build model that firms can use to consolidate power and undermine competition. By consolidating power gradually and incrementally through a series of smaller deals, firms have sometimes sidestepped antitrust review.

In the aggregate, these roll-up plays can eliminate meaningful competition and allow new owners to jack up prices to great quality and neutralize rivals without a competitive check. Antitrust enforcers are taking action to stop these potentially unlawful roll-ups. The 2023 merger guidelines make clear that in

order to faithfully enforce the Clayton Act, we cannot turn a blind eye to serial acquisitions and just look at each deal in isolation. As the guidelines note, we will consider individual acquisitions in light of the cumulative effect of related patterns or business strategies.

The commission's case against Welsh Carson and US Anesthesia Partners illustrates what this roll-up strategy can look like in practice. As our complaint notes, Welsh Carson created USAP to spearhead a multi-year roll-up strategy to buy out nearly every large anesthesiology practice in Texas and stomp out independent providers. Their roll-up scheme involved over a dozen practices, a thousand doctors and 750 nurses, and resulted in a substantial markup for the same services the patients were previously getting, raking in tens of millions of extra dollars for the executives at the expense of Texas patients and businesses.

We're also working with our colleagues across the federal government to ensure that illegal roll-ups do not evade antitrust scrutiny. Recently, the Commission, the Department of Justice and the Department of Health and Human Services agreed to exchange data and information to help identify potentially unlawful deals that might otherwise sidestep review.

A third practice we've seen is private equity firms and other alternative asset investors buying up significant stakes in rival firms that compete within the same industry, reducing competition by softening firm's incentives to compete. This ownership structure can incentivize firm managers to consider their common ownership interests in decisions about pricing output and business strategy, more generally. The problems of common ownership can be exacerbated by executive compensation structures. Common shareholders wanting to maximize the value of their stock may favor compensation packages that give managers no incentive to compete away industry profits.

The commission is well-positioned to challenge these types of ownership structures, and we are using our authority under Section eight to do so. The commission has long held that Section eight of the Clayton Act applies to corporations as well as to individual directors, and our recent action against interlocking directorates in the EQT matter should provide further clarity and notice to the market. We will continue reinvigorating the full scope of section Eight's prohibition on interlocking directorates as we work to faithfully enforce the antitrust laws and promote the rule of law.

Reinvigorating and modernizing our existing enforcement tools is just one way that the FTC is working to tackle modern market realities. Today we're taking new action to take on corporate profiteering in healthcare and we're asking for the public's help. Today, the FTC, the Department of Justice and the Department of Health and Human Services are launching a public inquiry to examine the role of private equity in healthcare as well as corporate profiteering, more generally. We're aiming to gather information from a wide variety of sources and experiences to ensure that we can best harness our tools and enforcement to address the challenges of today. Your engagement on these issues and your expertise is going to be critical.

When Congress passed the US antitrust laws, lawmakers made them flexible precisely because they knew that they could not predict the constantly new and evolving ways in which firms can undermine free and fair competition. Private equity acquisitions and healthcare are just one example of this type of evolution. Today we're discussing some of the extractive tactics that we've seen at the intersection of private equity in healthcare, but firms of all types should be on notice that we're on the lookout for these strategies and we'll continue to deploy the full scope of our authority to protect the American public from anti-competitive and unlawful tactics.

I really look forward to hearing from today's speakers speaker and continuing to work together on these critical issues. I'm delighted now to introduce Assistant Attorney General Jonathan Kanter, who heads up the Anti-Trust division, which has been just a critical partner to the FTC as we undertake this important work. Over to you.

Jonathan Kanter:

Thank you, Chair Khan, and thank you for those extremely important remarks. They're inspiring and essential and you'll hear a lot of similar themes from me today. I will also say that it's been an honor and a privilege working with you and the entire FTC on these healthcare issues that are of great and of most importance to the public. It's truly been a partnership and a collaboration, and together we are taking on the entire healthcare sector to make sure that we are protecting competition to benefit not just patients, but healthcare workers and the entire economy and the wellbeing of our fellow citizens. I'd also like to thank the FTC for inviting me to speak today and Tamar and the entire team for putting together this really important and exciting and thoughtful discussion along with a number of distinguished speakers that I look forward to hearing from as well.

When starting the discussion, I think it's important to begin at the center of healthcare, patients. It could be you and me, or it could be a close friend or family member, the doctors or nurses and workers who care for them. Think about that relationship. At its best it's truly a relationship, patient-doctor, patient-nurse, patient-health aide. We all want that direct personal care to be at the heart of our healthcare system. It's what healthcare providers such as nurses and doctors want too. Most of them went into healthcare to serve their communities and engage face-to-face with patients. They want to help people on their worst days, but too often these days they can't because of faceless intermediaries that often stand in the way.

Let me explain by providing an example. When we worked with our colleagues at the commission to update the merger guidelines, we heard from an ICU nurse in California. She once worked at a community hospital that had, in her words, remarkable care for patients. That quality of care vanished after a merger. She said that nursing ratios dropped, vacation time for nurses vanished and the practice expectations in the hospital became "unsafe." This nurse is not alone, far from it. We heard from many others like her, including a doctor whose medical practice crumbled, his words, as a result of healthcare consolidation.

Why is this the case? Because healthcare at almost every level is now dominated by intermediaries that act as middlemen between you and your doctor and take a huge cut from both sides along the way. These intermediaries, middlemen take the relationship out of healthcare and reduce healthcare to a spreadsheet. This comes at great risk to people. It becomes more expensive. It becomes more time-consuming and frustrating, even as quality of care decreases and doctors and nurses find themselves stretched past the breaking point. Private equity firms who have inserted themselves at virtually every level of the healthcare system are now positioned as intermediaries with the ability to pull these levers of healthcare. It's why it's so important that we're having this discussion today.

You see this research conducted by some of the very academics who will be speaking at this important workshop. For instance, professor Song along with colleagues showed that when private equity firms buy hospitals, patients are more likely to fall, more likely to get blood infections and more likely to suffer other complications. Researchers at the Department of Health and Human Services found that when private equity firms bought nursing homes, staffing fell while health code violations were on the rise. Yet another study found that private equity ownership of these homes was responsible for over 20,000 premature deaths in just 12 years.

So what could be done? Well, this is where antitrust can play and is playing an important role. You may have already seen some of the work that the Antitrust Division has been doing in the healthcare industry, including a guilty plea in a healthcare staffing case that resulted in lower pay for nurses that provided healthcare to children with special needs. You may have also seen our work to unwind interlocking directorate, something that Chair Khan talked about as well, between competing companies, including those organized by private equity firms.

So far, because of the division's efforts, 15 interlocking directors have resigned from 11 different corporate boards. This is the antitrust delivering results for the people, and there's much more that we can and need to do. We're continually looking for interlocking directorates imposed by private equity, venture capital and corporate venture capital firms and others. Our newly released merger guidelines provide direction for enforcers on how to consider serial acquisitions, sometimes called roll-ups, including those by private equity firms in the healthcare industry or elsewhere.

Our newly released RFI on healthcare and private equity will give us the information to tackle private equity and corporate greed head on, and we'll continue to explore whether and how private equity firms might violate state corporate practice of medicine and other statutes that implicate the antitrust laws and competition. More than anything, we will stay laser focused on the intermediaries that sit between you and your doctor.

What I hope this short discussion shows is how seriously the Antitrust Division takes the problems presented by private equity and healthcare. The stakes are about way more than money. They're about people's health, people's lives. Let me give you an example of that. As I've mentioned to some before, I sat just a few weeks ago by a loved one who received a life-saving surgery. It happened to be at a community hospital. The level of care and attention from the nurses, the doctors, the aides, the technicians were unheard of by today's standards at this community hospital. I can't help but think that type of care occurred because the community nature of that hospital. That type of care must be protected even when it doesn't comply with a spreadsheet. The American people value and demand that kind of care because it's what our loved ones deserve. It's what we deserve, and we will do everything that we can at the Antitrust Division to protect that.

I believe that the antitrust laws can make our healthcare system more free, more functional, and more fair, but it's going to take a lot of smart people, which is why I'm so grateful to get to speak with all of you, and I look forward to seeing all that this discussion accomplishes. Thank you so much. And now we are so fortunate to hear from someone that I know and I know who cares deeply about these issues, from HHS, Inspector General Christi Grimm. So take it away, Christi.

Christi Grimm:

Thank you so much, Jonathan, for your very inspiring and thoughtful remarks, and thank you, Chair Khan and the Federal Trade Commission, for hosting this very important workshop and the invitation for us to offer a few remarks. The topic of private equity involvement in healthcare is so critical to federal healthcare programs and patients, and as we continue to gather evidence and conduct research and perform oversight, it's so important to collectively build a better understanding of how private equity may affect patients' access to care, the quality of care patients receive, and the cost of those services.

As the Inspector General of the US Department of Health and Human Services, for folks that aren't aware of what it is that we do, very briefly, I lead an organization of nearly 1600 investigators, auditors, evaluators, data scientists, attorneys, and other professionals. At HHS OIG our mission is to protect the over 100 programs that make up the HHS portfolio such as Medicare and Medicaid and the millions of individuals served by those government programs. We have a long history of holding individuals and corporations accountable when they violate the law. For instance, we barred nursing home owners from working in Medicare and Medicaid because they put profits over patients by failing to invest in basic safety precautions leading to the death of seven residents following a hurricane. Residents were found in standing water without oxygen equipment and the consequences leading to those deaths where those consequences were dire.

The topic of private equity in healthcare is like many healthcare issues, complex. Private equity investors are often sophisticated organizations with complicated corporate structures, and this complexity can

make it difficult to know who is in charge, where the money is going and the effect on patients and providers. We're here at HHS OIG conducting oversight to provide independent and objective information to increase transparency around issues like ownership, and we're committed to using our authorities to improve accountability when entities owned by private equity or other types of private investors engage in fraud, waste and abuse, and I'll briefly explain.

In terms of transparency, understanding who owns a healthcare entity and where money is flowing is key to understanding the incentives that might be driving questionable conduct that can lead to patient safety and quality of care issues. HHS OIG has ongoing work that will shed light on how nursing facilities, including those with private equity ownership, use government funds, and our work will determine the percentage of Medicaid revenue for selected nursing homes that is being expended on direct patient care, that ratio. We are also examining related party costs at skilled nursing facilities with a better understanding of how nursing facilities, including those with private equity ownership, use Medicare and Medicaid dollars. HHS and other stakeholders can more effectively address quality and safety issues at nursing homes. And I commend CMS and the recent actions it has taken to improve nursing home ownership data that will further enhance transparency, and you'll be hearing from the principal deputy administrator Jonathan Blum following me.

Our interest in the impact of private equity and other forms of private investment on HHS programs extends beyond nursing homes to hospitals, home health agencies, and managed care. For example, in Medicare managed care, a fast-growing program, private Medicare managed care plans receive over $400 billion per year and cover over 50% of the Medicare population, and this growth has attracted more private investment. It's important then that this investment support well run managed care plans that both comply with Medicare rules and ensure enrollees have access to cost-effective high quality services for enrollees. In terms of accountability, when investors' conduct jeopardizes patient safety or crosses the line into fraud, OIG and our law enforcement partners are exploring the best ways to hold them accountable. We investigate and enforce against those who seek to use federal healthcare programs for their own gain no matter where they may be in the chain of ownership. In January, HHS OIG, working with our partners, settled a case involving alleged healthcare fraud and fraud by investors, fraud that potentially jeopardize the ability of their provider to keep its door open and provide care for its patient. This case included allegations that a long-term care hospital was falsely inflating its charges to obtain higher Medicare payments. During the investigation, we discovered that the hospital's investors fraudulently transferred millions of dollars from the coffers of the hospital to themselves despite the hospital's poor financial condition. Both the hospital and the investment group settled for a combined amount of over $30 million, and this case demonstrates how we can hold investors accountable for illegal conduct that exploits our healthcare system at the expense of patients, providers, and taxpayers. Strong partnerships like those you see today are essential to address complex issues in healthcare.

Working in partnership is a proven strategy that can enhance understanding of the impact of private equity ownership and ensure that we can hold wrongdoers accountable for fraud and abuse. Government agencies, private stakeholders and experts sharing information and listening to patients, providers, and others feed the ground to improve transparency and hold bad actors accountable. And this workshop is just a terrific opportunity to advance our shared knowledge, and a special thank you to Tamara and her team for getting this off the ground. I am excited to hear from the speakers at this workshop, and I thank you and wish all participants a fruitful and productive workshop. And now I hand you over to my colleague here at HHS, Principal Deputy Administrator, Jonathan Blum. Over to you, Jonathan.

Jonathan Blum:

Thank you so much, Christi, and it's been a great pleasure working with you and your team during the past couple of years during my time here at CMS. And I wanted just start off with just saying, just a couple of remarks from CMS's standpoint that it was certainly true, say 10, 15 years ago that CMS took a more quiet view towards consolidation within the healthcare industry, that CMS payment systems that ran through the Medicare program, for example, generally paid the same amount regardless to the consolidation. But what we're seeing now with newer ways that we're paying for care, that consolidation can grow CMS costs, can grow Medicare costs. So we have to in order to ensure that we're being strong stewards to the Medicare Medicaid programs, to really work more closely with our federal partners to ensure that we're doing everything that we can beyond just the cost to our programs, that we see quality of care issues that are heartbreaking.

We see nursing homes, some nursing homes produce harm to their residents. We see through our various programs run through private managed care plans that we see confusion and CMS gets per month more than 5,000 complaints coming into us just through that confusion. So we have to do more to ensure that those that are carrying out the Medicare programs, those that are carrying out the Medicaid programs really have good intentions. So we have to pay more attention, not just for cost reasons, but also for quality reasons.

For CMS, we really have four or five key strategies right now. We heard from the other speakers that we are working better together to share data. We really want to understand the impacts to what consolidation means for us and more complexity that we see in our programs, but to really understand what is happening to quality of care, what is happening to the overall costs, and that will be a commitment that CMS carries out to ensure that our data systems, that our data sets really help to ensure that we can be strong partners on both the DOJ to the IG, but also to the FTC.

The second thing that we're doing is working to ensure that there's more transparency to who owns nursing homes, who owns hospice organizations, who is running managed care organizations. We think there is tremendous value just to ensure that we can really see that ownership, that it's no longer hidden. That can bring much stronger accountability, much stronger oversight, and much stronger just knowledge to how our healthcare system works today.

The third thing that we're doing that I think is something that we have to do is to ensure that we have stronger standards to how we pay for, to how we oversee healthcare facilities like nursing homes. We want to have stronger protection, stronger standards to ensure that we have much stronger consistency to the overall care. As we see more private ownership, as we see more consolidation, we also see that the quality goes down. So therefore we have to think about stronger standards for how we staff or how we think about paying for nursing home care, for example.

The fourth thing we're doing is to ensure that as we see more shifts to our beneficiaries to care being organized by third party managed care plans, that they contract with who are often owned by for-profit, private equity-owned companies, that they behave with the best interests for those covered by our programs. And it's not necessarily the managed care organizations, but it's those they contract with that compete very vigorously for new members, which then creates more complexity to care, which creates more confusion for the beneficiary, which creates more complaints coming to CMS that we have to respond to. And so our goal is to see that when beneficiaries get information from the managed care plan that is clear, that is accurate, that is fair, and the beneficiary has the best possible information to ensure that he or she is making the right choice for themselves.

The last thing that I'll say is that with CMS programs that have worked to improve the quality of care, that have worked to reduce the total cost of care, that have shifted care to be more value-based relationships, that has brought much more complexity to our programs. And one of the reasons why we see there is more private investment is that the cost to participate in our programs is much greater.

Those that want to be in these relationships need to hire more staff. They need to have better data capabilities, which then creates more opportunities to either sell or to partner with private equity firms.

What we want to do going forward is to ensure that those that wish to be strong partners to CMS can afford to do so. They have their resources, we want to lower those costs, but those are our strategies. Couldn't be happier to be here today and again, look forward to the conversations. And with that, we'll turn it back to Tamar, and thank you again for the opportunity to be here today.

