September 11, 2024

The Honorable Bernie Sanders
Chair
The Honorable Bill Cassidy
Ranking Member
Committee on Health, Education, Labor and Pensions (HELP)
United States Senate
Washington, D.C. 20510

Dear Chair Sanders and Ranking Member Cassidy:

On behalf of the undersigned unions, we want to thank you for holding this important hearing and shining a light on the devastating impact that the bankruptcy of Steward Health Care has had on numerous working families and communities across the country. Closures of facilities in multiple states have resulted in job loss and reduced access to health care in communities that have faced these challenges for many years. Of course Steward is only one example of how health care consolidation and the growing role of private equity has hurt working families; it is one many examples of how corporate greed and anticompetitive actions have transformed and contributed to the financialization of health care sector. It is this larger trend on which we focus our comments.

The AFL-CIO is a voluntary, democratic federation of 60 affiliated unions representing more than 12.5 million workers in all sectors of our economy. The AFL-CIO and our affiliates are committed to fairness in the workplace and health security for working people and their families. Our core mission is to ensure that working people are treated fairly and respectfully, that our hard work is rewarded with family-supporting wages and benefits, and that our workplaces are safe. The AFL-CIO and our affiliates also provide an independent voice in politics and legislation for working women and men and make their voices heard in corporate boardrooms and the financial system.

Union members participate in the health care system in various roles. We are front-line health care workers in hospitals and nursing homes and caregivers in institutional and community-based settings; union workers are professionals, para-professionals, and support staff providing health care to vulnerable populations at the bedside and behind the scenes. For these workers, a caregiving job is not a profit-maximizing opportunity but a vocation of service. They know that putting profits over patients will not improve the health of our communities.

Union workers are also consumers of health care. Health insurance coverage through employer-sponsored insurance is significantly higher among union workers than non-union workers.[1] Individual unions also work closely with employers to administer jointly governed health plans for sectors of the economy that rely on a mobile workforce (e.g., restaurants, hotels, entertainment, transit, and construction) that wouldn't usually qualify for benefits coverage under more traditional employer-sponsored plans. These jointly administered health plans hold workers'

[1] Maanasa Kona, *The Impact of Unions on Employer-Sponsored Health Insurance*, CHIR Blog, Georgetown University Center for Health Insurance Reforms, November 20, 2023. Available at https://chirblog.org/the-impact-of-unions-on-employer-sponsored-health-insurance/#:~:text=Union%20workers%20tend%20to%20pay,tend%20to%20have%20lower%20deductibles.

wages in a trust that by law must be used for the sole and exclusive benefit of enrollees' health care needs.[2] The growing presence of private equity investors in the health care sector is a transfer of wealth that contributes to income inequality as the wages of workers pay for services that enrich individuals who are some of the wealthiest in society.

This Committee's continued interest in health care consolidation and the role of private equity is deeply appreciated. The price of health care in the U.S. continues to be significantly higher than in other industrialized countries. As a country, we continue to spend a greater share of our GDP on health care without seeing measurable gains in quality of care or lifespan.[3] For unions, rising health care costs are a key issue in bargaining. Across industries, almost without exception, companies have tried to force major health care concessions in the form of higher premiums, deductibles, co-pays, tiered prescription drug pricing, closed formularies, steep reductions in family coverage, and caps on employer contributions for retiree coverage. Efforts to eliminate or limit these benefit cuts come at the expense of wage improvements. For decades, union members have agreed to smaller increases and even wage freezes to ensure access to affordable coverage.[4]

Consolidation of the Health Care System

Hospitals have experienced significant consolidation over the last 25 years – with over 1,800 mergers eliminating a quarter of U.S. hospitals.[5] Many markets are left with a single dominant hospital.[6] Over two-thirds of hospitals are now part of a larger health system due to this wave of horizontal mergers.[7] Overall, more than 90% of U.S. metropolitan areas have hospital markets that federal antitrust authorities consider "highly concentrated."[8]

The more common concern of late is vertical integration, as health systems acquire physician practices, ambulatory clinics, ambulatory surgical centers, and home health agencies. According to 2021 data, approximately 41% of all physicians – both primary care doctors and specialists – are now in practices owned by a hospital or a health system.[9]

The Effects of Consolidation

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[2] *Introduction to Multiemployer Plans, Pension Benefit Guarantee Corporation*. Available at https://www.pbgc.gov/prac/multiemployer/introduction-to-multiemployer-plans. See also *Definition of Health Insurance Terms*, Bureau of Labor Statistics, Washington, DC. October, 2002. Available at https://www.bls.gov/ebs/additional-resources/definition-of-health-insurance-terms.pdf.

