Private Equity in Healthcare: Con Man or Straw Man?

David Burda:

Welcome to the 4sight Health Roundup podcast, 4sight Health podcast series for healthcare revolutionaries, outcomes matter customers count and value rules. Hello again, everyone. This is Dave Berta, news editor at 4sight Health. It is Thursday, March 14th. Sunday is St. Patrick's Day. A few years ago, I took one of those ancestry.com DNA tests. It turns out I'm 8% Irish, so I will be celebrating on Sunday. What people aren't celebrating Sunday or any other day of the week lately, is private equity ownership in healthcare. On today's show, we're going to round up some of the latest healthcare PE news and Dave Johnson, founder and CEO 4sight Health and Julie Murchinson, partner at Transformation Capital, are gonna tell us where all this activity is headed. Hi Dave, Hi, Julie. How are you two doing this morning, Dave?

David W. Johnson:

Well, it's a dark and stormy morning here in Chicago. What gives with thunderstorms in March? Then again, it's gonna be over 60 degrees here today. So when cold air meets hot air, thunder and lightning happen, just like when federal regulators meet avaricious corporate behavior. How's that for a segue into today's topic, Dave?

Burda:

Yeah. Yeah. That's a little foreshadowing there. Look forward to it. <Laugh>. Julie, how are you?

Julie Murchinson:

I am well. I'm in hot, sunny Florida, but I just spent yesterday with the really incredible NCQA board, and we heard from David Kelly from Pennsylvania Medicaid, who talked about just so inspiring, talking about outcomes related to data flowing related to focusing on quality related to, you know, efficiency and costs. Like it all works together when it works. So, I have renewed energy despite our topic today.

Burda:

That's great. His head's in the right place. Excellent. That's good to hear. Now, before we talk about what's going on with private equity, let's talk about St. Patrick's Day. You know, they say everyone is Irish on St. Patrick's Day. Dave, do you have any Irish blood in you?

Johnson:

Well, I'm Irish by marriage, and I'm pretty good at mass, so I think that makes me a hundred percent Irish.

Burda:

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<Laugh>, yes. Being married for 40 years, I agree 100% with you. <Laugh>. Yeah. Thanks Dave. Julie, is any part of you Irish the whole year round or just this Sunday?

Murchinson:

I definitely have some Irish, somewhere in my Northern European mutt nature. And green is my favorite color, but you know, I, it's more of a holiday for me. It's not a lifestyle.

Burda:

<Laugh>. Got it. Well, in addition to finding out that I'm 8% Irish, I'm also 14% Scottish and 22% English, and I thought I was 100% polish so I can have, so I could have vodka or whiskey <laugh>. That was, that was my silver lining.

Murchinson:

That's exciting. <Laugh>.

Johnson:

Well, all I know, Dave is, you're a hundred percent Chicago.

Burda:

That's, that is true. Thanks, Dave. That's a great compliment. Is there any silver lining in private equity ownership in healthcare? And there's your transition… Let me round up a few things that happened just in the past two weeks. The Federal Trade Commission Justice Department and HHS issued a public request for information on private equity acquisitions of healthcare providers, like hospitals and medical practices. Public comments are due May 6th, a study published in Health Affairs said the number of PE owned medical practice sites increased to nearly 6,000 in more than 300 metropolitan statistical areas in 2021 from about 800 in about 100 MSAs. In 2012, business Insider published a scathing expose on PE ownership of hospitals. The headline was “The Plundering of America's Hospitals”. Ouch. An organization called the Private Equity Stakeholder Project, which describes itself as a nonprofit financial watchdog launched a private equity hospital tracker. It also released a report that said 675 PE firms did 1,135 unique PE deals in healthcare in 2023. That's down slightly from 2021 and 2022. Dave, what's your take on these recent developments? Where are we headed with PE ownership in healthcare from a policy or reform perspective?

Johnson:

You know, David seems like we're discussing PE investments in healthcare at least every other week on the roundup here. But it's because PE is so ubiquitous in healthcare. On my walk to the Belmont EL, I pass at least half a dozen new dental practices. Most of 'em have the word smile in 'em, and, you know, they're all part of PE roll-ups. Our discussions remind me of the Arab folk tale about the frog and the

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scorpion, you know, where the scorpion convinces the frog to take 'em across the lake and then stings them halfway across. And is, they're both going down the frog goes, what gives, and the scorpion says, it's in my nature. Well, it's in the nature of PE firms to make outsized profits. You know, when they buy companies people seem to be surprised that they're handing 'em a knife and that it's sharp. You know, if PE companies had mission statements, it would be, you know, from that ’87 movie, wall Street, Gordon Gecko's, famous, iconic speech, you know, greed is good. In 1947, Disney created Scrooge McDuck, remember him, Dave ?