Tamar Katz:

Thank you all for such thoughtful remarks. Next, I have the pleasure of introducing Dr. Eileen Applebaum, co-director of the Center for Economic and Policy Research, who will be giving the keynote remarks this morning. In addition to her work at CEPR, Dr. Applebaum is a fellow at the Rutgers University Center for Women in Work and the co-author of the award-winning book, Private Equity at Work: When Wall Street Manages Main Street. Welcome, Dr. Applebaum.

Eileen Applebaum:

[inaudible 00:34:42] Tamar, for that very kind introduction and thank you to the FTC for inviting me to speak at this very important workshop. I'm very pleased to be able to be here and to share some of

Eileen Applebaum:

The insights that I gained from studying private equity, I've been studying private equity in healthcare since 2013, so I've seen a lot of the way in which they manage healthcare companies that they buy. As Chair Khan pointed out, healthcare is being transformed from a social good into a commodity that can be bought, sold, and sold again for private gain. Money that's intended to provide high quality care for patients is instead being diverted to the pockets of some of the most wealthy people in the country. What we see is that providers and clinicians whose mission is to care for patients are being gobbled up by private equity firms whose mission is to make outsized profits for themselves and their investors. Chair Khan has already spoken quite a lot about the private equity business model. I'll just describe it briefly and one of the reasons I wanted to do that is to help people understand why the FTC is focused on private equity.

After all, there are many for-profit companies operating in healthcare. What is private equity and what makes it different so that it warrants this kind of focus? So private equity firms are financial firms. They recruit investors into their private equity funds. They get about a third of their money from pension funds, public pension funds, and they are also funded by insurance companies, endowments, sovereign wealth funds, and high net worth individuals. And these investors are promised outsized returns that are going to beat the stock market and that are going to really pay off for them. And the way that it operates is that the private equity firm will buy a healthcare company or actually any company using a lot, a lot of debt. These are called leveraged buyouts. The private equity fund puts up a little bit of money. It's like the down payment on a mortgage, and then the rest of the purchase price is covered by debt. And the interesting thing about this, which many people do not realize, the private equity firm owns the hospital or the nursing home, loads the debt onto the hospital or the nursing home, and has no responsibility for repaying the debt. That debt falls on the hospital chain, the nursing home to repay. And that debt is what drives a lot of the poor quality care in private equity owned facilities. You have to pay back that debt ... or we'll see other ways that they do this when I give some examples, but initially they have to pay back that debt and this reduces their ability to staff properly, have proper safety provisions, provide the necessary time with patients, all of the things that the other speakers have already pointed out. The private equity firm then engages in a consolidation as we've already heard. It

begins by buying one company, a successful company, which it calls its platform and then it buys up the rivals.

It helps that platform company finance purchases of its rivals that it adds on to, or rolls up into the platform company, increasing its size, increasing its footprint, increasing its revenue, and increasing its ability to bargain with insurance companies for higher payments. It drives up costs, in many, many ways and it ends up raising premiums for all of us who have to have health insurance. It drives up the cost of the Medicare or Medicaid programs as well. So it's really wise that the FTCs new merger guidelines rightly recognized as Chair Khan pointed out, that the agency is empowered to block a platform company from acquiring rivals if the cumulative effect is to reduce competition and it's able to take action against companies that have already rolled up their rivals. A case in point, as Chair Khan pointed out is Welsh, Carson, Anderson & Stowe's creation of U.S. Anesthesia Partners.

They began in 2015 by buying the largest anesthesiology practice in the Denver area and then rolled up the competitors until it employed 330 anesthesiologists in Colorado, had contracts with 10 of the 15 largest hospitals in the state and went about its business of raising prices and reducing the quality of care. At that time, the FTC questioned this business model but didn't really do anything about it. If you fast-forward to September 2023 and to Texas where you see USAP doing exactly the same thing, you see that the FTC has sued USAP and Welsh, Carson, Anderson & Stowe for its non-competitive behavior and driving up prices and in this way boosting their own profits. If the suit succeeds, not only will it undo this roll-up of anesthesia practices in Texas, but it will have a chilling effect on this private equity financial strategy that is very common in healthcare.

I would like to just point out some of the ways in which private equity is different from just for-profit companies. A for-profit company may buy up a healthcare company, usually it will be a company that has experience in healthcare. It will be buying this company to hold it for the long term. It sees it as a good add-on to the business it already has and it wants to use it to continue succeeding. Well, the difference is that when private equity buys up companies and rolls them up and builds them up and has a huge footprint, it intends to remain there for only a short period of time. Three to five years is its preferred period, sometimes as long as seven years. So it needs to make a lot of profit in a short period of time. Those roll-ups give it revenue, make it look very successful, make it desirable to another buyer.

But the effect of it as we have seen, since these roll-ups are financed by a lot of debt, is to really encumber the healthcare companies that it buys up. So it buys them up with the idea of selling them in a short period of time, and it uses various strategies to extract as much profit from them, before it sells, as it can. So if it's a hospital chain or a nursing home that has real estate, it will sell off the real estate and pocket the proceeds. It also does something called dividend recapitalizations where it requires the private equity owned facility to take on additional debt in order to pay dividends to the private equity firm and to its investors. These are funds that should be used to improve the quality of care within the healthcare facility to upgrade technology, to better staff, to meet standards, to spend time with patients and to use high quality supplies. But instead it's lining the pockets of the private equity firm and their investors.

And one last thing that I will mention is that the private equity firm often contracts directly with the healthcare facility that it has taken over, for what it calls monitoring fees. It's supposed to be helping them succeed, but most people in the industry view these monitoring fees as money for nothing. They really do not earn this money at all. So we are in a situation in which a private equity company owns a healthcare facility. It has no sense of loyalty to the business that it owns. Ordinarily, corporations are concerned not to take actions that might drive a company they own into bankruptcy, but private equity firms don't care about that at all. And they're also not required or held to a standard of providing

highest quality care to patients. Instead, their standard is outsized profits for the investors who have come along with them.

So let's go to the next slide. I'm not going to dwell on this because the other speakers are going to tell you a lot more about private equities' penetration into many segments of the healthcare sector. But what you can see from this graph is that in just 20 years, from 2010 to 2020, private equity investments in healthcare increased 25 times over, from relatively small to being a dominant player in this industry. And now I'm going to give you three examples of different ways in which private equity has enriched itself at the expense of the healthcare system. The Steward Health Care hospital chain is very much in the news right now because it is on the verge of bankruptcy and many communities are scrambling to figure out what they're going to do if these hospitals are shuttered. Cerberus Capital private equity firm bought a nonprofit small chain of a couple of hospitals in small towns and cities in Massachusetts, called Caritas, changed the name to Steward Health Care and took over the ownership.

Now because this was a conversion from nonprofit to for-profit, the State Attorney General has some say in what would happen. And in Massachusetts, the State Attorney General, the person who is now the governor of Massachusetts, imposed conditions on Cerberus Capital and on Steward for five years. And in fact, Cerberus and Steward mostly complied with those conditions until 2015 when the conditions were lifted and immediately after the conditions were lifted we see Cerberus engaging in standard private equity practices for any company they buy, whether it's Toys R Us or Steward Health Care to make money immediately for themselves. The first thing they do is sell off the real estate. And so in this case, Cerberus sold most of the real estate of the hospitals that it owned to a real estate company called Medical Properties Trust or MPT. They sold the Real estate for $1.25 billion.

It paid out high dividends out of that money. And the other thing that it did is it went on a buying spree. And within three years, Steward had what ... 27 hospitals. There is no medical logic to their behavior. It's all driven by the idea that if they increase their size and increase their revenue, they will be able to sell at the end at a higher price. And so they sold off the real estate and now the hospitals which had previously owned their own buildings and their own land are paying rent to MPT. They are hooked into long-term leases, high rents that rise every year. This is really an unsustainable situation for a hospital. And so this is going to be very difficult for them to do. And we also understand why they now are cutting back, as we've heard, already mentioned on clinical care, on hours of doctors, on the quality of supplies, on the number of nurses, staffing of all kinds, even things like cleanliness in the hospital are cut back in order to be able to pay the rent.

And services that are considered not profitable, like maternity wards are just closed and women are left to drive to some other town, not nearby, in order to deliver their babies. This is not a good situation as we could see. And so this is very typical of the private equity business model. And in the case of Steward, it's really troubling because when we think about Steward in Massachusetts, four of the nine Steward hospitals in Massachusetts are safety net hospitals and 70% of the Steward systems revenue in Massachusetts comes from Medicare, Medicaid and other public programs. So it has taken the taxpayers' money, but it has not delivered value for taxpayers, for patients, for workers, or for the communities in which they are located. So breaking up these kinds of anticompetitive monopolization of local healthcare markets is really, really important.

This goes to the next slide. I want to talk about now, a completely different way that private equity makes money. So hospice agencies don't own real estate. They have an office someplace, and the hospice nurses and other employees operate out of that office. So how do they make money? And here I want to talk a little bit about how CMS is paying for healthcare services. CMS calls its payment model value-based healthcare. The logic of it is that CMS seems to be persuaded that the problem with our healthcare system and the reason that costs are rising is that seniors, Medicare beneficiaries, make too

much use of healthcare services. That doctors are ordering unnecessary tests, unnecessary lab work, unnecessary procedures, driving up the cost of caring for seniors. The idea behind it is that by controlling access to services, CMS is going to be able to save money. And what it wants to do is control unnecessary services. But the way that this payment system works, value-based care means that providers receive capitated payments.

They receive a flat payment for every person they have enrolled in their care network, in their care system. So in the case of hospice, which is easy to understand, we see that the hospice is paid more than $200 a day for every person enrolled in that hospice agency. The idea behind it is by giving the providers money upfront to take care of the patients, they will invest in caring for these patients at a very high level in order to keep them healthy so that they require less expensive care, less intensive care, and are healthier and that the private equity firms or the hospice providers are going to make money by improving the care of patients and cutting down on the use of services. Well, that may work if you ... and we have seen it work and of course our research, we have interviewed hospice providers in many parts of the country and we have seen really good nonprofit hospice providers that act exactly as CMS had intended.

But when private equity enters the hospice business, which they have, and were a for profit center, we see that taking care of patients and making them healthier is not the only way that you can hold down costs. You can hold down costs by denying patients the care that they really deserve. So in the case of hospice, all that is required once the hospice is certified is that a nurse visit the patient once every 14 days. So the hospice agency is collecting more than $200 a day for care of that patient. And the requirement is so minimal that you can get away with sending a nurse once every 14 days. Now, the nonprofits that we talked to said that a minimum is sending a nurse once a week, and that in their case, they typically have visits two to three times a week unless they can document that the patient is stable and does not require that much care.

And as the situation for the patient becomes ... they get closer and closer to actual death, much more care needs to be provided. But we can see the difference between the kind of care that the nonprofits are providing and the kind of care that the for-profits and the private equity firms are providing, if you just look at the line on this chart that compares the operating margins, this is what they do not spend on care. That's the money they get from Medicare, that they do not spend on care and that they get to pocket. And you can see what a high percentage of hospices are for profit and really, really large chains of 500, 600 locations owned by private equity firms.

You can see that the ... you can't quite see the last column on the slide, but it's the same story in all of these cases. By 2019, the for-profits had an operating margin of 19% compared to 6% for the nonprofits. So the operating margins, what they get to pocket is triple what occurs in the nonprofits, when you look at the for-profits. Private equity, the other for-profits as well, but as I've explained, private equity is even more dangerous. They are exploiting what CMS calls value-based payments, but what are actually capitated payments and which I would encourage CMS to think about whether these are value-based or valueless. This payment system shows up in Medicare Advantage where it is much more complex. I picked hospice because it's so obvious, but this is the same basis for payments in Medicare Advantage and in other programs. And CMS has announced a policy of getting all Medicare beneficiaries either into something like Medicare Advantage where you have to get pre-approval, where there are high rates of denial.

Denying services is built into any system that is based on capitated payments. And so they are intent now in getting everybody, including those in traditional Medicare, at least attributed to a program like ACO REACH or other programs in which the doctors are incentivized to reduce care, the amount of care. And I think this is really dangerous, and I would encourage CMS if we still have those folks on the line

here, but in general, I would encourage them to rethink this payment method because of the ease of both private equity firms and large insurance companies of gaming the payment scheme and profiting at the expense of taxpayers, patients and workers.

And the final slide, this really shows that it's not just taxpayers and the government that private equity is willing to rip off. This is from a report that we did on private equity in autism services, and there was a movement that nobody is aware of, of parents and advocates for kids with autism that went state by state because commercial insurance is regulated state by state and convinced the insurance companies lobbied to have the insurance companies pay for payment for care of kids with autism. And so private equity began buying up centers that provide ABA care. By 2015, most of the states in the country had regulations that required commercial insurance to pay for it. By 2019, it was all over the country, and you can just see the increase of private equity interest in this industry. They do not care about kids with autism and how they could improve care back before there were insurance companies that their practices could rip off. And Blackstone bought as its platform company, one of the most successful of these ABA clinic chains.

It was called the Center for Autism and Related Disorders or CARD. They bought it in 2018. They soon closed 100 sites in states where the payments were lower and concentrated on the sites where payments were higher. But nevertheless, their practices of loading these companies up with debt, taking money out of them, instead of putting money into them led to CARD's bankruptcy in 2023, leaving hundreds and hundreds of children who relied on those services for whom that personal interaction with a particular clinician was so important, without any ability to figure out what they were going to do next, finding placements for those kids.

So, I'll just conclude by saying that private equity continues to invest in healthcare. It's on the look for companies that it can consolidate, fragmented markets. And I'll just wrap up by saying, as you've seen, its use of debt, the ways in which it takes money out of these companies, is a threat to the healthcare system and to the American people. And thank you.

Tamar Katz:

Thank you. Thank you so much, Dr. Applebaum. We are now going to turn to a panel of individuals who have experienced the toll that private equity acquisitions take on patients, workers, and communities, as Dr. Applebaum just highlighted. Our first panel is a critical care nurse, working in a private equity-backed hospital in a rural community. They're participating anonymously due to concerns about potential workplace retaliation. And so I will now turn things over to our anonymous panelists. Thank you.

Speaker 1:

Thank you. I'm a local nurse who began my career in a small town hospital. I loved to travel and broaden my experience in large metropolitan hospitals, then came back to be home. I love what I do and I wanted to be close to my family and community. My local hospital was previously county owned, been taken over by a private equity firm a little over 10 years ago. Since the transition, it's evident that private equity-owned hospitals are unsafe and negatively impact patient care. The first point I'd like to make is that being chronically understaffed towards patient care. I've been a travel nurse at larger facilities and I've seen the importance of adequate staff-to-patient ratios. It seems obvious, but there has to be enough staff to take care of patients. At my hospital our private equity owners dictate staff-to-patient ratios that do not match national standards and there are life or death consequences to those decisions.

Our local hospital is reported to have approximately 140 patient beds, but is only staffed enough to maintain 32 patient beds between two campuses, which are 25 miles apart. In the emergency rooms

there is one doctor and two nurses per 12-hour shift. Prior to being taken over by private equity, the emergency rooms regularly employed a mid-shift nurse between the busiest ER hours of noon and midnight. On Thanksgiving Day 2020, a psychiatric patient being held in the ER bolted from his bed and sprinted out of his room into an adjacent room where an elderly woman was also being held on a psychiatric basis. He used his thumbs to gouge out one of her eyes and was attempting to gouge the second one when he was finally subdued. With the reduced staffing in the ER it took a while to get the situation under control. They stabilized her long enough to fly her to a larger facility where she eventually died from her wounds. There was no security guard on staff, and despite the presence of panic buttons hidden underneath the nurse's desk, police historically have not responded sooner than 15 minutes.