[3] *Why are Americans Paying More for Healthcare?* Peter G. Peterson Institute, January 3, 2024. Available at https://www.pbgc.gov/prac/multiemployer/introduction-to-multiemployer-plans.

[4] C.A. Olson, *Do Workers Accept Lower Wages in Exchange for Health Benefits?* Journal of Labor Economics, Volume 20, Number S2, April 2002. Available at https://www.journals.uchicago.edu/doi/10.1086/338675.

[5] Hoag Levin, *Hospital Consolidation Continues to Boost Costs, Narrows Access, and Impact Care Quality*, Penn LDI, January 19, 2023. Available at https://ldi.upenn.edu/our-work/research-updates/hospital-consolidation-continues-to-boost-costs-narrow-access-and-impact-care-quality/.

[6] Testimony of Cheryl L. Damberg, *Health Care Consolidation – The Changing Landscape of the U.S. Health Care System*, submitted to the U.S. House of Representatives Committee on Ways and Means on May 17, 2024.

[7] Id.

[8] Testimony of Zack Cooper, *Consolidation and Corporate Ownership in Health Care*, submitted to the U.S. Senate Committee on Finance, June 8, 2023. Available at https://www.finance.senate.gov/imo/media/doc/20230605_sfc_testimony.pdf.

[9] Damberg, *supra* note 6. See also Zach Levinson, Jamie Godwin, Scott Hulver and Tricia Neuman, *Ten Things to Know About Consolidation in Health Care Provider Markets*, Kaiser Family Foundation, April 9, 2024. Available at https://www.kff.org/health-costs/issue-brief/ten-things-to-know-about-consolidation-in-health-care-provider-markets/#:~:text=Consolidation%20may%20allow%20providers%20to,evidence%20on%20quality%20is%20unclear.

A substantial body of research shows that consolidation has led to higher health care prices, particularly for hospitals. According to a RAND study, mergers have boosted hospital prices by as much as 65 percent.[10] An analysis by MedPAC of 25 metropolitan areas with the highest rate of hospital consolidation from 2010 to 2013 found that the average hospital paid commercial plans between 11% and 54% more in the years following a merger.[11] It is not uncommon, according to one scholar, for hospital mergers to generate price increases of 20% or more; in some cases, a merger may generate price increases of more than 50 percent.[12]

There is a tendency for higher prices even with mergers between hospitals and health systems operating in different geographic markets. Studies show price increases ranging from 6% to 17% for these cross-market mergers. One study also found spillover effects – with prices of nearby hospitals increasing by 8 percent.[13] Even where there are savings – not price increases – they are generally not passed on to working families.[14]

At the same time, consolidation of physician practices and hospital-physician mergers also led to price increases.[15] A national study found that physicians in the most concentrated markets charged fees 14% to 30% higher than those in the least concentrated markets.[16] One study of vertical integration of hospital markets in California found that a significant increase in the share of physicians in practices owned by a hospital led to a 12% increase in premiums for Exchange-sold plans. A similar study with similar results was found for outpatient services covered by private insurance.[17]

This increase in consolidation translates into more significant health care spending by working families, employers, states, and public programs. One study even showed hospital mergers reduced wages among non-health care workers with employer-sponsored insurance.[18] As one scholar noted, the rise in concentration harms the public; consolidation raises prices, reducing access to health care services by increasing premiums and out-of-pocket costs. In turn, higher health care spending reduces tax revenue, puts pressure on public programs, and leads to lower wages; it also contributes to a loss of jobs and rising inequality.[19]

The literature also suggests that most mergers do not improve clinical quality and instead have led to reductions in clinical quality – particularly in the case of horizontal consolidation.[20] This is true for risk-adjusted mortality rates one year later for Medicare patients suffering heart attacks as well as for Medicaid.[21] Even in cases where neighboring hospitals have become "more efficient" because they serve more patients with the same number of beds, this happens simply by speeding

[10] Levinson et al., *supra* note 9.
[11] Id.
[12] Cooper, *supra* note 8.
[13] Levinson et al., *supra* note 9.
[14] Cooper, *supra* note 8.
[15] Levinson et al., *supra* note 9.
[16] Id.
[17] Id.
[18] Id.
[19] Cooper, *supra* note 8.
[20] Id. *See also* Levin, *supra* note 5.
[21] Levinson et al., *supra* note 9.

