

Testimony of Peter L. Murray on LD 2201

Sen. Donna Bailey, Senate Chair, Rep. Kristi Mathieson, House Chair, Members of the Committee on Health Coverage, Insurance and Financial Services:

Will you please accept the following testimony as you consider your recommendation on LD 2201?

My name is Peter Murray. I am an attorney and live in Portland, Maine. For some time, evident challenges facing Maine's health care system have caused me to study some of the current issues with which we are now faced, including the possibility of significant incursions by private equity into our largely non-profit health care providers.

My study and review of private equity takeovers of health care providers leads me to the belief that for-profit private equity ownership and operation of health care providers, particularly both rural and urban hospitals, is logically and economically inconsistent with the health care goals and priorities of the State of Maine.

Private equity functions on a for-profit model, under which the economic entity (in this case a hospital or other health care provider) is directly incentivized to increase revenues or decrease services, or both in order to generate entrepreneurial profits for investors. That means more money for the same level of health care performance, or less health care performance for the same money, or both.

This is contrasted with the non-profit model currently dominant at the hospital level in Maine, whereby the hospital or other health care provider is incited to provide as much service as it can with the available revenues without any pressure to generate a profit for investors.

No matter what a private equity owner or operator will say about its intentions, these basic economic incentives cannot be denied.

There are abundant examples of harm to the public from private equity takeovers of hospitals across the country, most prominently the case of the Steward Health Care in Massachusetts and other states. This scenario is a logical result of the structural incentives in private equity ownership and operation.

In my judgment, the only effective way to deal with the pressure of private equity seeking to acquire Maine health care facilities, especially hospitals, is an outright ban on private equity ownership or operation of hospitals or their real estate.

LD 2201 addresses private equity ownership as a regulatory matter, subjecting private equity acquisition transactions to various levels of scrutiny, but not banning private equity outright. In my judgment this approach, while well-intentioned, is not likely to be

effective. For instance, if a private equity entity proposes to acquire a hospital, either directly or indirectly through an associated “foundation,” what can the regulator do? Requiring reports may lend some transparency, but once a hospital has become privatized, there is very little a regulator can do to prevent price and rate increases on the one hand, or to mitigate reductions in services on the other.

Various other states have CON and material change transaction approval processes that cover private equity acquisitions. However, to my knowledge there has been no case in which any of these states has concluded that a private equity transaction should not be permitted to take place and there has been no evidence that any state has been able to prevent price increases or service decreases by such an approach.

My recommendation to the Committee is that LD 2201 should be AMENDED to include a BLANKET PROHIBITION OF PRIVATE EQUITY ACQUISITIONS OF HOSPITALS and their real estate, leaving in place the regulatory regime for other health care facilities.

The pending private equity acquisition of Central Maine Health Care System in Lewiston may give us some first-hand experience with private equity stewardship of an important health care provider. That transaction is probably too far advanced to be stopped. Based on the performance of private equity in localities with similar economic and patient profiles, the likelihood of future problems seems very high.

Banning an economic player from a particular economic activity merely because it is “for profit” seems to many of us to smack of a kind of unfairness. Why should a for-profit hospital be banned from competing in the marketplace for health care services? The problem is that with hospitals there is no effective competition in most parts of Maine. Hospitals operate as quasi-monopolies and can increase prices or reduce services without having to worry about competition from other hospitals. This makes them attractive investments for private equity players. Because of 1) the vital necessity of good hospitals to the welfare of Maine’s entire population and 2) the quasi-monopolistic position of almost every one of Maine’s hospitals so far as prices and services are concerned, the only real way to protect Maine’s public is an outright ban.

With regret over my inability to attend the hearing in person and hope that the Committee will consider my testimony,

Peter L Murray