After that incident, ER nurses were given de-escalation training with the assumption that the handyman maintenance staff will act as security. Hiring a full-time security guard is simply too expensive. The hospital doesn't pay local pediatricians an adequate wage for them to justify staying onsite at the hospital outside of the regular clinic hours. This year, a woman came to the hospital in labor and we immediately called the OB doctor and pediatrician. There was not enough time after the OB doctor arrived to give the patient a C-section, so the patient delivered the baby naturally. When the baby was delivered, it was immediately apparent the baby was not doing well. The baby needed a doctor, but the pediatrician still hadn't arrived. The OB nurse, a respiratory therapist, and I assessed and treated the baby. I had to do two separate rounds of chest compressions on the baby before the doctor even arrived. When the pediatrician finally came, we were able to stabilize the baby. The baby was flown to an intensive care unit in a large hospital out of state. The baby died 48 hours later.

The second point I'd like to make is that our parent company doesn't invest resources back into the hospital. Instead, our profits are sent back to corporate. This causes major patient safety issues. A few months ago, the portable X-ray machine at the opposite campus was broken beyond repair, so patients had to be transported via wheelchair to the radiology department to receive a simple X-ray. For patients with chest tubes, this is unsafe because disconnecting the chest tube from the suction unit on the wall would cause their affected lung to deflate. Portable X-ray machines are imperative for these patients, so doctors can visualize if the affected lung is getting better. The solution for this predicament was to transfer the patient's 25 miles via life flight, either a fixed wing plane or a helicopter to the opposite campus where there was a functioning portable X-ray machine.

As an ER nurse, I'm no stranger to violence or trauma. However, there are toxic working conditions which go beyond the scope of expectation for an ER nurse. A man with dementia and episodes of violence was held in the ER for nearly three weeks waiting for placement at a more appropriate facility. During this time, he called the nurses whores and told him he was going to F their brains out and that they were worthless. There was no intervention to these behaviors as there was no qualified provider on site to treat him. Every ER nurse is familiar with violent or unruly patients who are on drugs, but they often are out of the ER in a matter of hours. We had to get called whores for three weeks because there were no psychiatric resources available to treat the patient. Nurses at my hospital lack the support available at most other hospitals.

Besides the nursing aides, most hospitals have people from lab who draw blood and pharmacists who mix medications for each department, as well as housekeeping for each unit and unit secretaries to answer the barrage of phone calls we receive during the day. We have none of those positions, so the nurses must do all those jobs in addition to our own. One evening I found myself talking to the anesthesiologist on the phone trying to schedule an emergency surgery while scrubbing a toilet because there simply wasn't anyone else who could help. As a supervisor, I oversee 120 nurses and nurse aides, 70 of those are travelers. Our county has a population of 30,000, and there is a local nursing college

which graduates 20 to 30 RNs yearly. However, the hospital cannot maintain local staff because of low pay and poor working conditions.

During COVID no nurse at this hospital received hazard pay or a raise. We never received any sort of bonus during the COVID surges. Our Christmas bonus last year was a $50 gift card. When our timekeeping system went down, we resorted to paper time sheets. Even though I worked overtime during the holidays, I never received my overtime, holiday pay or charge nurse pay from that period, despite multiple attempts at contacting the director as well as HR. A coworker of mine told me a few weeks ago that he has documented $2,300 worth of bonuses for picking up overtime that the hospital has never paid him. Prior to COVID, our parent company was worth 350 million. Now they're worth 3 billion.

I want to reiterate that this is the only hospital in the county. If I wish to stay a critical care nurse supervisor, this is my only opportunity. In addition, this is the only hospital available to provide care for the people I grew up with. It's not a matter of finding a nearby facility with better ratings and driving 30 minutes to get there. People in my hometown come because they have to. The private equity-owned model has destroyed the compassionate, attentive care that this small town hospital used to be known for. When we speak up, our concerns fall on deaf ears. We try to stay for the sake of our loved ones, but we know that if we push against the administration too hard, we risk losing our jobs. I hope these stories illuminate the trials of those who work in and are treated within private equity-owned hospitals, particularly in a rural setting. It will take massive change to resolve these issues. The change begins by listening to the ones who experience those issues every day. Thank you.

Tamar Katz:

Thank you so much for sharing your experiences with us. Our second speaker, Brian Alexander, is a journalist and an author whose work has focused on the effects of private equity on people, communities, and local businesses. Thanks for joining us, Brian.

Brian Alexander:

Thank you, Tamara. It's a pleasure to be here. I'm here because I wrote a couple of books that deal with private equity. One is called, Glass House: The 1% Economy and the Shattering of the All-American Town. The other one is called, The Hospital, it's about a small community hospital in Northwest Ohio. I'm now working on another book to be called, Purgatory of Profit. So for the last, almost a year, I've been living part-time and working in Chester, Pennsylvania. I hadn't intended to spend a lot of time reporting in this particular book that I'm doing now on hospitals and on private equity, but it turns out that the local hospital, Chester-Crozer Hospital in Chester is owned by Prospect Medical. Prospect Medical in turn was owned by a private equity outfit called Leonard Green Partners. Chester-Crozer Hospital has a long history. It was originally founded as an infirmary for union soldiers during the Civil War. It incorporates a Baptist Seminary

Brian Alexander:

Where Martin Luther King spent three years studying. It is a safety net hospital, and as you've heard, safety net hospitals are critical for underprivileged areas, poor areas, and Chester is indeed a poor area. It's one of the poorest cities in America. It is currently in bankruptcy. The city is in bankruptcy. Officially, the hospital sits in what's called Upland Borough, which is just across the street from Chester City Proper, but everybody just calls it the Chester Hospital. In 2016, it was taken over by Prospect, and a lot of promises were made at a public hearing about what was going to happen and how great it was all going to be. But you've just heard Eileen Appelbaum, who's one of the world's leading experts in private

equity, describe how this usually works, and exactly the same playbook has happened here in Chester. The real estate was sold off in a sale leaseback.

Hundreds of millions of dollars were taken out of Prospect Medical. The current real estate, well, the former real estate owner, was Medical Properties Trust. So the hospital was then paying lease money to Medical Properties Trust on land that it had owned for 100 years. It couldn't afford to do that. So what happens? Well, care disintegrates. About six weeks ago, I was sitting in the office of Chester's new mayor, Stefan Roots, and his phone rang. Somebody said, "Have you heard that the surgical residency program at Chester Crozier has just been de-accredited?" Stefan, knowing that I wrote a book about a hospital, hung up, and he said to me, "Tell me what that means." I said, That means something is seriously wrong because an accreditation agency does not de-accredit a program with 48 hours notice, and in fact, something was seriously wrong. I have interviewed employees and former employees of Chester Crozier who tell me staff morale has sunk to all-time lows.

They're holding equipment together with duct tape and bailing wire, and the quality of care has disintegrated. Now, Leonard Green already took hundreds of millions of dollars out of Prospect Medical, and you'll hear more about that, I imagine, from Rhode Island's attorney general, Peter Neronha, who had a conversation with me about this subject just a couple of weeks ago. So I won't spend a lot of time on that, but I want to tell you how this affects people. Chester Crozier is a big employer in Chester. As I mentioned, Chester is a poor city. A lot of people are in poverty there.

The kinds of jobs that people get in the hospital are maintenance, housekeeping, kitchen staff, health aides, and so on. They depend on these jobs. If Chester Crozier goes bankrupt and it is in danger of going bankrupt, those people lose those jobs. Secondly, Prospect, which owns four hospitals in this Keystone Crozier system, is stiffing local communities of the taxes that these communities are owed, to the point that one community, Ridley Park in Delaware County, has just had to raise taxes on its citizens to make up for the taxes they're being stiffed by Prospect Medical.

Just about almost nine months ago, Medical Properties Trust sold Prospect Medical back the land that they had purchased. They sold Chester Crozier back for $149 million. Well, Chester Crozier didn't have $149 million. So what is this? This is a mortgage, and the reason that Medical Properties Trust did this was because it puts them first in line for a reimbursement in case of a bankruptcy. As one stock analyst has told me, "This is the biggest Ponzi scheme nobody's talking about." About three weeks ago, I was sitting with an anti-violence coordinator having lunch in Chester. He got a text message over his phone. There had been a police-involved shooting.

A bad guy was being trailed by a detective, spotted the detective. A chase ensued. He wrecked his car, emerged from the car, shooting at the detective. The detective was shot in a gap in his bulletproof vest. Fortunately, he was located about 300 yards from the emergency room at Chester Crozier. I got there about 15 minutes after the detective was admitted there, and his life was saved. If that hospital's not there, there's a good chance his life is not saved. People in Chester depend on this hospital because there is not a single primary care doctor in the city of Chester, Pennsylvania, a city of about 33,000 people. So they go to this hospital, they depend on it, and the hospital itself is disintegrating. The stroke program has just been de-accredited. They have a famous burn program, that is at risk, so the services are declining and the people depend on it, so where are they going to go? They have to go much further, and transportation is a problem for them. I'd like to just spend just a couple of minutes talking about a bigger subject.

It's been mentioned several times the issue of roll-ups. I happened to be an ophthalmology patient at the Shiley Eye Center in San Diego. It's part of the University of California San Diego. Just last week, I was there for my appointment, and the director of the Shiley Eye Center and I were talking, I was commenting on how overwhelmed they are with patients. And why are they overwhelmed? Because so

many ophthalmology practices have been rolled up, and then the ophthalmology practices that have been rolled up by private equity fire the patients that require the most care and follow-up care and they dump those patients on UCSD.

Tamar Katz:

Brian, that is such a good point, and actually, to that end, our next speaker, Joe, is going to be speaking about a very similar experience, and he's going to be talking about his experience as a nurse at a private equity hospital. So we're going to thank you, and we're going to move on to Joe.

Brian Alexander:

Thank you.

Tamar Katz:

Thanks so much.

Joe Thon :

Good afternoon, everybody, and thank you for the opportunity to speak at this forum. Sounds so familiar hearing from everybody. I'll start off with I stand before you as Joe Thon, a registered nurse at St. Joseph's Regional Medical Center in Lewiston, Idaho. Having dedicated my career since July of 2005 to serving our community, I also take on a role of a shop steward for the Teamsters Local 690 Union, that represents the compassionate, hardworking registered nurses at St. Joseph's. Today I wish to shed light on the profound impact that transitioning from a community hospital to a large private equity-owned hospital chain has had on both the dedicated staff and the quality of our patient care. Time constraints are going to prevent me from delving into the myriad of cutbacks following our sale in May of 2017, but I'll give you a quick snapshot of the significant changes that have taken place.

Picture a scenario where after being acquired by a private equity group on May 1st, 2017, we gathered in meetings on May 20th to learn about the sweeping changes ahead. Our 6% 401k match vanished replaced with a zero to 2% match based on profitability, only to be paid out the following year. Healthcare benefits shifted, premiums rose by approximately 25 to 30%, and coverage diminished. Illness banks for sick time disappeared, along with several payroll deduction services ingrained for decades. In September of that year, a heavy toll continued with an abrupt layoff of 62 employees, a day marked by sorrow and shock in our small community. Departments that once thrived in our hospital were outsourced, resulting in a ripple effect that reached every corner of our healthcare system. As a consequence, individuals face the brunt cutbacks often forced to navigate a landscape where benefits were slashed. The consequences rippled further as inventory dwindled, departmental stocking became sporadic, and the capital budget for each director was capped at $1,000, causing delays in acquiring essential equipment.

The most poignant change impacting not just staff but our entire community was the loss of our urgent care. The decision to [inaudible 01:19:14] urgent care with the emergency room translated to higher medical bills for patients billed at an emergency room rate instead of a more affordable urgent care rate. Minor health ailments now incurred major financial burdens. The emergency room, a lifeline for many, underwent cuts in nursing staff, pharmacy tech eliminations, and reduction in psychological evaluations, resulting in longer stays and potential delays in trauma treatment. Services once thriving in our hospital began to erode. Urology, ENT gastroenterologists, and general surgeons became increasingly scarce, oftentimes only able to get a traveling surgeon to cover for call trauma only. Our cath lab, a critical department to treat strokes and heart attacks, faced staff shortages, causing

intermittent diversions and inconveniencing patients and their families who had to be sent to the next nearest cath lab over two hours away. The most heartbreaking change occurred on our surgical unit, a hub for orthopedic total joint care and various surgeries.

Our former CEO, Tim Trottier's, decision to shut down the entire medical oncology unit, combining it with the post-surgical unit, eradicated beds and left us ill-equipped to handle the flu season demand. This confluence of patients from those admitted from the ED to post-surgery patients and ICU downgrades leads to patients being transferred due to insufficient beds, an unfortunate reality that we now face. In October of 2019, negotiations commenced between the hospital and Regence BlueShield of Idaho, a healthcare insurance company catering to over 15,000 individuals in our community. Faced with the challenge of inadequate premiums, the hospital declared its attention to sever ties with Regence's network on January 16th, 2020. This decision meant that non-emergent services, including lab tests, office visits, elective surgeries, to name a few, would be subject to out-of-pocket network payment rates, which were much higher. Only critical services, such as those related to heart attacks, strokes, and emergencies, would retain in-network billing.

The repercussions were profound, compelling individuals to navigate abrupt changes during their mid-treatment, seeking new facilities, doctors, and even places for elective procedures and childbirth. While the hospital and Regence eventually reached an agreement, the period of uncertainty exacted a heavy toll on our community, particularly those grappling with chronic illnesses and expectant families. As I reflect on these changes, it's disheartening to acknowledge that no department has grown or had cutbacks since our acquisition except for those far removed from direct patient care. Those departments, being administration and human resources, our community, and dedicated healthcare professionals deserve better, and I implore you to consider a human cost of these decisions. Together, let us advocate for return to the principles that put patient wellbeing and community care at the forefront of our mission. Thank you very much.

Tamar Katz:

Thanks so much, Joe. And we're now going to hear from Dr. Jonathan Jones, an emergency room physician with broad experience in urban and rural medicine as well as with multiple different practice models. Dr. Jones.

Dr. Jonathan Jones:

Hi. Thank you, Tamar. Hi, I'm Dr. Jonathan Jones, and I'm an emergency physician in Jackson, Mississippi. I've been in practice for over a decade. I'm also the president of the American Academy of Emergency Medicine, and like all of our members strive to live by our mission, which is to ensure that every single patient who comes to an emergency department receives expert and compassionate care. I've worked at multiple hospitals and under multiple employment models, and I can definitively say that working under a private equity backed managed group has been the worst experience of my professional life. More importantly, it's also been the worst possible experience for my patients. Until about a year ago, I worked at a community hospital whose emergency department staffing had recently been changed to a PE-controlled group. It was a fairly large hospital with multiple specialties, and we received referrals from the more rural parts of the state.

After the PE group took over, the contract for emergency physician services changed immediately. The first change was obviously reduction in staffing levels, as there were fewer doctors in the ED at any one time. The overall number of patients in the ED changed little. The result was that each physician was now responsible for more patients. Specifically, for example, instead of managing up to eight to 10 patients at one time, I was now responsible for managing up to 18 patients at a time. This is far outside

what is considered safe by any of the emergency medicine specialty societies. Additionally, this change was not made in consultation with the physicians or the medical director, which is typically the case. Instead, these changes were simply dictated to us despite having no discussions that they would be made. When we said this was unsafe, they said too bad. Very soon after the coverage was decreased, the PE-backed contract group, in conjunction with the hospital, started to place an even greater emphasis on accepting as many patients in transfer as possible.

This was done regardless of our actual availability of inpatient beds. When we, doctors, again questioned the safety of this, we were frankly told that the transferred patients had better insurance. I and the other doctors were told multiple times that we had to accept the patients even if the ED and hospital was full. This resulted in more patients, despite no increase in nurse staffing and an actual decrease in the physician staffing. Patients routinely completed their entire hospital stay without ever leaving the emergency department. At times, patient transferred to us with the promise of an inpatient bed and of seeing a specialist instead replaced overnight in the hallway of the emergency department. I and the other doctors communicated this again was unsafe. We were told it was non-negotiable and that we had two options. We could stop complaining, or we would be terminated. I'd like to briefly share one example which left an impact on me and ultimately led me to look for a new hospital and group.