Burda:

Right he sat, he was always sitting on a pile of money, right?

Johnson:

And he described himself as an adventure capitalist. How hilarious is that? So like the poor, the tycoons, like Scrooge McDuck will always be with us. The least we could do is tax their carried interest. But that's a story for another day. There are two issues when it comes to regulating PE investments in healthcare. And the regulators can do a lot about the first one and absolutely nothing about the second one. And the second one's probably more pernicious where they can be very effective and are trying to be more effective is stopping companies from getting monopoly pricing power in given markets. And as we've talked about, you know, numerous times, healthcare is replete with micro markets, regional markets where payers, providers, suppliers, exercise monopoly pricing power, the Fed should be all over that and be preventing it. So more power to 'em there. The second issue, as I, you know, hinted at is beyond the regulator's power to control. And that's the artificial economic model upon which the US healthcare system operates. The entire system depends on differential pricing for identical services. You know, I went back and reread Clay Christensen's the Innovator's Prescription. And he does a brilliant job of talking about the different waves of innovation and disruption that happen across all industries. And then applying that, those theories to healthcare. And wave one is almost always centralization, right? You go from an analog world to an industrialized one, and, and it usually requires centralizing production capacity, which is expensive. You need expertise. And then there are various waves of innovation and disruption that come subsequently that enable manufacturers, suppliers to decentralize and get closer to customers, reduce pricing and so on. And so, you know, wave one in healthcare is centralization. Think of hospitals, you know, high cost, high priced lots of expertise. And then you've got these subsequent waves you know, going from hospitals to ambulatory care centers that reduces cost to creates efficiency even further going into doctor's offices, doing procedures even further going into the home doing procedures. The trouble is that healthcare is stuck in wave one when it comes to pricing. We know how to do all these other disruptive things that should be driving down prices and improving customer service. But the hospitals still wanna get paid hospital prices for doing all of these activities outside hospitals. So is it really a surprise when we have these kind of perverse pricing mechanism and perverse pricing incentives, economic incentives that PE firms when they take over control, try to exploit them to the max? It's what they do. Now the dangerous thing is that as PE firms kind of push these perverse economics incentives and healthcare's artificial market to the max, they're creating fault lines within the overall ecosystem that are manifesting themselves with facility closures in low income

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communities, urban and rural. And, you know, a lot of the coverage wants to blame PE for the fact that we have stupid healthcare pricing and stupid healthcare incentives. That's not PEs fault, and unfortunately, the regulators can't do anything about it. This is why, you know, on every version of our show, we talk about how do we fundamentally transform the model? How do we create value-based pricing and delivery of healthcare services? I mean, Julie was just talking about it from her inspiring session in Pennsylvania. We're never gonna regulate our way to that outcome. I'm gonna make two last points about PE. Not all PE firms are created equally. And many of them actually do focus on true value creation to earn their profits and more power to them. Obviously, there are a bunch of others that choose to exploit perverse payment incentives, and we want them to go under the dustbins of history. But that probably is not gonna happen anytime soon. And I guess the second point, and this gets lost in this discussion a lot is, you know, PE firms make investments. They come in and they try to, you prop up companies, improve their performance and then get out, you know, five to seven years later. But in order to do that, they have to find buyers. And buyers for the most part, aren't stupid. So they're gonna pay a price that they think reflects the value of the entity they're purchasing. So PE firms doing it the right way, create enough value to create an exit so that somebody buys a more valuable company than the PE firm acquired when it first did the investment. You know, if value comes from monopoly pricing power or exploiting perverse incentives, economic incentives you know, kind of shame on all of us for letting that happen. And it does happen. But it doesn't have to be that way.

Burda:

Right? It's not the PE, it's what you do with it. That's a great analysis, Dave. Thank you Julie, any questions for Dave?

Murchinson:

Yeah, well, it is a little bit PE and it is the market environment that we've created. So shame on us. So Dave excellent analysis, and gosh, we should all go back and read Clay Christensen. Ugh, so helpful.

Johnson:

Oh, I know, I know. What a loss that he's no longer with us.