up patient treatment – reducing the value to the consumers and increasing patient mortality rates.[22]

Health care providers are also the economic pillars of communities. Mergers and buy-outs that lead to closures and reduced services can devastate municipalities and regions. One example is the Northside Regional Medical Center in Youngstown, Ohio – a key driver of economic growth in the community. An acquisition of Northside by the non-profit Forum Health was one of several changes in ownership that eventually led to the hospital's closure in September 2018 and layoffs for 400 workers. The area, already struggling economically, lost nearly $1 million in income tax revenue and $500,000 in property tax revenue. The health impact on the community was even more significant. Northside was the only labor and delivery department in the city. These negative effects were imposed on a community in a county that already ranked 72nd out of 88 Ohio counties in terms of health outcomes.

There are many other examples of similar fallout from private equity transactions. This Committee heard testimony earlier this year how the purchase of Mission Hospital by the Healthcare Corporation of America (HCA) led to short staffing and the necessary triaging of care that endangered both patients and nurses. HCA's acquisition of this non-profit community hospital serving the Western half of North Carolina led the new management to cut staffing and reduce necessary supplies, in the process exposing patients to a higher risk of avoidable complications, falls and injuries, pressure ulcers, increased length of stay, increased readmissions and higher mortality. Reports of similar behavior at other HCA hospitals, including two facilities in Live Oak, Florida (closed down and turned into urgent care centers), Houston, Texas (600 workers laid off and building converted to a free-standing emergency center), San Jose, CA and Osceola, Florida, among many others.[23]

The impact of such closures and conversions is particularly difficult for rural communities, where hospitals are often the largest employer in the community.[24] A 2020 study of rural hospitals found that for the municipalities where they are located, closures led to a 4.3% reduction in employment, a 2.7% reduction in per capita income as well as a 2.8% reduction in labor force participation, and a 1.3% reduction in overall population. These impacts grow over time and spill over to the non-hospital sector. The research found that closures led to a 1.8% reduction in non-hospital employment and cost the county approximately $1.5 million in reduced revenues. For landowners, the impact is even greater: a loss of $377,000 in annual profits. Hospital closures also hurt economic growth in the area. Hospitals provide a unique mix of jobs critical to economic growth, ranging from highly skilled licensed providers to unlicensed providers and non-medical staff.[25]

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[22] Soroush Saghafian, Lina D. Song, and Ali S. Raja, *Towards A More Efficient Healthcare System: Opportunities and Challenges Caused By Hospital Closures Amid the COVID-19 Pandemic*, Health Care Manag Sci, 25(2): 187-190, March 16, 2022. Available at https://pubmed.ncbi.nlm.nih.gov/35292872/.

[23] Testimony of Hannah Drummond, RN, on behalf of National Nurses United before the Senate Health Education Labor and Pensions Subcommittee on Primary Health & Retirement Security, April 1, 2024. Available at https://www.markey.senate.gov/imo/media/doc/drummond_testimony_help_subcommittee_hearing_4324.pdf.

[24] Saghafian, et al., *supra* note 23.

[25] Jacob Vogler, Rural Hospital Closures and Local Economic Decline, SSRN, March 9, 2021. Available at https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3750200. See also Tyler Malone, Arriana Marie Planey, Laura Bozovich, Kristie Thompson, George Holmes, *The Economic Effects of Rural Hospital Closures*, Health Serv Res.

These changes can have additional consequences for communities. When the acquiring system is religiously sponsored, the new hospital often eliminates or restricts vital reproductive health services, pregnancy emergency care, gender-affirming care, and end-of-life options.[26] When an independent urban hospital in an urban neighborhood closes or joins a major health system, the acquiring health system often closes services like intensive care units, labor and delivery units, psychiatric care, and cardiac care. In the Philadelphia area, the closure of Delaware County Memorial Hospital left patients in the region stranded, without access to emergency care.[27] When Hahnemann Hospital in Philadelphia closed, African-American and Latino residents were forced to cope with what was effectively a "healthcare desert."[28] In other communities, the closure of a safety net hospital has led to a higher volume of patients and longer wait times in the other facilities. In Atlanta, the closure of the safety net Wellstar Hospital reduced access to health care at Grady Memorial, which had to handle many displaced patients. The same was true in Philadelphia, where ER visits increased by 14% when Delaware County Memorial closed.[29]