A patient was transferred to us from a small rural hospital after having an acute stroke. This was on an evening shift, and that day we didn't actually have a neurologist on call. We were told the neurologist would be in the next day, and that was good enough. In regards to stroke care, time is of the essence. I knew we did not have anything to offer this patient during the acute phase of his stroke. Other nearby hospitals did. However, despite my objections, the patient arrived and spent the entire night on a stretcher in our hallway. I cared for him as best as I could, but he effectively received no treatment for his stroke. He could have received timely evaluation by a neurologist and potential treatment had he gone to multiple nearby hospitals. I will never know if he suffered irreversible harm from his experience, but I do know that he did not receive the expected level of care for an acute stroke.

I know that I was disgusted and I was disappointed. I believe I did the best that I could in that situation, but I was ashamed that I even participated in this case. That is about one example of the complete disregard for patient health in exchange for profit, which happened once the PE group took over. Emphasis was solely on profits, not patients. The health of the patients, the work environment for doctors and nurses, the entire patient's experience, none of this seemed to matter, only short-term profits. I studied and trained to be a doctor to help patients, not to extract every dollar out of the experience. When I realized that helping patients was clearly not the top priority or even any priority under this contract and that this would never change, I left. Given that the same PE backed group staffed four other emergency departments in the city and had a commanding share of the market in general, I had to leave my city as well.

I traveled over two hours away to a small rural hospital in the northern part of the state. PE had no involvement at that hospital. While it was small and lacked many resources of the larger medical center, the experience couldn't have been more different. I was not only allowed but encouraged to ethically treat my patients. The PE-backed group later went bankruptcy just last year. While I shed no tears for the firm, I also realized that they were no longer covering my or any of the other doctor's malpractice insurance. Despite that we paid for it and that they made promises to us. That gross violation of their contract with us perfectly exemplified their approach to healthcare in general. I now work at a large tertiary care center back in Jackson, Mississippi. This emergency department is busy, and there's no private equity involvement. Yes, there are still some long wait times, and sometimes patients stay too long in the ED when the hospital is full, but the level of care these patients receive is completely different.

Extra nurses are actually called in, and when it was clear that we were getting busier, physician staffing levels were increased. Yes, the emergency department can still be busy and stressful. This is where patients are most vulnerable. This means we have an even higher ethical obligation to our patients in the ED than anywhere else. It is refreshing to now work with a group and at a hospital that understands and embraces this. I'd like to close by saying there is good in medicine and there is bad, and then there is dangerous. Quite simply, private equity is dangerous. It's dangerous for patients, for their doctors, and for their nurses.

PE is a threat to the health of this country. To be completely honest, I'm scared for the future of US healthcare. I also know that I would be scared to be treated at a PE-backed hospital or physician staffing group, but my recent experiences have also given me hope. We can make healthcare healthy again. We can bring the care back to it. There are innumerable good people working in every emergency department right this second. I as well as thousands of others, doctors and nurses, care about you. Removing the [inaudible 01:28:43] of private equity would free us to actually be able to care for you the way we want. Thank you.

Tamar Katz:

Thank you so much for those remarks, Dr. Jones. Our next speaker is Karen Simonton, who is the president of the OrthoForum, the largest independent association of musculoskeletal practices in the United States. Thanks so much for joining us, Karen.

Karen Simonton:

Thank you, Tamar, and again, thank you to the FTC for lifting this valuable workshop. Yes, we are. We are a network of independent musculoskeletal physicians at the OrthoForum. 5,000 physicians strong in 45 states, and soon to celebrate our 25th anniversary. Our physician members lead community centers of excellence, delivering access and cost-effective care to their respective communities. They get people back to their families, their employers, and their lives. They get us back to moving. I'm here today to speak on behalf of the Coalition for Patient-Centered Care (CPCC) where we are a founding member. CPCC represents a diverse group of independent physicians and their allies. We stand together in opposition to PE's acquisition and subsequent control of independent physicians, which upends the sacred physician-patient contract by emphasizing profits and revenue growth as well as moving decision-making outside of the communities where we are serving. We fundamentally believe that physician's autonomy leads to better patient care.

The OrthoForum is proud to work on this important effort with other CPCC founding members, including the Association for Independent Medicine led by Dr. Marco Fernandez and other esteemed physician colleagues including Dr. Keith Smith, Dr. Doug Lundy, Dr. Marty Makary, and Dr. Matt McCord. We care because we actually have experienced the termination of several of our own members, about a dozen, who've been acquired by PE because, to be in the OrthoForum, you must be fully independent and in control of your practice. We knew someone had to begin educating the public and government on how PE, something that is not part of the community, negatively impacts our patients and the communities where we're serving. Private equity interferes with the social contract between the doctor and the patient, and the interference has far-reaching consequences to the community. You've heard a lot today about access. Case in point anesthesia.

There is not a community across the nation that has not been impacted by PE's work in the anesthesia space, and anesthesia is an integral partner of our MSK physicians. Without them, we can't perform surgeries, and we can't get people back to their activities of daily living. Reduced anesthesia access takes the form of long-term community anesthesiologists who must move out of town, similar to Dr. Jones'

experience as an ER doctor to find a place to serve their patients directly, or anesthesiologists who are not allowed to serve in specific facilities or maybe out of network due to third-party contracting that is no longer in the control of the physicians and done in the interest of the community. For 22 years, I lived in one of these community centers of excellence here in Virginia, and I saw firsthand how our physicians work directly with other stakeholders in the community with the singular goal of serving patients.

This means sideline coverage of youth sports, serving in the ER for trauma coverage, and on safety panels for industry and manufacturing employer partners, and to serve on nonprofit boards to enhance the community's quality of life. Our independent physicians and their clinical teams worked with other primary care and facility partners to build quality and efficiency into all plans of care. This hard work is done in the spirit of the community's greater good, not as a paycheck. Their work supported the vibrancy of the businesses, but also their families and friends, because we are of the community as independence. And every community is different. Staffing and facility decisions have to be made at the community center of excellence level, not by a third party who is disinterested in the community. They have to be made in the interest of patients and outcomes and not spreadsheets and income statements.

So why is all of this independence worth preserving? Because independent physicians are the foundation of a healthy community. Ask any employer who is getting ready to expand their business footprint. Healthcare resources in a community are part of that decision-making process for expansion, and we are tax-paying members of the community. We pay BPO and real estate and personal property taxes, and to echo Dr. Appelbaum's comments, independent medicine, we are Main Street, not Wall Street. And further, we are in it for the long haul. Some of our members are more than 100 years old and standing in the gap, keeping our communities healthy and vibrant. We are in it for stewardship for the long haul. Thank you, Tamar.

Tamar Katz:

Thank you so much, Karen, for your remarks. I am now pleased to welcome Commissioner Bedoya to share his thoughts and reactions to what we just heard. Commissioner Bedoya.

Commissioner Bedoya:

Thank you, Tamar. Hearing the remarks from the prior panel reminds me of the Hippocratic Oath, and while that oath is old, I think it's about 2,300 years old, and if you read it, parts of it are quite dated. I think the core of it remains clear in at least three ways. First, new doctors who take the oath swear that the sick under their care will "suffer no hurt or damage." That's the do no harm part of the Hippocratic Oath that all of us are familiar with, but that's not it because another part of the oath, a different part, has new physicians pledged that "I will not cut for the stone but will commit that affair entirely to the surgeons." What's that about? That's actually originally about urinary stones, but that is a broader pledge where new doctors swear that they will not attempt care and not attempt surgeries that they're not qualified for.

And a third and separate part of the oath, right at the end, the doctors swear that " if I faithfully observe this oath, may I thrive and prosper in my fortune and profession." And I think that if matters. For 2,000 years, doctors have sworn that they will put their patients first above profits. If I faithfully observe this oath, may I thrive and prosper. I think our society recognizes that physicians and licensed healthcare providers are special. I think our society recognizes that because they've taken a solemn oath and have a solemn duty to put their patients first, and for that reason, around 30 states require that doctors, not businessmen, own and run hospitals and medical practices. Hearing the testimonies today, I fear that private equity threatens to turn the Hippocratic Oath on its head, and when private equity undermines or flouts corporate practice of medicine laws, I think it puts people in danger.

And sadly, I have to think that so many of the warnings and allegations that we're hearing today from experts like Professor Appelbaum, or Nurse Joe Thon, or Dr. Jones stem from situations where private equity is taking control away from doctors and medical professionals. I have a hard time thinking that doctors would close an urgent care center to shunt their patients into an emergency room and emergency level prices. I have a hard time thinking that doctors would accept a stroke patient when they know for a fact, as Dr. Jones explained, that no doctor is on staff who could adequately care for that patient. I have a hard time thinking that doctors would sell out the land from under their hospital. I have a hard time thinking that doctors would force unresponsive hospice patients into occupational therapy. And so for all these reasons, I'm particularly interested in the responses to our request for information that get at the way providers practice medicine under the private equity model, their incentives, their prescribing decisions, as well as the changes to management that providers have experienced under these models.

As a reminder, comments on that request for information are due in about 60 days. You can comment at regulations.gov, and I encourage everyone listening to comment. In closing, I'll just say that I'm proud that, under Chair Khan's leadership, the FTC has shown its willingness and resolve to address anticompetitive business strategies used by private equity in all industries, but particularly healthcare. You see this commitment in the recently issued merger guidelines and you see it in the cases that the FTC is bringing, and I'm also proud to be doing this work alongside Assistant Attorney General Kanter and the experts at the antitrust division. So with that, we will now take a five-minute break. When we return Bureau of Competition, deputy director Laura Alexander will moderate our second panel, which will feature experts that have been researching, documenting, and advocating against the harmful effects of private equity investment in healthcare. See you soon. Thank you.

Laura Alexander:

Hi, everyone, and welcome back to Private Capital, Public Impact, an FTC Workshop on Private Equity in Healthcare. I'm thrilled to be moderating our second panel, featuring a diverse group of experts from various backgrounds who have been actively researching and documenting aspects of private equity investment in healthcare. I am confident that there are combined expertise promises to offer valuable and diverse insights into our discussion. And I'm going to turn to each panelist to provide brief opening remarks, and then we'll have a discussion among the group. We'll first hear from Brendan Ballou, author of Plunder: Private Equity's Plan to Pillage America. Mr. Ballou has served as a special counsel for private equity in the DOJ's antitrust division. Brendan, the floor is yours.

Brendan Ballou:

Thank you, Laura, and thank you, everybody, for organizing this panel and for joining in to listen. As Laura mentioned, my name's Brendan Ballou. I'm the author of a book called Plunder: Private Equity's Plan to Pillage America. I also work at DOJ, but I always want to give the disclaimer that I'm speaking in a purely personal

Brendan Ballou:

... capacity and not necessarily on behalf of the government.

So I wanted to start off by talking a little bit about what the private equity business model is generally and how it applies to healthcare, and then try to talk a little bit about how private equity works in hospitals and in nursing homes and throughout what makes private equity different from other kinds of investment.

So let's just start off with the basics. We have been talking about private equity for a whole afternoon, but I confess that I imagine some of you might not be completely confident in what the private equity business model is, and I certainly was not until I was several months into researching this myself.

The basic business model as Chair Khan alluded at the outset of this is very simple. Private equity firms take a little bit of their own money, some investor money, and a whole lot of borrowed money to buy up companies. They then try to make financial or operational changes to those businesses with the aim of flipping them for a profit in a few years. So it's a very simple idea.

But there are a couple core challenges with the private equity business model, and I know that some of the other panelists, Erin in particular, are going to talk about really the specifics of these challenges. But let me just touch on three.

One is that private equity firms... And it's almost implicit in the business model that we just described, private equity firms tend to hold the businesses that they buy for just a few years. So they might try to buy a business and hold it for seven years, for five years, maybe just three or two years. And how long you hold something changes your perspective on it. It changes whether you're going to invest in infrastructure, in R&D, in your employees, in your customers, and in your patients. So that's one problem.

The second is that private equity firms tend to use a lot of debt to buy up their businesses and tend to extract a lot of fees. So one of the magic tricks of the private equity business model is that when they use debt to buy up a business, it's the business they buy, not the private equity firm that's responsible for paying off the debt. It's a little bit like getting to use somebody else's credit card. And at the same time as the company is piled up with debt, oftentimes that company is going to have to pay lots of fees to the private equity firm, transaction fees when the company makes a big sale, management fees, which are paid for the privilege essentially of being owned by the private equity firm.

The third problem, and I think it's fundamental to what makes private equity different from other kinds of investors and other kinds of companies, is that private equity firms are extraordinarily successful at insulating themselves from liability for the consequences of their portfolio company's actions. What that means is when something goes wrong at a portfolio company in the healthcare space or elsewhere, very often it's going to be hard to hold the private equity firm legally or financially responsible. And we'll talk about that with a few examples in just a moment. So that's the basic private equity business model. Those are some of the problems.

What does it look like in hospitals and in nursing homes? Well, for one thing, they are getting extremely active in both industries by one measure. Private equity firms own 460 hospitals in the United States. That's 8% of all private hospitals in the country and 22% of all private for-profit hospitals according to that estimate. In the nursing home industry, private equity firms own an estimated 11% of all nursing homes in the country, which may not sound like an enormous amount, but consider... This goes back to what Chair Kahn and Assistant Attorney General Kanter were alluding to. Many of these acquisitions are part of roll-up strategies that are in specific geographies, specific cities, specific states and so forth, so their economic and power is concentrated in specific areas. That's just the scope.

Now, what have been the consequences? Now you're going to hear in much more detail about the people that have actually been doing this research, Dr. Song and Dr. Bruch, but you've seen in the hospital context where there's research suggesting that private equity acquisitions lead to increased infections, increased falls among patients in nursing homes. There's the blockbuster paper that both Chair Kahn and Assistant Attorney General Kanter alluded to suggesting that private equity ownership of nursing homes has led to an estimated 20,000 premature deaths over a 12 year period. Now, those are the statistics.

What about the specific stories? What about the human stories? The story that I often return to, and it's the one that I think illustrates what makes private equity unique in healthcare and elsewhere, is about Carlyle's acquisition of the nursing home chain HCR ManorCare. HCR ManorCare was at one point the second largest nursing home chain in the United States, and Carlyle bought it in about 2007. It then executed a number of what are fairly familiar tactics in the industry. So they had required HCR to sell its underlying real estate and then lease it back, something that we heard about in the last session, staffing got cut, and health code complaints rose.

Eventually, at least one resident died at one of these allegedly understaffed facilities. She needed to go to the bathroom by herself, but hit her head on a bathroom fixture, ultimately died of subdural hematoma. When her family sued Carlyle, the private equity owner for wrongful death, Carlyle was able to get the case against it dismissed saying that it was not the technical owner of the nursing home chain, rather it merely advised a series of funds who, through several shell companies, ultimately owned the nursing home chain. And that was enough to get the case against Carlyle, the private equity firm, dismissed.

And I think it's illustrative of what makes private equity unique, which is that private equity firms typically have effective operational control over the businesses they buy. But when things go wrong, when somebody gets sick, when somebody dies, it is going to be very hard to hold the private equity firm responsible. So when you consider what would happen if the exact same thing happened, but it wasn't a private equity firm, but it was a healthcare conglomerate or a hospital or somebody else that bought up that nursing home chain, they probably would be held responsible. The private equity firm was not. So that's just one way in which I think healthcare private equity firms are unique in the healthcare industry and elsewhere and I think what makes the business model lead so often to negative consequences. There's a lot more that I'd like to say, but I know that we're already a little behind time, so I'll cede the floor.

Laura Alexander:

Thank you, Brendan.

Next, we have Dr. Zirui Song, Associate Professor of Healthcare Policy and Medicine at Harvard Medical School and Massachusetts General Hospital. Dr. Song, Health Economist, researches healthcare spending and the impact of financial incentives in the delivery system.