Murchinson:

What a loss. Yeah, let's just, let's bring all that back, Burda. So I agree with so much of what you said, and I read this scathing article about the MPT firm. It's effectively like taken down Steward and a bunch of other systems because of their real estate deal that they did. So talk a little bit about, like, really even the more evil side of these stories.

Johnson:

In my last point from my opening remarks was that buyers aren't stupid. Well, no rule is a hundred percent true. I thought the REIT money in hospitals or have thought the REIT money in hospitals is dumb

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money. When I was ending my banking career a little over 10 years ago, I went around to every health system in the country and said, you should sell your hospitals to the REITs. They're overpaying for the assets. And so you health system can actually reduce your financial risk by by selling your hospitals and, you know, pocketing the money, investing it wisely and so on, couldn't get any takers. The fact that MPT is losing their shirts on all of these hospitals that they've bought into, I mean, kind of classic dumb money move. So they're paying a price. And of course, the penalty manifests itself by hospitals closing in low income areas. And that's not fair to the people who live in those communities. Although I think we could question how many of those hospitals we actually need if we had a rational delivery system. But again, it's not the private equities fault that MPT decided to step up and overpay for assets that haven't materialized.

Burda:

All right, Julie anytime you have a tracker named after you, it's usually not good. What's your take on what's happening and where we're going from a market innovation perspective?

Murchinson:

Well, I find myself in more and more of these conversations every day, and I hear healthcare veterans say all the old adages, ah, the nuns say, no margin, no mission, or, you know, good health is good business. So it's funny, like, we see the money, but we don't want those who aren't in it for the right reasons to make it, right. So it's such evidence of our systemic issues, unfortunately. And I also find myself helping people who aren't close to the finance industry under the understand the difference between, you know, innovation investors and traditional private equity, and they're different and, you know, traditional private equity, even in this case of, you know a lot of rollups and what Leanna con's focused on versus privately that's actually working with health systems to create something more competitive in their market. Like, you've seen one PE firm, you've seen one PE firm kind of, to Dave's point and look, disruption is everywhere. And it's not like PEs creating the majority of the problem. But I do look at this as a bit of a perfect storm. You know, antitrust is having a moment, no doubt, at the same time that the hospital business model is turned completely upside down and may not be repairable in its current form, right? So to Dave's point, private equity is doing what it does well, it's finding opportunities and driving efficiency and scale, and taking advantage of revenue enhancement opportunities, which are, by the way, probably limitless. And, you know, they're not the only ones, though. I guess my point in seeing this opportunity, so my point today for me is big payers are acting like PE but with potentially longer term effects on shaping the market landscape. You know, how car is accessed and delivered and they wanna control utilization of spend, and they wanna control premium dollar. I mean, things that really will shift markets. So when I look at PE, you know, PE funds, I've seen different stats on this, so I'm hesitant to quote numbers, but there's something like $500 billion at PE funds around that number focused on healthcare. And that's, you know, all of healthcare and not just services, I don't think. But when you look at, you know, at Optum, CVS Aetna, <laugh>, they're making, what, 300, $400 billion a year. United's done, I don't know, a hundred billion dollars of transactions in the last decade. So, you know, they're aggressively moving into everything but hospitals, and while people complain about, yes, PE timelines are are short, they wanna hold for 3, 5, 7 years and get out and

turn a profit. And healthcare systems have been around for a hundred years and are gonna be around for hundreds more. You know, health plans have a longer term investment thesis, but that will shape markets. So you know, while these emerging cases that the FTCs focused on, almost appear criminal, the problem is what is the problem besides the cost of healthcare? The problem is that you know they'll carve off all the profitable services and it puts the essential, but unprofitable services at risk. If all the profitable services are gone, health plans also want effectively what's gonna create more profits, so the health systems are left holding the bag. So I see an opportunity for health systems to really think seriously about where they have opportunity to leverage PE for driving more focus into what they do. Do they wanna grow in these few areas? Do they have to because they have to compete in their geography. You know, banners started Atlas Health Partners acting as their own PE partner with other health systems to be able to create a more PE like relationship with their surgeons to compete with {inaudible} and Optum who came into their area. So there's a lot of creativity here and <laugh>, yeah, a lot of good and bad actors. There's no doubt.

Burda:

Right? You're saying it's being painted with a pretty broad brush, but there's a lot going on under the surface that's differentiates the players. That, that's great, Julie, thank you. Dave, any questions for Julie?

Johnson:

You were walking that line between value and exploitation, I guess. So where is that line between healthy competition, which we all want level field competition and antitrust activities, or activities that deserve antitrust scrutiny where the FTC and the Justice Department could really be productive? Where if you were running those agencies, where would you direct their attention?