Private Equity

The growth of private equity is the latest manifestation of a corporatization of health care that stimulated the consolidation of hospitals, physician practices, nursing homes, and other providers. Although we are concerned with the monopolistic integration of providers that consolidation has produced, we focus the remainder of our comments on the role of private equity because the basic business model is fundamentally incompatible with sound healthcare that serves patients.[30] Private equity funds focus on short-term revenue generation and consolidation rather than the best provision of care or the long-term well-being of patients and individual workers providing care. The private equity model incentivizes revenue generation over the quality of care; it is unconcerned about the long-term financial health of the companies purchased. It is not uncommon for private equity managers to strip providers of assets and load the companies with debt to pay back their initial investment. Private equity investors close departments and trim services, preferring to structure the provider's operations based on which services offer the highest profit margin. The growth of private equity investments in health care has led to a deprioritization of the health of American communities in favor of market performance.

Private equity investments in health care have grown significantly in size and scope, with annual investments increasing from $41.5 billion in 2010 to $119.9 billion in 2019.[31] In 2021, the most recent year we have data, there were more than 1,400 private equity deals in health care, totaling

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2022; 57:614-623. Available at https://pubmed.ncbi.nlm.nih.gov/35312187/. Kritee Gujral and Anirban Basu, *Impact of Rural and Urban Hospital Closures on Inpatient Mortality*, NBER Working Paper Series, August 2019. Available at https://www.nber.org/papers/w26182.

[26] Levin, *supra* note 5.

[27] Judith Garber, *What Happens When Safety Net Hospitals Close?*, May 4, 2023, Lown Institute. Available at https://lowninstitute.org/what-happens-when-safety-net-hospitals-close/.

[28] Joseph Williams, *Code Red: The Grim State of Urban Hospitals*, US News, July 10, 2019. Available at https://www.usnews.com/news/healthiest-communities/articles/2019-07-10/poor-minorities-bear-the-brunt-as-urban-hospitals-close.

[29] Garber, *supra* note 27.

[30] Richard Scheffler, Laura Alexander, James Godwin, *Soaring Private Equity Investment in the Healthcare Sector: Consolidation Accelerated, Competition Undermined, and Patients at Risk*, University of California, Berkeley, Petris Center and the American Antitrust Institute, May 18, 2021. Available at https://petris.org/soaring-private-equity-investment-in-the-healthcare-sector-consolidation-accelerated-competition-undermined-and-patients-at-risk/.

[31] Damberg, *supra* note 6.

$209 billion. These investments touch virtually every aspect of health care, including nursing facilities, hospitals, physician specialties such as gastroenterology and anesthesiology, emergency medicine, dentistry, travel nursing, durable medical equipment, behavioral health, disability services, and health care services for people in prisons and jails.[32]

The growing role of private equity as a driver of consolidation hurts individual healthcare workers practically every day. While a private equity firm may look at financial data to seek additional profits, those numbers are workers and patients. When a private equity firm seeks to implement "lean" or "flexible" staffing, we know that is another word for understaffing. Of course, this puts impossible pressure on workers to provide quality care with fewer resources. Private equity's emphasis on increasing "utilization" often means running more unnecessary tests — all in the pursuit of profit, without regard for the patient's well-being. These additional tests take up valuable time that could otherwise be spent with patients and often cause patients to feel ignored. The decline in quality of care and the physical danger of understaffing (both for the worker and the patient) are common consequences of private equity's singular focus on profit in the healthcare market.

Private Equity in Hospitals

In the 1990s, private equity firms began taking over hospital chains, often converting them from religious, non-profit, or government-run institutions to private, for-profit firms. Although private equity ownership of hospitals may have reached a high-water mark in 2011 when 7 of the 12 largest for-profit chains were owned by private equity firms, a 2024 tracker of hospital ownership shows 460 hospitals are now owned by private equity firms, comprising 30% of for-profit hospitals.[33]

A 2023 study showed that private equity ownership has diminished patient care. Medicare patients had a 25% increase in hospital-acquired complications in a hospital owned by a private equity firm compared with patients admitted to the same hospital before acquisition. Patients also had 27% more falls and 38% more bloodstream infections.[34]

Emergency rooms have been a particular area of focus for private equity investors. As of June 2022, more than 40% of the country's emergency rooms were overseen by private equity-backed staffing firms – raising concerns about patient care. One private equity-backed staffing company, American Physician Partners, employed fewer doctors in its emergency rooms as a cost-saving initiative. A typical private equity strategy is to replace emergency physicians with other medical staff, which puts patients at a greater risk of preventable hospital admission. Patients facing medical emergencies should not have to deal with additional dangers created by private equity's focus on profits.