Zirui, take it away.

Zirui Song:

Thank you, Laura. And thank you to all of my colleagues as well and very grateful to the FTC and the commissioners for holding this event today.

My work focuses on healthcare spending and the effects of financial incentives in the delivery system on health and economic outcomes, so privileged to be here with my colleagues, Joe and Erin and Brendan, in covering some of the research behind this emerging trend. I will discuss the peer-reviewed evidence to date on private equity acquisitions of healthcare providers, specifically focusing on hospitals. Hospitals are a mainstay of the U.S. delivery system and one of the initial types of providers to receive private equity investments. I will review two of our larger studies on the estimated impact of private equity acquisitions of hospitals, then introduce some of the evidence around the other types of healthcare providers to be increasingly acquired, leaving acquisitions of physician practices in nursing homes as well as policy levers to my esteemed colleagues, Professor Brown and Professor Bruch here.

Our first empirical evaluation of private equity acquisitions of U.S. hospitals was published in the 2020 in the Journal of JAMA Internal Medicine. This was led by Dr. Bruch in a collaboration with Dr. Suhas Gandhi. Our study examined 204 hospital acquisitions compared to 532 similar but non-private equity hospitals, the so-called matched control group, using data from 2005 through 2017. We focused on changes in economic outcomes associated with private equity acquisition. We looked three years before through three years after acquisition. The study found that private equity acquisition was associated with a 27% increase in net income. That came out to be about $2.3 million per year on average relative to the control group of non-private equity hospitals.

Hospital charges, the so-called asking prices or list prices for services, and the charge-to-cost ratios both increased between 7% to 16% after acquisition relative to control hospitals. The share of admitted patients were on Medicare declined by about 2% after acquisition relative to the control hospitals, while the share of admissions comprising patients with Medicaid did not change. This signaled that the share of admissions of commercially insured patients increased. Commercial insurer prices exceed Medicare prices by an average a factor of two for U.S hospitals, 1.9 for inpatient services, 2.6 for hospital outpatient services, and a separate study by other colleagues showed similar results.

Our study also looked at changes in quality of care through process measures. Of note, process measures have long been used in quality payment programs, but evidence shows they're often less clinically informative than outcome measures, which we studied next. And often, subject to gaming behavior, process measures that is. Nevertheless as a first step, we examined the eight process measures available at the time grouped into three conditions and found mixed results ranging from small improvements to small reductions in performance after private equity acquisition. The shortcomings of process measures limited the drawing of strong conclusions on quality of care, but overall, this study showed that private equity acquisitions of these U.S hospitals was associated with financial gains through higher charges and shifts in payer mix towards higher priced payers, and it gave us the opportunity or the motivation to further understand what's happening with quality of care on the ground.

To improve this evidence based on quality, we recently studied what happened to patients during their hospital stays. Instead of process measures, we examined federally defined per CMS hospital acquired complications. These are clinically important adverse events or complications that happen to patients after hospital admission. The technical term is hospital acquired conditions. Using 100% Medicare part A data from 2009 through 2019, we studied about 660,000 hospitalizations at 51 private equity hospitals compared to 4.1 million hospitalizations at 259 matched control hospitals not acquired by private equity. Again, we looked three years before through three years after acquisition using a similar study design.

Our findings published in December of this last year in a paper led by Dr. Sneha Kannan in the Journal of the American Medical Association showed that hospital-acquired adverse events, these conditions acquired in the hospital, in aggregate increased 25% on average after private equity acquisition relative to the control hospitals. This was driven by a 38% increase in central line associated bloodstream infections, despite 16% fewer central lines being placed after private equity acquisition. It was also driven by a 27% increase in falls relative to the control hospitals. Here, control hospitals exhibited a decline in patient falls during the study period, consistent with a national trend towards improved hospital safety.

But the private equity hospitals did not exhibit such a decline. In addition, private equity hospitals exhibited a doubling of surgical site infections while such infections declined at control hospitals, even though surgical volume declined 8% at private equity hospitals. This increase in surgical site infections, despite fewer surgeries being done, was less statistically precise because the smaller sample size of

hospitalizations that involved surgery, but it was nevertheless concerning to us. Private equity hospitals also increased their transfer rate of patients to other acute care hospitals by about 12% and notably, by 36% for patients with sepsis, whom we typically considered to be on average sicker patients in the hospital. All of this was relative to the non-private equity control group. Medicare beneficiaries admitted to private equity hospitals after acquisition were younger and less likely to be dual eligible for Medicaid than beneficiaries at control hospitals. This signaled a shift towards lower risk patients as younger patients are healthier on average and dual eligible beneficiaries are more socioeconomically disadvantaged and sicker on average. Although coded diagnoses at private equity hospitals increased after acquisition, we could not disentangle that from coding intensity, sometimes phrased upcoding, which is independently financially rewarding relative to actually sicker patients coming into the hospital. And again, because patients were younger and less dual eligible, we believe that on average these patients were lower risk and likely healthier. Lower risk patients and increased transfers to other hospitals were both consistent with our finding that in-hospital mortality actually declined by about 3% after acquisition among what is plausibly a healthier population. At 30 days after discharge, however, there was no longer a differential change in mortality at private equity hospitals relative to control.

So in brief, on evidence in other domains of healthcare, in recent years, private equity firms have acquired, as you've heard, healthcare providers across a variety of clinical settings. In addition to physician practices and nursing homes, acquisitions have also been described in other important clinical domains. For example, private equity has acquired hundreds of OBGYN practices across the country, over 500 as of 2020, in another one of our studies. Private equity has also invested in the large majority of fertility chains in the U.S., which has been found to be associated with an increase in the volume of IVF procedures resulting in increased IVF successes, births. Towards the end of life as opposed to the beginning of life, private equity has increasingly acquired hospice providers, as noted earlier. For hospices, the payment system, also noted earlier, generally favors patients who use less healthcare near the end of life.

Historically, patients with cancer comprised most patients in hospice. Comparatively, patients with dementia increasingly prevalent today in the U.S., often require less medical care at the end of life. Consistent with this trend and early studies showed that private equity acquisition was associated with a 6% increase in patients with dementia, raising the issue of possible patient selection, and that study was done by our colleagues at Cornell University. In conclusion, private equity acquisitions of hospitals have been associated with increased healthcare spending and increased adverse events for patients including infections and falls at least among Medicare beneficiaries. In parallel, private equity acquisitions of physician practices, nursing homes, and other providers have also been evaluated. Potential policy levers are increasingly considered by state and federal policymakers.

And I look forward to Dr. Bruch's expert comments on this additional evidence, and I look forward to the expert remarks of Professor Erin Fuse Brown on the policy responses. Thank you for the time.

Laura Alexander:

Thank you so much, Zirui.

And as you alluded to, we are going to turn down to our third panelist, who is Professor Erin Fuse Brown. She has conducted extensive research on legal and policy solutions related to private equity's impact on healthcare. Professor Fuse Brown is the director of the Center for Law, Health and Society and a law professor at Georgia State University College of Law.

Erin, the floor is yours.

Erin Fuse Brown:

Thank you, Laura, and thank you to the Federal Trade Commission for hosting this important workshop. I've really learned a lot from today's discussion.

My remarks today will open just with a brief summary of the trends in private equity investment focusing on physician practices. Second, I'll identify the key public policy concerns raised by private equity's entry into physician markets, to patients, to physicians, and to have the healthcare market overall. And third, to figure out how to address these risks, we really have to ask what revenue strategy is driving the investment into a particular market segment? Because if we can identify the payment loophole or the revenue playbook that is being pursued, it will tell us where to target enforcement or policy change. And finally, at Q&A, I hope to have an opportunity to highlight potential legal and policy levers to address some of these risks.

Recently, the trend has shifted from private equity's initial focus on hospitals and nursing homes with facilities to physician practices. And over the last decade, private equity has entered the physician market quite aggressively, but targeting particular specialties, which can be grouped, when we've studied it, into three main categories.

The first category that we saw entry into were hospital-based physicians. These are emergency physicians, anesthesiology, radiology. The second category would be what we call office-based specialties, and these are office-based procedures that do a lot of fee-for-service reimbursed procedures including dermatology, ophthalmology, gastroenterology, orthopedics. And then third, we would say is another category of specialty that would be primary care, but other specialties also paid under a capitated or value-based model. Other reports and researchers have identified new and emerging areas for private equity investment. We've heard about hospice today, but we also see increased interest in behavioral health in telehealth and other types of providers.

Private equity investors have identified a particular revenue strategy for each of these specialty categories, but there is one thing that all of these revenue playbooks have in common, and that is consolidation through serial acquisitions via the roll-up model, which we've heard about already today. In the case of physician practices, private equity investors almost exclusively use this platform roll-up model where multiple small companies in the same market are acquired and merged. The private equity sponsor forms a management company to manage the operations of all of the portfolio practices. But due to state laws restricting the corporate practice of medicine, the private equity-backed management service organization may not outright own the practice, at least not on paper, but they have exert de facto control over the practices via contract. What we see also is that the platform and roll-up model explains how private equity investment into physician specialty markets leads to greater consolidation of those markets illustrated by the FTC's complaint against USAP and Welsh Carson. Greater consolidation increases market leverage and the ability to command higher prices.

There are three main public policy risks that policymakers are voicing concern about related to private equity investment in healthcare. The first is consolidation and cost increases both from the increased market power but also from the up-coding and aggressive risk adjustment behavior that we've heard about today. Private equity revenue increases from exploitation of various payment loopholes and financial engineering translate to higher healthcare costs for everyone else. Second is the harms to patient care. These may be driven by staffing reductions, cross-cutting, closures of less profitable services or facilities. And third are harms to the clinical workforce, including as we heard from the powerful speakers on the last panel, moral injury and burnout among clinicians, exit staffing shortages, and loss of professional autonomy.

My colleagues and I have posited that we can use private equity investment as a divining rod to identify market dysfunctions and payment loopholes. Robbers rob banks, so the saying goes, because that is where the money is, and the same premise can apply here. Private equity investors target certain

market segments because they have found a revenue opportunity to exploit. We follow the money to identify the revenue playbooks that are drawing the investors. If we can find the loopholes, then we can potentially fashion a policy response to close them.

So payment loopholes tend to be very specific to the particular sector or specialty being targeted. However, some strategies are common across specialty types. As I mentioned before, consolidation via the roll-up model is a common strategy across all specialty types to increase the market power of the physician practice then and portfolio that is being acquired and merged.

Another common tactic across the board is for the investors to control the captive physicians. The management services organization takes control over the practice, again, not necessarily by outright owning it, but through management service agreements, including control over hiring, firing, scheduling, contracting, billing, coding, all of which can threaten professional autonomy, cause burnout and moral injury while using non-competes and gag clauses to prevent physicians and clinical staff from leaving or speaking out if they have concerns about these practices or about the quality of patient care.

Here are some specific revenue playbooks that private equity has pursued across these three categories of physician specialties. The first for hospital-based physicians, the revenue playbook here was an out-of-network surprise billing strategy. About a decade ago, private equity investors like KKR and Blackstone moved heavily into hospital-based specialties. And what makes hospital-based specialties is unique is that patients don't choose these physicians, so their patient volume doesn't depend on being in-network with health insurance plans. They can stay out of network, they can charge higher rates, they can even balance bill patients before the No Surprises Act for whatever the health plan didn't cover, and that was a revenue opportunity for private equity.

There is a different revenue strategy at play for office-based specialties like dermatology, ophthalmology, and gastroenterology. These are specialties that engage in a lot of outpatient procedures, typically reimbursed on a fee-for-service basis by Medicare and commercial payers. In particular, these practices can self-refer a number of lucrative ancillary services, physician-administered drugs, pathology labs, imaging, or physical therapy for which they can bill intensively. Here the strategy is to capture and consolidate the market, increase the volume of patients and self-referrals for these ancillary procedures, increase the intensity of the procedures or at least the coding intensity, reduce the staffing levels to increase revenue. All of this can lead, of course, to higher prices, to unnecessary services, potentially understaffed or inadequately supervised care.

And then finally, for primary care, investors have figured out a way to exploit the ability to gain coding practices to increase capitated risk-adjusted payments from Medicare Advantage and other value-based payment models. One strategy is to invest in and expand practices predominantly serving patients enrolled in Medicare Advantage plans or to combine the private equity-owned primary care practice with a Medicare Advantage plan into a vertically integrated payvider. The revenue strategy is to extensively code, even exaggerate, the Medicare patients' diagnoses and comorbidities, which increases federal payments to the plans and translates into more revenues for the investors.

But value-based payment models, as we've heard today, may also create financial incentives to stint on care through prior authorization and other denials of care, increasing the risk that patients will be denied of care when they need it. There is also an incentive to reduce costs by substituting less expensive providers for physicians, cut staffing levels altogether, or close less profitable service lines or shunt people toward more highly paid sites of service. This further threatens patient care, patient access, and quality.

I'll hold my further remarks about policy levers for the Q&A and I will turn it back to Laura and Dr. Bruch.

Laura Alexander:

Thank you, Erin.

And our last, but certainly not least, speaker today is Dr. Joseph Bruch, who's an assistant professor of public health Sciences at the University of Chicago. Dr. Bruch's research focuses on the compatibility of different financial actors with medical expenditure, healthcare quality, and population health.

Dr. Bruch?

Dr. Jonathan Jones:

Thank you. I want to first begin by expressing my gratitude to FTC Chair Kahn as well as Commissioners Bedoya and Slaughter for hosting this workshop, as well as to Mark Katz and Carter Page for organizing this event. I'm honored to speak here on this panel with my esteemed colleagues.

My name is Joseph Dov Bruch and I'm an assistant professor at the University of Chicago. As mentioned, I study the role of the financial sector and how financial actors in healthcare influence population health and healthcare delivery.

As my colleagues have noted, private equity activity in U.S healthcare has surged in recent years. More and more we are seeing a small number of private equity firms acquire larger and larger swaths of our health system. Dialysis clinics, fertility centers, hospitals, nursing homes, physician practices, and behavioral health centers to name a few. As private equity has become a growing force within the healthcare industry, several researchers have tried to study its implications.

Generally, researchers examine before and after a private equity acquisition and compare changes in the quality operations and finances of a private equity acquired entity to an entity that was not acquired by private equity. Because of limited transparency on private equity activity, researchers have had to go to great lengths to identify when a healthcare entity is acquired by a private equity firm. Nevertheless, a body of research has emerged that provides us with important insights into what private equity means for patients, clinicians, and ultimately our health system. Dr. Song has already mentioned some of the research on this and I will review the remaining body of research briefly.

Let me start with what we know about what happens when private equity firms acquire physician practices. Across almost every physician specialty, we are seeing increases in private equity ownership. Singh and colleagues found the highest private equity penetration in dermatology followed by gastroenterology, urology, obstetrics gynecology, and then orthopedics.

In a recent study, Scheffler and colleagues found that in 28% of metropolitan statistical areas, a single private equity firm had more than 30% market share. In 13% of metropolitan statistical areas, a single private equity firm share exceeded 50%. These researchers also found that private equity acquisitions were generally associated with price increases ranging from 16% in oncology to 4% in primary care and dermatology. In several specialties like gastroenterology, obstetrics in gynecology and dermatology, prices were higher in markets where a single private equity firm controlled a sizable portion of the market share.

Singh and colleagues also recently found that private equity acquired physician practices exhibited an average increase of $ 71 charged per claim and $23 in the allowed amount per claim compared to non-private equity acquired practices.

Within the nursing home space, there's also been extensive research on private equity. Gupta and colleagues recently found that private equity acquisition of nursing homes were associated with an 11% increase in risk of mortality.

During the start of the pandemic. Braun and colleagues found that private equity owned nursing homes performed similarly to for-profit and nonprofit nursing homes based on Covid-19 cases and deaths.

However, the authors found that private equity acquired nursing homes had less personal protective equipment than other nursing homes.