Murchinson:

Well, I wish I were qualified enough to answer this question, but I'll give you my idealistic view. First of all, I'd love to see the FTC work closely with CMS and start to work on true long-term policy changes that could impact the behavior that we're seeing. But that's a pipe dream. So I guess two things, you know, first this current FTC leadership talks a lot about market analysis, and they put a tremendous amount of effort into market analysis to make sure that they're really looking at the monopoly monopsony all the impacts, right? But I don't really feel like they're looking at this national reshaping by retailers, by health plans, by other innovators. It's happening. So I just worry that, that that's not as strong, you know, and present in their work. Second, you know, it'd be nice for FTC to signal what productive characteristics of PE involvement in healthcare would look like out of all these cases that they're looking at. And that's not their role necessarily. But you know, we've talked today about productive characteristics that could exist. So I, you know, I'd love to see more of that.

Burda:

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So you want 'em to look at more than just the market share of hospital beds, right? There's a lot going on. Thanks Julie. I think the next step on this train will be congressional hearings with a lot of horror stories about PE that seems to be the natural course of things after that, I'm not sure, but we'll be here to comment on it, and that's for sure. Now let's talk about other big news that happened this past week. Julie, what else happened that we should care about?

Murchinson:

<Laugh>? Well you know I'm not a spring chicken anymore and in my social feed this week, I was delivered two articles that are highly relevant to healthcare and also like, hilarious to me that this is how I'm being targeted. But first <laugh> there,

Johnson:

Welcome to Medicare.

Murchinson:

Yeah, yeah, totally. There's a certain species of whale who scientists have discovered, experienced menopause just like humans and chimpanzees. And there was a whole article about why the whales go through menopause. I was like, oh my god, <laugh>. So the second menopause article that I was targeted with is actually pretty interesting. You know they did a study in Finland and I guess in Northern Europe and early menopause can cause women to retire earlier. And it's mostly they're saying, because once women go through menopause, they're more likely to perceive their job skills poorly than other women, making them more likely to retire on disability or what have you. So this is concerning. We should keep an eye on that.

Burda:

And I'm not even gonna comment on that. I'll just, I'm just gonna go right over to Dave

Johnson:

<Laugh>. Well, do whales have hot flashes? That's what I wanna know.

Murchinson:

They do underwater. Isn't that amazing? <Laugh>? Yeah. I was shocked. I read the whole article. I was so intrigued.

Burda:

Oh man. Okay.

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Murchinson:

A sucker.

Burda:

Alright, Dave anything you have that could top that? I'm not sure.

Murchinson:

<Laugh>,

Johnson:

No, I definitely can't top that. But I will highlight that the FDA last week announced that Wygovy the GLP one drug that doctors can prescribe it for heart problems. And I think this raises one of these kind of really interesting questions about the structure of the healthcare system. If these GLP one drugs are really miracle drugs, right? That reduce obesity and all of the related things that obesity causes heart, heart conditions various cancers diabetes and so on, then shouldn't we be broadly figuring out how to get these drugs to everybody who needs them in the country? And yet the short term price tag of doing that's pretty expensive. So there's all kinds of pushback to it. But you know, since we here at the roundup are always looking for fault lines, this strikes me as a really interesting story to follow because I'm pretty sure the long-term benefits of these GLP one drugs are gonna be enormous and we're gonna have to figure out how to pay for it. And I do think the market will help out here in the long run in the sense that more manufacturers will come in and the prices will come down. But at this moment this trade-off between long-term and short term is front and center in healthcare. And it's the type of thing we as a society need to figure out.

Burda:

You know, my old primary care physician thought we should put statins in the water supply like fluoride for teeth. And I said, you know, that's a little much, but you know, it's wow. Kind of makes the point, right? Yeah. same with what we're seeing with vaccines and the measles outbreak in Chicago right now.

Murchinson:

Oh my gosh. Know it's gonna be my other one.

Burda:

Yeah, yeah. We know it's good for us, but we just can't seem to pull the trigger. Thanks Dave, and thanks Julie. That is all the time we have for today. If you'd like to learn more about the topics we discussed on today's show, please visit our website at 4sighthealth.com. And don't forget to tell a friend about the 4sight Health Roundup podcast. Subscribe now and don't miss another segment of the best 20 minutes in healthcare. Thanks for listening. I’m Dave Burda for 4sight Health.