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[32] *Letters to the Regulators: Group Response to Request for Information on Consolidation in Healthcare Markets*, https://ourfinancialsecurity.org/2024/06/letters-to-the-regulators-group-response-to-request-for-information-on-consolidation-in-healthcare-markets/.

[33] Memo from James Durkin, Legislative Director of AFSCME Council 93 to Senator Edward Markey on the Impact of Private Equity Ownership of Hospitals, as part of the April 1st hearing of U.S. Senate Committee on Health, Education, Labor, and Pensions Subcommittee on Primary Health and Retirement Security. April 1, 2024.

[34] Durkin, *supra* note 33.

Efforts to protect consumers from balance billing from out-of-network providers at in-network health systems have been seriously undermined by the efforts of private equity investors in emergency rooms. The law that accomplished this, the *No Surprises Act*, was also supposed to reduce premiums for enrollees in health plans.[35] Unfortunately, a flood of disputes over billing from health care providers funded by private equity has paralyzed the independent dispute resolution process – calling into question the viability of the law.[36] Though consumers remain shielded from individual surprise bills, the efforts of a small number of private equity-backed providers cast doubt on whether enrollees in private health plans will see the projected savings from lower insurance premiums.

Private Equity in Physician Practices

Another major area of concern is the "roll up" strategy that private equity firms use to purchase physician specialty practices. PE firms use a platform company to purchase individual practices that individually are valued at levels that fall below the threshold that would trigger the Hart-Scott-Rodino Antitrust Improvements Act (HSR) – avoiding notification of the FTC and the Antitrust Division of the DOJ. Though each transaction may be relatively small, the aggregate effect is to provide the private equity owners with enough market power to charge higher prices, charge consumers excessive fees by staying out-of-network, promote ancillary services not covered by insurance, reduce staffing levels, and cut workers' wages and benefits. Abundant evidence shows that consolidation of medical practices causes prices to rise, putting pressure on consumers, patients, and workers.

According to a 2023 study, private equity acquisitions of U.S. physician practices rose more than sixfold in just over a decade, from 75 deals in 2012 to 484 in 2021. As a result, private equity firms are amassing significant market shares in some local physician practice markets. In 28% of metropolitan statistical areas (MSAs), a single private equity firm has more than 30% market share of full-time-equivalent physicians; in 13% of MSAs, the single private equity firm's market share exceeds 50 percent.[37] This degree of market presence has led to significant price increases, particularly in specialty practices like oncology.[38]

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[35] Loren Adler, Matthew Fiedler, Paul Ginsburg, Mark Hall, Benedic Ippolito and Erin Trish, *Understanding the No Surprises Act*, Commentary. Brookings Institute, February 4, 2021. Available at https://www.brookings.edu/articles/understanding-the-no-surprises-act/.

[36] *Understanding the Biggest Threats to the No Surprises Act Achieving Its Full Potential*, Families USA, March 2024. Available at https://www.familiesusa.org/wp-content/uploads/2024/03/SMB2024-4_NSA-Threats_v4.pdf. Mary Bugbee, *No Surprises Here: PE Takes Center Stage in the No Surprises IDR Process*. Private Equity Stakeholder Project, January 2023. Available at https://pestakeholder.org/news/no-surprises-here-pe-at-center-of-surprise-billing-controversy/.

[37] Richard Scheffler, Laura Alexander, Brent Fulton, Daniel Arnold, Ola Abdelhadi, *Monetizing Medicine: Private Equity and Competition in Physician Practice Markets*. American Antitrust Institute, Petri Center, University of California, Berkeley, Washington Center for Equitable Growth, July, 2023. Available at https://www.antitrustinstitute.org/wp-content/uploads/2023/07/AAI-UCB-EG_Private-Equity-I-Physician-Practice-Report_FINAL.pdf.

[38] Id.