In another study, Gandhi and colleagues found that nursing homes owned by private equity were more sensitive to competition than non-private equity owners. Specifically, they found that in highly competitive markets, private equity owned nursing homes increased staffing by more than $72,000 worth of care. However, in less competitive markets, they reduced staffing by an average of $18,604 in care.

So I've discussed physician practice in nursing homes, but the research on private equity activity extends way beyond these two areas, as discussed by the previous researchers.

In a recent systematic review by Borsa and colleagues, we reviewed the evidence across 55 studies that focused on the prevalence and impact of private equity across all of the other areas as well as including physician practices and nursing homes. What we found is that private equity ownership has rapidly increased, but in terms of impact, we found that private equity ownership was most consistently associated with increasing cost to patients and payers. Additionally, private equity ownership was associated with mixed to harmful impacts on quality. Health outcomes showed both beneficial and harmful results as did cost to operators, but the volume of studies for these outcomes was too low For conclusive interpretation. Private equity ownership was also associated with reduced nursing staffing levels or a shift towards lower nursing skill mix. What is important is we found no consistent beneficial impacts to private equity ownership across the literature.

While understudied, we are also seeing private equity firms working with real estate investment trusts, REITs. Here, healthcare entities sell their real estate to REITs and then pay yearly rental fees to the REIT in what is referred to as a sale leaseback. Generally, these transactions consist of a 10 year triple net lease whereby the healthcare tenant is responsible for facility rent, maintenance, insurance, and taxes. Sale leasebacks can provide desired capital for healthcare entities, allowing healthcare operators to use the proceeds from the sale to invest in patient care expansions or capital investments. However, oftentimes private equity firms are selling the real estate of the acquired healthcare operator and the income from the sale leaseback is flowing as dividends back to the private equity firm, leaving the healthcare operator with escalating rental fees. In 2021, REITs owned the real estate to more than 6,000 healthcare real estate properties.

The rise of private equity acquisition though is part of a larger trend, the financialization of health. More and more we are seeing the influence of financial sector actors in our health system. As discussed in a recent article, financialization builds on, but also departs from previous and better studied processes affecting healthcare. Financialization is not simply corporatization where large corporations have consolidated healthcare entities in order to maximize profits, nor is it privatization where more of our health system has shifted away from government-owned to private-owned. The financialization of health refers to the merging influence of financial sector ownership and influence in our U.S. health system where healthcare entities have become saleable and tradable assets from which the financial sector may accumulate capital.

I'll end by saying that private equity, while pressing, represents only one dimension of financialization and any policy change that seeks to address the rise of private equity should also consider the larger forces of financialization that are transforming the structure and the function of our health system.

Thank you.

Laura Alexander:

Terrific. Thank you, Joe, and thanks to all the panelists for sharing your insights.

We now have about 20 minutes to spend on Q&A, which is not nearly enough, but let's go ahead and dive in and see what we can cover.

I'd like to start with you, Zirui and Joe. Both your presentations discussed the evidence about how and whether private equity acquisitions have been associated with different effects than other types of acquisitions, particularly increased costs and mixed or negative impacts on patient care and quality.

Could you explain why private equities' acquisition of hospitals or physician practices might lead to these different outcomes that have been observed in literature?

We'll start first with you, Zirui, and then, Joe, if you want to add on.

Zirui Song:

Sure, Laura. Thank you for the question.

We have a primary hypothesis that staffing reductions and cuts and expenses likely explain these changes in patient adverse events and patient outcomes within hospitals. We are starting to work on this second phase of this overall broader project and understanding hospital acquisitions and beginning to see evidence consistent with that hypothesis. We don't yet have estimates that we can report, but it seems to be clear that staffing reductions, which you've seen in nursing homes and that's been well documented and in physician practices, which a study led by Joe has also documented last year in Health Affairs, likely translates to a similar or analogous type of mechanism within hospitals. The staffing reductions are part of what you might call more broadly cost cutting. Both salary and non-salary expenses might be involved, and there might be variation across hospitals in exactly where the costs are cut or what types of labor or non-labor types of costs

Zirui Song:

[inaudible 02:20:01], but that remains our primary mechanism and we look forward to presenting evidence on that in the near future.

Dr. Jonathan Jones:

Yeah, I agree with Dr. Song. I'll add though staffing I think is definitely contributing to the more acute quality implications, but I also think the financial implications here may create long-term quality and patient related harms. So while we may not see in the short term the effects of the high amounts of debt private equity firms generally load onto the healthcare entities as well as the stripping of real estate and other financially engineered tactics that private equity firms may pursue, over the long term we may expect to see that these financial changes may have really lasting impacts all the way leading to closures ultimately, as well as patients having limited access and staff no longer having jobs in the places that they've held jobs for decades.

Laura Alexander:

Thank you. Building on that, I wanted to turn next to you, Brendan, and ask you to weigh in on to what extent this is the types of staff cutting, et cetera, building on Joe's remarks about this greater issue with commercialization and monetization of healthcare, and to what extent can the kind of accountability changes that you talked about in your presentation go to address those issues?

Brendan Ballou:

Yeah, it's really interesting and maybe I can talk more about some of the tactics that Joe was talking about and then transition to staffing specifically. So one of the basic challenges of the private equity

business model is that the incentives of the private equity firm are not often, are not always aligned with the incentives or what constitutes success for the portfolio company or even for the investors that invest with the private equity firms, so the pension funds and sovereign wealth funds that fund the private equity firm's acquisitions.

So just to give you an example, Joe was talking about sale leasebacks. Just to reiterate the idea here is the hospital or the healthcare facility owns its real estate, will sell that real estate and then lease it back to itself. Now that generates a quick hit of cash, but suddenly you're responsible or the company's responsible for indefinitely paying for something that it used to own. Sometimes that might make sense, often it doesn't.

But why would a private equity firm do it? Well, oftentimes a private equity firm's compensation structure is such that it will get a "transaction fee", which is a fee that they get specifically when a sale leaseback or other sort of deal is executed. So the private equity firm will actually get more money from the sale lease back then just the ordinary profits and that money from the transaction fee will go to the private equity firm alone, not its other investors. So that's just one example where a private equity short-term interests might not be aligned with the portfolio company's long-term interest.

I think you have a deeper and similar problem when you're talking about staffing, which is for a bunch of reasons, private equity firms are really incentivized to take very high risk strategies, levering the company up with a lot of debt, hoping for a very quick expansion. If it succeeds, they will get an enormous amount of upside. So some of the participants or listeners today may be familiar with the 2 and 20 compensation model or a private equity firm will get 20% of the profits that the portfolio company makes once it reaches a certain threshold. So the private equity firm gets a lot of upside if things go well, but if things go poorly, if the company stagnates, or even worse, if the company goes bankrupt, it is going to be very hard for the creditors of the portfolio company, so the suppliers, the lenders, the customers, the employees, it's going to be very hard for them to recover any money from the private equity firm itself, which may have been extracting money from the company through all these various fees.

And so what that means is private equity firms often have a heads I win, tails you lose sort of business model where it makes sense actually for them to lever the company up, to cut staffing in the hope of ambitious growth or increased profitability. Because if things go well, that's great, but if things go poorly often nothing bad will come of them.

Laura Alexander:

Terrific. Erin, turning to you, you highlighted in your presentation the potential here for policy solutions and I would love to hear beyond fixing or realigning incentives as far as the overall investment model that Brendan's discussed, what policy solutions do you see as available to address private equity and healthcare specifically in the issues that you've seen?

Erin Fuse Brown:

Yeah, thank you. I think there are five overall policy strategies, there are probably more, but I'll talk about five right now. The first is ownership transparency, and this is just a fundamental starting point. It's not going to solve the problem, but it'll make it easier for regulators, for policy makers, for enforcers, and for researchers and the public to actually just know the extent of ownership and investment in the healthcare space by private equity and other investors and private investors. So right now, as my colleagues have mentioned, it's very difficult even for researchers who have access to a lot of data to put two and two together. I mean, certainly if you're were a patient, it would be very difficult to know whether your doctor's office is owned by a private equity or controlled by a private equity company.

And so if we can't study the effects of this and we honestly can't regulate it and can't oversee it if, we don't have ownership transparency. So to me, that's a starting point as a bedrock principle for all of the other policy solutions.

The second is antitrust enforcement and competition policy. And we're here with the Federal Trade Commission and the Department of Justice, but this is core because the roll-up strategy employs a consolidation approach, the use of competition policy, the use of the existing antitrust laws to apply it to the strategy used by private equity is very important. It's also important as we've seen the Federal Trade Commission doing, to modify, and the merger guidelines from both agencies, to modify some of the guidance that might've been developed in earlier days to embrace the type of consolidation we're seeing with the serial cumulative effect roll-ups that we know individually may not appear to have an anticompetitive impact, but when you add them all together as we see across an entire market, that is certainly the case. So using antitrust and enforcement policy is extremely important to potentially constrain the cost effects, but also the access and quality effects that we're seeing, the non-price effects as well.

The third policy lever I would say is fraud and abuse enforcement. We heard a lot of strategies about this incentive to increase revenues, captive referrals, upcoding and other revenue generating tactics may violate in many instances federal and state fraud and abuse laws. And so to the extent that there is investigation, again that linking those strategies not just to the portfolio company or the end of the line clinician or the billing and coding person who's just being told what to do, but to actually link it back to the revenue strategy of the management company and the private equity fund that's in the driver's seat. I think it would be really important. It's challenging under current laws, but I think that that's another potential avenue to create at least some guardrails around some of the most nefarious billing and coding activities.

And then a fourth would be policies to protect the clinical autonomy of the workforce, including the physicians, the nurses, and other clinical workforce. So we heard today in the first panel about ways in which private equity investment in particular, like a lot of other corporate behemoths coming into the healthcare space, is stripping away clinical autonomy, professional autonomy, and putting the clinical workforce in a bind through reduced staffing levels, through the revenue incentives that they are being forced to carry out.

And so one way to protect the clinical workforce would be to strengthen state Corporate Practice of Medicine Doctrine. There are a couple of states that are trying it right as we speak, Oregon being one of them. It's trying to strengthen the Corporate Practice of Medicine Doctrine in order to get at the contractual workarounds that private equity and other investors have been using for years to control physician practices, even if they don't own them outright, as well as physician non-competes and other types of anticompetitive employment agreements, gag clauses and the like. Again, the Federal Trade Commission has a proposed rule on non-competes, and I think a lot of states are also looking at shoring up those requirements.

And the final policy option is to close those payment loopholes that are being exploited by private equity to increase revenues as we see primarily without increasing value for patients or the taxpayer. But those are, again, a bit specific and in the weeds, but I would just characterize that as find the revenue loophole and figure out if there's a way to close it that allows the flow of patient care to continue without necessarily allowing profit to be made unnecessarily.

Laura Alexander:

Excellent. Brendan, I wanted to turn it back to you and to ask, Erin mentioned competition policy as one of the policy levers and obviously we're here at the Federal Trade Commission. So from that perspective,

I'm curious the types of conduct that we've been talking about here, and Erin mentioned roll-ups, serial acquisitions, these are issues that go beyond private equity and certainly are competition problems that are not specific to private equity. I'm curious about your perspective on whether this is a particular issue with private equity in this area or whether this is simply a broader competition issue related to roll-ups and other factors, and what makes private equity roll-ups different?

Brendan Ballou:

Yeah. Well, at the risk of being a little repetitive, I'd say that what makes private equity roll-ups a little different is that when a private equity firm rolls up an industry, it's going to be very hard to hold the private equity firm responsible for those portfolio company's responsibilities. If the exact same roll up occurred by a traditional company, a hospital or an insurer or something like that, generally you would be able to hold the hospital or the insurer responsible. So I think that makes private equity acquisitions qualitatively different in some ways than other kinds of roll- ups.

Now, I need to be a little circumspect here because as I said at the outset, I'm speaking in a purely personal capacity, but let me just emphasize some of the things that you already heard from Assistant Attorney General Kanter, and a lot of the participants over the course of the day, private equity firms are engaged in all sorts of roll-ups. You can essentially throw a dart at any part of the healthcare industry and you'll see private equity getting active there. One of the challenges that I think all parts of government face is often these acquisitions are occurring below what's called the HSR reporting threshold. So that's the threshold at which the companies need to report to the government that an acquisition is happening. Individually each one of these acquisitions might not be anticompetitive, but collectively they have the power to raise prices, reduce the quality of care, reduce employment and so forth. And you hear that again and again in the research that we've been talking about over the course of this panel.

I will say I think that there's been a lot of interesting work done to address that. For instance, as Chair Khan mentioned at the outset, new merger guidelines are helping to add some precision to what we mean by a serial acquisition and when such an acquisition might be anticompetitive. You see actions happening at the state level. California right now is considering a bill that the State Attorney General have the authority to review hospital acquisitions before they're approved, separate and over and above from the traditional antitrust analysis that goes on at the federal level. So I think that there are things that make private equity acquisitions unique, but again, speaking personally, I'm encouraged by some of the things that we're seeing both at the federal and state level to help address the problems posed specifically by private equity.

Laura Alexander:

Thank you. I want to open it up to the rest of the panelists to the extent anyone wants to jump in on that question or respond to any of the other points that have been made.

Dr. Jonathan Jones:

I would like to speak to the first comment Erin made, which is about transparency. And all of us have, we're like a broken record on this panel. If you come to any of our talks, that will be one thing that you will be sure to hear. But think about it for a second, we actually don't know, and the government doesn't know who owns a lot of our healthcare and who the owners are of our healthcare. And CMS has recently with nursing homes tried to enhance transparency. But a study came out actually just this week led by Amanda Chen in Health Affairs showing that even with this new effort by CMS, we are still not

able to capture all the private equity deals in real estate investment trust ownership structures within our nursing home industry.

So that means regulators can't regulate. That means researchers like us cannot assess the impact of private equity and other financial actors, and it ultimately means patients are not able to know who owns the healthcare operator that they're going to. It means they don't know whether it's a financial firm that has a history of doing X, Y, Z or it's some other type of healthcare entity. And so at the very, very minimum, and I imagine all of us are going to keep having to say this, transparency really does seem like a baseline for this conversation.

Laura Alexander:

Thank you.

Zirui Song:

I would just add another fact that I think is helpful for just keeping on the table, which is the heterogeneity across all of the private equity acquisitions we see in the delivery system. When we speak about private equity, especially across many of our research papers, we tend to present them as the average effect of an average private equity acquisition. But there are sort of two facts to consider there. One is that around every average there's a distribution. There are some acquisitions that produce results that don't give you the average finding that we report in a paper or that most studies report.

And the second fact is that increasingly in today's world, private equity acquisitions are on the margin at least deviating from the classic private equity approach, meaning the high level of debt or leverage or the high debt financed price of the acquisition, be it 70 or 80% debt, 20 to 30% existing equity, that classic approach, which may have applied more to hospitals and nursing homes may not apply as frequently, though it still is relevant to physician practice acquisitions and the acquisitions of other healthcare providers. So understanding the variation and the heterogeneity across these acquisitions is important as well as understanding the variation and the heterogeneity beneath, one level below the average results that we see in these studies.

Erin Fuse Brown:

I'll just jump in with one other comment, and I think Joe made this comment earlier and I just wanted to again elevate it. And that is to say even though both things can be true, private equity can have its own unique set of risks because of its business model, and yet the policy responses really ought to be generally applicable because the playbooks that private equity is using can be taught to any actor in the economy.

And so what we see is that if there's a consolidation risk or if there's a payment loophole manipulation risk, that that can be utilized by anyone in the healthcare system, whether it's a nonprofit health system or whether it's a payer or a publicly traded company or Optum, which is now the biggest owner of physician practices in the country. So I think when we think about crafting these policy responses, even if what is rising to the top of the policy urgency is private equity investment, the policies themselves should be somewhat agnostic as to the type of owner, but really should be generally applicable regardless of who's using the revenue strategy. If it's the same risk, it should apply equally no matter who is pulling the lever.