Private Equity in Nursing Homes

Private equity has been a growing presence of private equity firms in the nursing home industry. Between 2000 and 2017, private equity firms acquired more than 1600 nursing homes – accounting for 9%-11% of all facilities.[39]

For most of these facilities, the result is pressure to generate short-term profits by focusing on higher acuity residents and reductions in staffing, services, and supplies. One study of more than 300 private equity-owned facilities found that residents were 11% more likely to visit the emergency room and were 8.7% more likely to be hospitalized for ambulatory care-sensitive conditions, such as complications from diabetes or heart failure. The researchers examined outcomes for people with these conditions because hospitalization is largely preventable through proper disease management.[40] The same longitudinal study of nursing homes acquired by private equity firms between 2000 and 2017 showed a significant decline in resident health, reduced staffing, and a 10% increase in short-term mortality compared to the national average. According to this study, private equity-owned facilities produced an additional 20,150 deaths over 12 years.[41] A study by the Americans for Financial Reform also revealed the adverse impact of private equity on nursing home care during the pandemic. Facilities owned or backed by private equity firms had higher rates of resident infection and death than other facilities, even compared to other for-profit facilities.[42]

Private equity is harmful to workers as well. According to one study, employment at firms bought by private equity shrank by 4.4% over the two years following the transaction, and wages fell by 1.7 percent. Private equity owners tend to take a "low road" approach to productivity by cutting wages, benefits, and staff.[43] With labor costs typically accounting for a large percentage of overall facility costs (often as much as half) and the need for new owners to service significantly higher levels of debt, we expect the purchase of a nursing home by private equity buyers to result in significant cuts in wages and employment.

Though private equity firms own a relatively small share of the industry, their aggressive use of related party transactions and other tactics have channeled significant public funding away from

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[39] Atul Gupta, Sabrina Howell, Constantine Yannelis and Abhinav Gupta, *Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes*, National Bureau of Economic Research, Working Paper 28474, February 2021. Available at http://www.nber.org/papers/w28474. *See* also *Congressional Request: Private Equity and Medicare*, Report to Congress: Medicare and the Health Care Delivery System, MedPAC, June 2021. Available at https://www.medpac.gov/document/http-www-medpac-gov-docs-default-source-default-document-library-jun21_ch3_medpac_report_to_congress_sec-pdf/.

[40] Robert Tyler Braun, Hye-Young Jung, Lawrence Casalino, et al., *Association of Private Equity Investment in US Nursing Homes With the Quality and Cost of Care for Long-Stay Residents*, JAMA Health Forum. 2021;2(11):e213817. Available at https://jamanetwork.com/journals/jama-health-forum/fullarticle/2786442.

[41] Gupta, *supra* note 39.

[42] *The Deadly Combination of Private Equity and Nursing Homes During A Pandemic: New Jersey Case Study of Coronavirus at Private Equity Nursing Homes*, A Report from Americans for Financial Reform, April 6, 2020 (Washington, DC). Available at https://ourfinancialsecurity.org/2020/08/report-3-private-equity-nursing-homes-coronavirus/.

[43] Steven J. Davis, John Haltiwanger, Kyle Handley, Ben Lipsius, Josh Lerner, and Javier Miranda, *The (Heterogenous) Economic Effects of Private Equity Buyouts*, Working Paper · No. 2019-122, Becker Friedman Institute for Economics, University of Chicago, July 2021. Available at https://bfi.uchicago.edu/wp-content/uploads/BFI_WP_2019122.pdf. *See also Effects of Private Equity Investment*, Private Equity Stakeholder Project. Available at https://pestakeholder.org/private-equity-risks/effects-of-private-equity-investments/.

care and into private profits. These for-profit firms typically have multiple corporate layers of ownership and contracts with independent property, management, and staffing entities that use related party transactions to boost profits; these intentionally complex corporate relationships also avoid disclosure of the individuals involved.[44] One estimate found that in 2015, nearly 75% of nursing homes in the U.S. had related-party transactions totaling $11 billion in profits.[45] Such practices raise concerns about the concealment of profits and the diversion of funds intended for care.

The rampant use of related-party transactions and multiple corporate entities makes it increasingly difficult for regulators or the public to determine the adequacy of reimbursement, the ownership of a nursing home, and the relationship of a particular facility to other poor-performing facilities. Ensign, the country's second-largest nursing home chain, is a good example. It reported to CMS owning 22 separate companies. Those 22 companies, however, owned 409 legal entities that directly owned or operated 198 separate nursing homes and senior care communities under various unrelated corporate names.

These corporate practices harm residents and workers. Nursing homes with related party transactions employed fewer nurses, were more likely to have had fines for serious violations, and incurred more serious penalties than independent homes.[46] Such practices make unionizing difficult when the entity that controls the facility is unknown and unreachable.