Laura Alexander:

And I think that's a terrific point to end on. I want to thank all of our panelists for sharing your insights and findings, and I would now like to welcome Commissioner Slaughter and Rhode Island Attorney General Peter F. Neronha.

Rebecca Kelly Slaughter:

Thank you so much Laura, and thank you to that amazing panel. I was absolutely rapt listening to everything that you had to say, but I don't want to delay us from diving into our conversation with the Rhode Island Attorney General. Let's just jump right in. Mr. Attorney General. Today we are talking about the role of private equity investment in healthcare throughout the United States, and one of the things we've heard a lot about is how private equity investment has hurt local community hospitals. Can you tell us about the hospitals in Rhode Island that are private equity owned?

Attorney General. Peter F. Neronha:

Yeah, two in particular, Roger Williams and Fatima Hospitals are two community safety net hospitals here that are owned or were owned by Leonard Green as a majority owner until 2021. And I'm sure we'll get into that transaction, but private equity has really endangered those hospitals to the point where a really strong intervention by us was necessary to keep them open and moving forward.

Rebecca Kelly Slaughter:

So let's talk about that. How did you first learn about the way private equity was operating in the Rhode Island healthcare system, as Attorney General or before?

Attorney General. Peter F. Neronha:

Yeah, so as Attorney General. And so we have a regulatory function here when it comes to healthcare, the transfer of any ownership interest beyond 20% requires approval not only by our Department of Health, but also by my office as well. And so this first came on our radar screen in my administration when Prospect Medical Holdings, which a majority ownership of interest was owned by Leonard Green was before us for a change in ownership. They originally came into the market, Prospect Medical Holdings came into market under the administration of my predecessor. So it was in the context of that proposed change of ownership interest where Leonard Green, a California-based private equity firm was trying to sell its ownership interest, it was in the context of that proposed change of ownership that they got on our radar screen.

Rebecca Kelly Slaughter:

And that regulatory structure you mentioned is that the Rhode Island Hospital Conversions Act?

Attorney General. Peter F. Neronha:

That's exactly right. That statute gives us the authority to review, requires us to review all changes in ownership above 20%. So that comes up most often in the context of mergers and acquisitions, but it also came up in this context because Leonard Green was trying to sell its 60% ownership interest to two individuals, the remaining 40% owners at the time, a Mr. Lee and Mr. Topper.

Rebecca Kelly Slaughter:

So what raised red flags about that to you? What made you skeptical or did you take the same kind of interest you might take in any other [inaudible 02:41:52]?

Attorney General. Peter F. Neronha:

What really concerned me was how the financial security, the financial wherewithal of Prospect Medical Holdings had changed over just a couple of years. They had gone from a firm that was well financed, was financially stable to one that was financially unstable. Now remember, this is a national hospital company. They owned 17 to 20 hospitals all around the country, including our two here in Rhode Island.

And so what had happened was that Prospect Medical Holdings had gone from a company in say, 2018, where their assets exceeded their liabilities by $67 million to really being now upside down to where their liabilities were greater than their assets by about a billion dollars. And the reason that was important to us here in Rhode Island as regulators was, was because Prospect Medical Holdings had been propping up our hospitals here for some time as community safety net hospitals, they needed the financial backing of the parent company in California, which was in position to do that in 2018 but was pretty clearly not in position to do that in 2021. And the reason that that landscape had changed was because of what the private equity firm had done to that company in the interim.

Rebecca Kelly Slaughter:

So that's a pretty powerful picture that you see on the papers. One of the things that I think has been amazing about this event today is the combination of seeing and hearing about data and statistics and financial models and hearing about the real life experience of doctors and providers and patients, and I'm wondering if that played any role in your evaluation of the proposed transaction?

Attorney General. Peter F. Neronha:

Well, it sure did because I was really worried that without that support from California, that the California principal company that owned our hospitals and others across the country, that our hospitals would be in danger of closing. We really did not see a future where our hospitals, or for that matter, the parent company, were going to be solvent in the foreseeable future. And frankly, they had brought that on themselves in a deliberate effort to use these hospitals, all across the country, including our two hospitals here, to pay investors back on their investments., And then some. I mean, they had taken out all that debt that I alluded to earlier, that over a billion dollars in debt to put money back in their pockets to private equity firm, Leonard Green and their investors, and Mr. Lee and Mr. Hopper, they had borrowed all that money to pay themselves dividends of the tune of $457 million leaving their parent company without the wherewithal to continue to support our local hospitals, putting those hospitals in danger and putting hospitals all across the country in danger.

And the two years since have really confirmed exactly what they did. They deliberately pulled all of the money out of the parent company to pay themselves back, or off, a better way of putting it. And in doing so, put a lot of community hospitals in danger, and many of those hospitals have already closed. Ours are only open today, I firmly believe because of the actions we took in conditioning that transfer of ownership interest back in 2021.

Rebecca Kelly Slaughter:

So tell us more about those specific actions. So you used the Hospital Conversions Act to do what exactly?

Attorney General. Peter F. Neronha:

Yeah, so most principally we required a prospect as a condition of the change in ownership interest. So in other words, Leonard Green selling off at 60% interest. And there's no doubt in my mind Leonard Green wanted to sell that interest because as a private equity firm that wanted to go into the future

being able to raise funds, they didn't want to be anywhere near this hospital company when it started to become insolvent. So that was the motivation for them getting out. There's no doubt in my mind. They didn't want to still be on board the ship when the ship hit the rocks.

And so what we did was we forced them and the other two owners, the individual owners, to put $80 million in an escrow that this office controls as a backstop for their promises. Their promises were to keep the hospitals open, their promises were to pay their vendors. Their promises were to keep lines of services open and not reduce workforce, and a number of other promises. But I didn't feel like we could take those promises at face value, we needed security for them. And so we took what was then, and I think still is, the unprecedented step of forcing Leonard Green and Mr. Lee and Mr. Topper to put $80 million in escrow that they only got back in pieces as they kept the hospital operations going. And again, what's happened since has only confirmed what I worried about, Prospect is in tough shape today, frankly. We're in court, we're suing them to pay their vendors, but I think this is all something we could see coming two years ago, but we could see it because we had the regulatory authority to look into these hospitals in a really careful way.

Rebecca Kelly Slaughter:

So let me just go back, and playing devil's advocate a little bit, you said that Leonard Green didn't want to be there when the ship hit the rocks and they wanted to make sure they got out of the way. A skeptic might say, "Look, it's not any investor's obligation to take a loss, they can do that." But I think what I heard you say is the reason the ship was headed towards the rocks was because they steered it right there in terms of the extractive model. Is that correct?

Attorney General. Peter F. Neronha:

Yeah. So let me make the analogies seem to work a little better. Imagine a cruise ship getting ready to hit the rocks, but the private equity investors all get in the lifeboats and leave the ship leaving the patients and the doctors and the community on the boat as it hits the rocks. So what they did, what Leonard Green did, and Mr. Lee and Mr. Topper did together, remember Leonard Green had a 60% interest, they controlled the board. They took out a million dollar loan and pocketed $457 million of it as dividends. They then sold the hospitals off and leased them back to raise revenue to pay off some of the debt and adding additional debt to the bottom lines of these hospitals. That's why the company went from $67 million to the good to over a billion to the bad in just a couple of years because private equity sucked the money out of it, and then they left the hospitals essentially to fend for themselves.

Mr. Lee and Mr. Topper didn't care at that point, they made their millions and that's why hospitals have closed in the year since. And it's why even our Rhode Island hospitals are in danger today. It's why private equity should never be let within 10 feet, 100 feet, 1,000 feet, 1,000 miles of healthcare. They just cannot be trusted with what we care about most.

Rebecca Kelly Slaughter:

I think it's a really compelling point and the background to the proposed transaction is important in understanding why you had to take the action that you did. What about the key stakeholders in the community, healthcare workers, doctors, providers, patients? How did you gather their input and hear from them? Because one of the things we've heard about is people don't always know when these things are happening, [inaudible 02:50:11] it's coming their way.

Attorney General. Peter F. Neronha:

No, it is astonishing actually. And look, these private equity firms are smart, they know how to hide the ball through layers of ownership and more. So part of what the Hospital Conversion Act envisions here in Rhode Island is getting public comment and being very deliberate about that. So we had a number of public meetings where the community was invited to come forward and share with them, share with us their perspectives. And I will tell you there was community support for this change in ownership, and a lot of that was because the public didn't have the information that we had. There was something called the Health Advisory Council here in Rhode Island that advises the Department of Health. They voted in favor of the transaction, I think in large part because they couldn't see what we could see. The Lieutenant Governor came out and supported the transaction along with other political leaders because they couldn't see what we saw.

And so it was really important for us when we issued our decision some months later, back in June of 2021, to be really clear and explicit as to why we took the steps we did. And look, they were not happy with us, Prospect Medical Holdings, Leonard Green, Mr. Lee and Mr. Topper were not happy with this office. There was an attempt to blame us for any bad outcomes going forward. But we knew, I knew at that point that we had to fight right then and there, we couldn't wait because we had to act while we still had leverage over Leonard Green. They so badly wanted out, they were willing to put up a big part of that 80 million in escrow because they were so desperate to get out.

Reputationally, they just can't be there when a hospital closes with patients waiting outside the doors, as it literally happened in Pennsylvania. They just can't be the owner at that point for purposes of their reputation. So they desperately want to get out. That's why we knew we had to and could act at that moment in time to get that extraordinary relief or remedy, if you will. But as I said, private equity is smart, they know exactly what they're doing and they're going to siphon every last dollar out of healthcare. They're not interested in doing healthcare, they're interested in making money.

Rebecca Kelly Slaughter:

We didn't prep this particular point, but I just want to highlight your point about some of the political influence pedaling that happens in these transactions and particularly compliment you for focusing on your constituents and the people of Rhode Island and what was really in their best interest. I have both witnessed and have been on the receiving end of a substantial amount of well-financed lobbying around healthcare transactions, and basically everything else we do, and it is really critically important to keep going back to, what are the actual facts on the ground? What are the states? Who are the people that we are in office to serve and making sure we're hearing from them and getting their narratives and data and information as well. So I just compliment you because I know that that's not an easy thing to do always. And I didn't see this lobbying effort, but I can imagine how ferocious it was.

Let's pivot a little bit to talk about other policy changes. There've been proposed amendments to strengthen The Hospital Conversions Act over the years, and you've already talked about what a powerful tool it has been for your office. But if you could wave a magic wand, are there any key changes you would make to the act or any ways you recommend it be replicated elsewhere?

Attorney General. Peter F. Neronha:

Yeah, look, I think it could state... The way the act is written and because it's been amended over time, it is not always a model of clarity. So if you look at the criteria that we can apply in reviewing a hospital transaction, it's very, very specific. It talks about charitable assets and the makeup of the board and whether the assets have been valued the right way, but it doesn't speak directly, it speaks implicitly, but not directly to the need to take into account at the end of the day, what is in the best interest of Rhode

Islanders in their healthcare. And so I think that could be clarified. I mean, one of the major things that we added to it, if you were to look at it four years ago, what it didn't

Attorney General. Peter F. Neronha:

It didn't have antitrust as a criteria, and it was really important that we add that just as a... before we had to look at, along with the FTC, a very large merger proposal, we were able to add antitrust into our statute so that we effectively flipped the burden of proof where my denial of that merger would've required the parties to go to court as opposed to me going to court much the way the FTC would have to do to try to block it. I mean, that was a critically important addition that if anyone is thinking of one of these laws, certainly have antitrust in there for that reason, even though we had separate antitrust authority.

But I think it's really important, particularly for attorneys general, to have this authority in the various states across the country. Healthcare is incredibly complicated, but we have to build in our office's disability to understand these transactions because many times, as we sort of alluded to or talked about, the locals won't necessarily... the local management won't necessarily understand how financially fragile their own hospitals are, and that was the case here. Local hospital management was in favor of the transaction, and I think it was genuine, but I think it was born of not understanding just how weak the company that they had been relying on to keep them going for so many years, just how weak they were.

Rebecca Kelly Slaughter:

What do you think other law enforcers can take away from your experience? And if other states don't have something analogous to the Hospital Conversions Act, what are other tools they might have to address the effects of private equity in healthcare, either state or federal partners? We're always looking for ideas.

Attorney General. Peter F. Neronha:

Yeah, sure. I think certainly antitrust is something that really could not have been used in the context where we had it, but antitrust is a power that most attorneys general have, I think, across the country, and so I would certainly look at that a Deceptive Trade Practices Act, a consumer protection statute perhaps, but attorneys general have this very broad parens authority. This common law authority to act on behalf of their residents and here, at least in this administration, wherever we haven't had explicit authority, we have come back to our parens authority as something we would try to insert ourselves into a situation where the public needed a voice but lacked one.

And one of the great benefits having been in private practice at the early part of my career, one of the great benefits of being in public service and representing the public as your only client, which is true here in Rhode Island for us, is that you can try things that you don't know going into them whether they'll be successful or not. But if you know the cause is righteous, then it is worth taking a try, taking a shot at it because, at the end of the day, all you walk away from is that the fight didn't turn out the way you wanted it to, but the fight was probably worth it. And so I would just rely on that common law parens authority if you've got nothing less, and see if you can't make that work.

Rebecca Kelly Slaughter:

The way I think about that principle is that it is always our obligation to seek justice, even if we are not always guaranteed to achieve it.

Attorney General. Peter F. Neronha:

Yes.

Rebecca Kelly Slaughter:

And I think that it is a really important guiding principle for enforcers. How have you worked with other state AGs or federal regulators in some of this work? When you talk about the Leonard Green transaction, you mentioned that it was ongoing in multiple states simultaneously.

Attorney General. Peter F. Neronha:

Mm-hmm.

Rebecca Kelly Slaughter:

Do you compare notes? How does that work for you?

Attorney General. Peter F. Neronha:

Yeah, one of the challenges here, when I was a United States attorney, we all read off the same sheet of music, meaning we all were applying the same statutes across the country, criminal and civil. So you could pick up the phone and call the US attorney in another state and instantly be know exactly what each other were facing. This was harder because I don't know, for example, what William Tong, he's a great attorney general in Connecticut, but what's his ability to deal with the three Prospect-owned hospitals over there? It's very different than the ability for me to take action here.

Same thing in Pennsylvania with my colleague there and Governor Shapiro when he was AG. Certainly, somebody wasn't afraid to take on a powerful interest, but if you don't have the tools in the toolbox, it could be much harder climb to make. So certainly, we compare notes. I talked to my colleague, Attorney General Tong, about this issue of the Prospect-owned hospitals that we're facing today because things did turn... take a turn for the worse as we had forecasted two years ago, but without... because we're often so differently structured, our ability to cooperate as much is... can be much more of a challenge.

Rebecca Kelly Slaughter:

You're also all, I think it's fair to say, grossly under-resourced. I mean, we think that we are grossly under-resourced at the federal level, and we are. It's not just a feeling or a perception. But when I think about the ways in which state attorneys general can punch above their budgetary weight, it is particularly impressive, and I think makes the ability to coordinate and collaborate where laws line up and fact patterns line up particularly important because you are financially outmatched by probably every company that you have the obligation to be investigating.

Attorney General. Peter F. Neronha:

Well, that's true, and so our partnership with the FTC and that large proposed 80% merger of healthcare systems a couple of years ago was really critically important, and we could not have done the work we did there without our partnership with the FTC, so I was incredibly grateful for that then and now. But you're right. I mean, I have a 30-person civil division that's got to cover everything from defending the state when the state gets sued to environmental work, healthcare work, energy work, consumer protection, and so trying to leverage those assets is really important.

But I will say this. When an office, how do I put this, picks up its game and takes on more challenges, you can really attract some great talent, and our healthcare team today has some amazing lawyers that get

out of public service what I like to think I've always gotten out of it, which is you go home every night, or at least most nights, and you feel pretty good about what you did that day in a way that I didn't have that experience in private practice. At Big Law back when I started out of law school. I learned a lot there, taught me a lot of great lessons, but I've stayed in public service because the gift is the work, and I think lawyers appreciate that more than ever today. Young lawyers in particular.