The data shows that the increasing presence of private equity investors in health care has serious consequences for healthcare workers beyond patient outcomes. In 2020, healthcare workers were involved in more than 75% of all incidents of workplace violence nationwide. They were almost four times more likely to suffer a serious injury from workplace violence than workers in other workplace settings.[47] Such incidents are more likely to occur in private equity-owned health care institutions with lower staffing levels.

The impact of private equity on patients' out-of-pocket costs is also evident. Given private equity's sole focus on short-term financial gains, research has found that higher prices are a

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[44] Charlene Harrington and Toby Edelman, *Private Equity and Nursing Home Care: What Policies Can Be Adopted to Address the Growing Problems*, Public Policy & Aging Report, 2023, XX, 1-5. Gerontological Society of America (April 2023). Available at https://doi.org/10/1093/ppar/prad001. *See* also Charlene Harrington, et al. *These Administrative Actions Would Improve Nursing Home Ownership and Financial Transparency In The Post COVID-19 Period*, Health Affairs Forefront, February 11, 2021. Available at https://www.healthaffairs.org/do/10.1377/forefront.20210208.597573/

[45] *Where Do The Billions of Dollars Go? A Look At Nursing Home Related Party Transactions*, Report by the National Consumer Voice for Quality Long-Term Care, 2023. Available at https://theconsumervoice.org/uploads/files/issues/2023-Related-Party-Report.pdf. See also Jonathan Rau, Care Suffers As More Nursing Homes Feed Money Into Corporate Webs, New York Times, January 2, 2018. Available at https://www.nytimes.com/2018/01/02/business/nursing-homes-care-corporate.html.

[46] Rau, note 45, *supra*.

[47] Kate Lapne, Catherine Dube, and Bill Jesdale, *Worker Injuries In Nursing Homes: Is Safe Patient Handling Legislation The Solution?*, J. Nurs Home Res. Sci 2016 (Oct 28; 110-117). Available at https://stacks.cdc.gov/pdfjs/web/viewer.html?file=https://stacks.cdc.gov/view/cdc/89153/cdc_89153_DS1.pdf. *See also* Adam Dean, Jamie McCallum, Atheendar Venkataramani and David Michaels, *The Effect Of Labor Unions On Nursing Home Compliance With OSHA's Workplace Injury And Illness Reporting Requirement*, Health Affairs, September 2023. Available at https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2023.00255?journalCode=hlthaff

common byproduct of health care institutions being acquired by private equity. A meta-analysis noted that of the studies reviewed, 75% found higher costs associated with private equity firm acquisitions. One study estimated that private equity acquisitions were associated with an increase of $407 in total charge per inpatient day.[48]

This hearing is timely and necessary. The financialization of the U.S. healthcare system has enabled corporate provider entities to improve market share and profits, despite the costs to communities in terms of health outcomes and employment. Continued consolidation will only continue the trend of reduced competition, higher prices, and the failure to improve patient outcomes. The proliferation of private equity accelerates these outcomes. The cumulative impact of these separate but related trends requires further analysis and congressional action.

Recommendations

We support the efforts of the Senate HELP Committee to use its investigative powers to shine a light on the damage inflicted on the healthcare system by private equity firms. This includes demanding information from market participants and corporate leaders so that the committee can investigate the impact of private equity on health care and prepare reports on issues of concern. These issues include:

- Billing practices by health care entities owned or managed by private equity companies; Collection actions against patients by health care practices owned or managed by private equity;
- Quality of care at health care entities owned or managed by private equity companies;
- The use of affiliated private equity-owned providers of services or products;
- The impacts and prevalence of private equity investors' use of sale-leaseback arrangements with health care facilities;
- The reliance of private equity-owned health care entities on federal health programs including Medicare, Medicaid, and the Indian Health Services; and
- The ownership structures and interrelation with medical real estate investment trusts.

We believe the *Health Over Wealth Act* and the *Corporate Crimes Against Health Care Act of 2024* are important approaches to holding private equity accountable for the adverse impact of its business model on working families. Introduction of these bills are an important first step; we urge this committee and others in Congress to convene additional hearings exploring the growing financialization of health care and the leading role of private equity in driving that trend. Given the impact of private equity on public health programs and private markets, we urge this committee to work with colleagues in other committees to develop a broad and coordinated policy response.

Among the issues that we believe should be further explored are:

1. 1. Addressing the impact of private equity on providers by:

[48] Joseph Bruch, Suhas Gondi, Zirui Song, *Changes in Hospital Income, Use, and Quality Associated With Private Equity Acquisition*, JAMA Intern Med. 2020;180(11):1428-1435.

a) Require providers participating in public health programs to submit audited consolidated cost reports that contain exhaustive disclosure by each facility, the owners, and all of the myriad related party companies associated with the facility.
b) Require a portion of each revenue dollar a provider receives to go to direct care staffing. CMS adopted a similar approach in the Medicaid Access Rule, which requires 80% of each Medicaid reimbursement dollar to go to staffing. This committee should explore adapting that policy for other providers and other revenue sources.
c) Public disclosure on CMS' Medicare Care Compare website that a provider or facility is owned by private equity along with the implications for patients or residents. Like other disclosed information, private equity ownership is often an indicator of poor care and increased resident mortality.

2. Developing legislation that requires private equity companies that invest in health care facilities, directly or indirectly, be required to periodically disclose data on the transfer of funds from the health care portfolio company to the limited partnership and the private equity managers' affiliated companies. This disclosure should include monitoring and management fees, dividends, related party transactions, and interest paid on lines of credit.

3. Developing legislation that would impose additional reporting requirements on private equity-owned hospitals that engage in sale-leaseback arrangements and other financial transactions that have a particular impact on the breadth of their health care operations. Private equity-owned health care companies should be required to report sale-leaseback agreements prior to their execution, including the terms of such agreements. Private equity-owned health care companies should periodically be required to disclose staffing levels at facilities (disaggregated by position and ratio of staff to patients) and the number of health care facilities or providers owned by the private equity firm that have closed the previous year.

   The noticing of proposed sale-leasebacks and other related party transactions is particularly important, given how such transactions change the apparent financial health of providers and the demand for taxpayer dollars. The experience of unions nationally is that these transactions are often used to pay dividends to investors (or to pay down debts taken to pay dividends), and usually portend service cuts and other disruptions. Most importantly, these transactions do not appear to be covered under the Hart-Scott-Rodino reporting regime and, therefore, provide limited opportunity for regulatory intervention.

   Finally, there needs to be greater disclosure of workforce data for private equity-owned health care companies. This should include any reduction in health care worker wages or benefits, complaints of, or citations for, violations of state and federal antidiscrimination law, wage and hour law, and whistleblower complaints. To assess staffing adequacy, private equity managers should be required to report on staffing, disaggregated by position and ratio of staff to patients; number of job postings and vacancy rates by position. As private equity tactics may change, we suggest that regulations include a provision that requires reporting any other information that the Secretary deems relevant for evaluating the impact of private equity ownership on the provision of health care, health care quality, and safety.

4. Modernize the Hart-Scott-Rodino Antitrust Improvements Act of 1976. There is a broad consensus that the current reporting thresholds under the HSR fail to capture many health care mergers and acquisitions that could impact competitive markets. This is particularly true for vertical acquisitions by platform companies owned by private equity firms. We urge Congress to modernize the reporting thresholds.

5. Develop legislation requiring for-profit providers participating in Medicare to notify the Secretary of HHS at least 180 days before the discontinuation of services or a complete facility closure. Health care providers are often the economic pillars of the community, particularly in rural areas. If such a provider must close due to unforeseen events such as a natural disaster, a hospital should be required to notify the Secretary of the closure within 30 days of the event. Such notices should be subject to public posting and comment. The Secretary should evaluate each proposed transaction to determine whether the stated discontinuation or closure would negatively impact access to essential services. If so, the facility should be required to submit a mitigation plan to the Secretary that outlines a plan to preserve access to essential services for the community via partnerships with surrounding facilities, including patient transportation plans, and a plan to support the transition of health care employees to other positions. There should be a public comment period regarding the mitigation plan and extensive notification to the public regarding this comment period. If the Secretary deems the mitigation plan insufficient, an alternative mitigation plan should be developed, which may include delays to the discontinuation or closure plans.

Conclusion

The AFL-CIO and our undersigned affiliates applaud the Senate HELP Committee for examining the adverse impact of provider consolidation and shining a light on the destructive role of private equity in diverting public resources intended for care for their own gain, reducing access to health and fracturing the careers of health care workers. We hope this effort is the beginning of a sustained regulatory effort to combat private equity's anti-competitive practices to stop its abuse of our health care system.

Sincerely,

AFL-CIO
American Federation of Teachers
American Federation of State County & Municipal Employees
International Association of Machinists and Aerospace Workers
National Nurses United
United Steelworkers