Rebecca Kelly Slaughter:

Yeah, I think that's absolutely true, and we have experienced that very much in our recruitment efforts, which have included recruiting from the incredibly talented staff at the state AGs offices because we all don't have non-compete clauses that prohibit our staff from moving from office to office and we want the best people doing the best work in the environment that is the most satisfying to them. I'll just mention that I recall well that large transaction that you referenced from a few years ago and how critical our partnership was, and it was another one in which there was very extensive political lobbying-

Attorney General. Peter F. Neronha:

[inaudible 03:03:05] absolutely.

Rebecca Kelly Slaughter:

... and keeping our eyes on the facts and the information in the case in front of us was really critical to make sure we got to the right outcome for the people of Rhode Island and the areas that those systems served.

Attorney General. Peter F. Neronha:

You know, Rebecca-

Rebecca Kelly Slaughter:

[inaudible 03:03:20]... Sorry, go ahead.

Attorney General. Peter F. Neronha:

... [inaudible 03:03:21] if I could. I just... You've asked me a couple of times, "How do you do?" And I think part of it is just understanding what your job is. But I'll never forget meeting a former nurse who had lost her pension because regulators had not been careful enough when I was running for this office back in 2017. And her words to me have stayed with me ever since, and I knew coming in that we just had to pick up our healthcare game. But there are many ways in which running for political office have forced me to do things outside of my comfort zone.

I don't think I was born to do politics, but I will tell... I will say this. Getting out there and talking to voters or residents of your state will really reinforce while the... why the work is important. [inaudible 03:04:15] sometimes, as an assistant US attorney and as US attorney, I felt sometimes we were so divorced from everyday Rhode Islanders that I couldn't really put our mission in context. One thing about being an AG and an assistant attorney general is you are much closer to the people you serve, and it helps remind you of why it's really important to do what's best for them.

Rebecca Kelly Slaughter:

Yeah, I think that's such a great and key point. And I'd like to particularly express admiration and appreciation for the work of Chair Khan and AAG Kanter in, as they say, democratizing the work of the

federal antitrust agencies and making sure we have the opportunity to hear from real people about their real experiences in the markets, not just at workshops like this, at the FTC, at our open meetings, going out into the community, meeting people hearing from people. I think I agree it's among the most compelling information I have the opportunity to digest in my job, and it does really help you remember why you do the work that you do.

Attorney General. Peter F. Neronha:

[inaudible 03:05:23].

Rebecca Kelly Slaughter:

Let's pivot a little bit and talk about another impressive colleague, Attorney General Phil Weiser in Colorado, who announced last week that Colorado entered into a settlement agreement with US Anesthesia Partners, about whom we've heard a bit today.

The settlement resolved that state's investigation into a series of acquisitions of surgical anesthesia practices in the Denver metro area by the PE-backed company that drove up costs for patients and insurers, caused delays in cancellations of surgeries, and restricted anesthesiologist job mobility.

In an effort to restore competition the settlement requires USAP to divest its exclusive contracts with clinicians at five Colorado hospitals, release and relax the terms of non-compete agreements with clinicians, and end its non-compete agreement practices within 18 months. So what lessons can enforcers and regulators take away from Colorado's victory in the surgical anesthesia space?

Attorney General. Peter F. Neronha:

Yeah, that's a great result by Attorney General Weiser and his team. There's an example of using your antitrust powers that I would be shocked if every attorney general didn't have the power... didn't have antitrust powers under an antitrust statute in their state and understanding the marketplace. And then taking action to cure a problem like that is really, really important. But I will tell you a lot of that, and I think you've talked about it a little bit on the workshop because listened in a little bit here and there that this keeps coming up that we don't know where they're... where private equity is operating.

We don't know when they're combining practices. I think one of the challenges here in Rhode Island, I'm sure is true everywhere or in many, many places, is not having the look in all the time. So, for example, we can really see inside the financials of a hospital system or a healthcare system that's come before us for a regulatory decision, but we just don't have that authority in a vacuum. So I can't say, "Well, look, I want to take a look at hospital system X today to see how they're doing, how financially stable are they? If they have a parent company, who is it? How financially stable are they? How has that changed over the last few years?" I mean, that's the kind of thing that without Prospect trying to come forward or coming forward with that proposed change of ownership, we wouldn't have seen.

I mean, going into that transaction, their lawyers tried to convince me that there was nothing at all to worry about. It was a 500 million dollar line of credit that backed them up that everything was great. And boy, when you started looking into it really carefully, you saw just how untenable the situation was. And so, again, the lesson for all of us out there as regulators are is we really have to flex. We cannot get rolled over by companies and corporations and systems that have more lawyers than we do or fancier lawyers than we do, or, as I like to say, the big shiny briefcases. When the shiny briefcases come out, that's when we know we have to roll our sleeves up and really fight for the residents of our states.

Rebecca Kelly Slaughter:

Well, I think a really important point in that too is effectuating deterrence. I think something that is critical about the work you did with respect to this key transaction was sending the message to the marketplace that you were willing to do it and that taking that model of value extraction and then get out of the business is not something that's going to fly in Rhode Island and sending that message loudly and clearly, hopefully, will send... will prevent other players from trying to repeat that playbook because they will see that it doesn't work.

We focus very, very much on making sure that not just which cases we bring but the way we bring them and the way we resolve them will help deter other bad actors in the market because, ideally, we don't want to have to go in after the fact and fix a problem. We want it to not happen in the first place. And I'm wondering if that's how you think about some of these things.

Attorney General. Peter F. Neronha:

Yeah, I do, and you just have to look across the border to Massachusetts, where they're facing crisis with 13 safety net hospitals and Steward Health Care, which has done something very similar to what Leonard Green and Mr. Lee and Mr. Topper did as owners of Prospect. Again, we've got 13 community hospitals in danger of closing because the equity has been sucked out of them, and the properties have been leased back. It's the same playbook, and we see it over and over and over again.

And Massachusetts now is really scrambling to figure out what to do with these 13 hospitals, how to save them and keep them open when the money's gone, and they really don't have much leverage over them. We've really got to just accept the fact that private equity is going to keep doing this and give ourselves the tools to try to prevent it because if we don't, we're going to see the same thing playing out. And look, it's not like the remaining hospitals can absorb the closures. That's what Massachusetts worries about. If you close those 13 hospitals, it's going to weaken the other hospitals that are in Massachusetts.

As great and as powerful as those hospitals are, they're world-renowned, but they can't absorb the closure of those 13 hospitals just like we can't afford to lose two hospitals here. It's 10% of our beds that can't be absorbed elsewhere. So the stakes are really high in this work, and if there's anything that keeps me up at night, it's how these fundamental structural problems within healthcare, regardless of who owns them, make healthcare a challenge. And when you have owners who are pirates effectively, it makes the outcomes unfortunately all too predictable and all too detrimental to the people of our states.

Rebecca Kelly Slaughter:

I actually thought to that end, Erin Fuse Brown, on the last panel, wrapped up with a really key point that we're talking a lot about private equity and the model that private equity uses, but it's a model that could be picked up by anyone else and making sure that the enforcement efforts we take, the policy solutions we act are agnostic or are equally applicable to anyone employing same more patient business model is really critical because... and it strikes me that that's what your Hospital Conversions Act allows. It doesn't only allow you to look at private equity transactions.

Attorney General. Peter F. Neronha:

Correct.

Rebecca Kelly Slaughter:

It's all leadership transactions-

Attorney General. Peter F. Neronha:

Correct.

Rebecca Kelly Slaughter:

... or transfers.

Attorney General. Peter F. Neronha:

Yeah, that's right. That's right.

Rebecca Kelly Slaughter:

I'm wondering if, in thinking about deterrence or how to use the tools that you have most effectively, you draw any lessons from your time as US attorney. Obviously criminal enforcement is a little bit different but is similarly plagued by too many problems, not enough resources, and real serious stakes for real people.

Attorney General. Peter F. Neronha:

Yeah. Look, I think there my... one thing from that experience was a case we brought against Google for helping foreign pharmacies import opioids into the United States without a prescription, and if we could have seen... if had known then what we know today, that that alone, the fact that there was so much money to be made by Google simply by doing that, simply by helping foreign pharmacies get their ads higher up in the ad search, it showed how addictive opioids were or are, and that what a problem it was becoming for people all across this country. And the actions we took there seemed like they had an impact at the time, but looking back on it was a 500 million dollar forfeiture, one of the five largest in the history of the United States, but I don't... Certainly, it changed Google's behavior on that particular issue, but how much of a deterrent effect it had, I'm not entirely certain. There is so much money to be made out there from clever schemes that try to stay two steps ahead of the regulators.

We really have to be on our games. And when we take our eye off the prize for a minute, that nurse loses her pension and loses her house. I mean, I met her in a public housing complex, and she was there because she lost her house, because she lost her pension because private equity didn't take over the pension when they bought Prospect, and the regulators let it spin off into a pension system that was destined to fail.

Those are the people who get impacted, and it's why it's so important to do this work with a careful and enthusiastic guy. I mean, I call it objective skepticism. We should always be fair, which means we should be objective, but we should always be skeptic... always be skeptical of what the proposed outcome's going to be from the perspective of the people that are trying to sell the transaction to us. We just can't get rolled, and we have to stand up for the people of our states.

Rebecca Kelly Slaughter:

Yeah, I think about that as the consider the source lesson in terms of evaluating an argument. I mean, it doesn't mean the argument is wrong, but you understand what are the interests of the person who is making that argument, and that is important context. I think the lesson that I hear in what you say about that Google case, though, is important and does reflect some of the work that you've been talking about as Attorney General, which is follow the money.

You pay attention to where the money is going, and that can help you understand incentives and outcomes. I'm wondering when you talk a little bit about... you talked about stepping up the healthcare

game, and we talked a little bit about this one case, but what are some other steps your office has taken to follow the money and really focus on the healthcare effects in Rhode Island?

Attorney General. Peter F. Neronha:

Yeah. I think, Rebecca, that one of the concerns I have is the way we're paying for healthcare here in Rhode Island. And I believe there are echoes of it around the country, is that we're just not able to sustain parts of our healthcare system if we continue to do Medicare the way we've done it, if we continue to do Medicaid the way we've done it, if we continue to do commercial insurance the way we've done it.

And what I mean by that is if we can't see holistically how we're paying for healthcare, the role of commercial insurance versus public insurance, Medicaid and Medicare, how that compares to other states, where it fits in the marketplace of what's fair and unfair, what do those differences in public payer versus private payer mean for how we deliver healthcare? I worry about the sustainability of healthcare systems, particularly in states like ours, where we have a high percentage of older residents and residents on Medicaid.

It makes up writ large about close to two-thirds of our healthcare buyers, if you will, people who are being insured when two-thirds of them are nearly two-thirds are on public insurance. Are we reimbursing public insurance at a high enough level so that hospitals that want to do the right thing, meaning they're not owned by private equity, they're true not-for-profits or nonprofits, and what they're interested in is delivering quality, affordable, and accessible healthcare? Can they make it on this payer model or fee-for-service, for example?

We could talk forever about getting away from fee-for-service. But when we're talking here about healthcare in this office today, in addition to making sure that we are robust enough as regulators, we're trying to become healthcare thinkers as well because, at least in this state, there's a real absence of strategic thinking around healthcare. And so when you come out of a situation post-merger decision like the one we did together where we have rejected a merger that would've supposedly, I don't think, accurately made healthcare better. What's our obligation?

We are still here. The FTC, as much as I love and respect you go back to Washington, we're still here. We have to play a role in fixing why the merger was proposed in the first place, and that's a capacity that we need, I think, on the national and local level. We split... We're trying to do healthcare jurisdiction by jurisdiction when healthcare organizations don't necessarily work that way, and until we solve that problem, I think we're going to continue see problems in healthcare, some certainly caused by private equity and some caused by other forces as well.

Rebecca Kelly Slaughter:

Well, look, it's fair to say that the FTC have had an interest in healthcare markets since long before private equity took a particular interest in them and have been... There's some really interesting economic research going on about cross-market incentives and cross-market mergers that sort of go exactly to the point that you're talking about. So, okay, we have to think about more than just private equity. We have to think about the healthcare system generally. Pivoting away from healthcare. Maybe we can just wrap up on this note.

Attorney General. Peter F. Neronha:

Yeah.

Rebecca Kelly Slaughter:

When you're scanning the horizon, are there other areas where you're concerned about the sort of private equity style model of acquisitions affecting important services?

Attorney General. Peter F. Neronha:

Well, look, one thing I worry about in terms of any competitive behavior is broadband. In some places, like Rhode Island, for example, there are some parts of the state where there's only one broadband provider, and yet it can't be regulated by state authorities, or at least that's what I'm told by my team. And I don't know whether the federal regulation is robust enough to ensure that that lack of competition, those anti-competitive forces don't lead to bad outcomes for Rhode Islanders. What do you say to the older Rhode Islander who relies on broadband as their connectivity to the outside world?

What do you say to that Rhode Islander, the parent in a Rhode Island household of challenged economic means that has to make the decision between clothing and food and whether they can pay their broadband bill that they need for their child to do their homework because you got to do your homework online? Or, certainly, given that we are doing more remote learning today. Hopefully post-pandemic, we're getting back to in-school learning. But look, it comes up, and certainly, there's homework that needs to be done. So that's one area that I worry about where more regulation, effective regulation is needed.

Energy's another. The energy marketplace is going to have to change. And there's a lot of rogue actors out there in places like solar, for example, that are unregulated and are causing real consumer problems. Rebecca, I could go on and on about some of the work we're doing here that may or may not oversect... overlap or intersect with what the FTC is interested in. But I know one area that I'm worried about that certainly has federal involvement is broadband and anti-competitive behavior and the broadband market that's really impacting everyday Rhode Islanders in significant ways.

Rebecca Kelly Slaughter:

Well, I think it's a great point to wrap up on because you're pointing back to the concept that we started with, which is how are real people, the people that we serve, going about their lives? How are the markets in which they're operating helping them or not helping them live full whole lives, participate in the economy, do work that is meaningful, provide for their families, go to school? And I'm so grateful to have the opportunity to talk with a public servant who's clearly focused on that bottom line stuff for his constituents all day. So I thank you so much for joining us today and for your participation, and I will just briefly wrap us up now because we're coming to the end of this incredibly exciting panel. I just want to reflect on how valuable it has been for me to hear the whole range of experiences we heard today from doctors, nurses, providers, researchers, policymakers.

I think we get a pretty clear picture about how critical this area is, and as the Attorney General and I were just saying at the end here, this is not the only problem in healthcare, and addressing private equity in healthcare is not going to solve all the problems that we have. This is also not the only market where there's a private equity problem. We see it in retail. We see it in veterinary healthcare. It's all over the place. And I mentioned earlier the comment that Erin made about how we need to really attack the underlying model, not just name... the name of private equity, but really think about where incentives lie and how we can best bring the tools each of us have to bear on these problems to cut them off. I'll just finish by saying that my youngest brother is a doctor and the stories I hear from him about cuts to care or the inability to do the work that he really wants to do, which is serve patients, it's really heartbreaking, and his... there's sometimes an image of doctors is fancy and off playing golf all the time.

What I've seen with my brother is he worked so hard to go to medical school to get through medical school and his residency and his training, and he didn't do it for personal profit. He did it because he wants to serve. And that's what I heard from the folks we heard from today. And I'm so grateful to Chair Khan, to Tamar, to AAG Kanter, to our colleagues at HHS for convening this important event. And I will finally wrap up by reminding and encouraging everyone to participate in our request for information on the impact of corporate greed and healthcare. You can provide comments on deals conducted by health systems, private payers, private equity funds, or other alternative asset managers that may harm patients health, worker safety, quality of care, and affordability. Comments are due in 60 days, so please, please submit via regulations.gov. Thank you again to everyone who's watching and to all who participated, and our workshop is now adjourned.