

Role of private equity in vascular care

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ABSTRACT

Objective: Private Equity (PE) investors have been rapidly expanding their presence in the health care industry, including investments in physician practices, asserting that this will benefit patients, physicians, and the health care system.

Methods: We summarize the literature related to PE partnering with physicians, discuss the pros and cons, illustrate the financial implications through a case study, and offer glimpses into the future clouded by governmental pushback.

Results: In a time of increasing regulatory burdens and decreasing reimbursement, PE offers vascular surgeons (VS) options for private practice, and corporate employment. PE contends that this relationship adds value by reducing inefficiencies and waste, and the capital infusion allows procurement of the latest technology and tools for better outcomes. Furthermore, PE management will negotiate with insurance companies to increase reimbursement, manage human resources tasks, billing, and accounting and allow the VS to concentrate on quality patient care. Management will also prepare the practice for new models of care (eg, whether value-based reimbursement or accountable care organizations). PE projects to expand market share and have VS partners share profits, based on a formula, when the entity is later sold to another buyer in the future.

Conclusions: Although there may be some advantages for VS to partner with PE entities, it may not be ideal for all career stages and requires considerable expertise in negotiations and vigilance for unfavorable regulatory actions. (JVS-Vascular Insights 2025;3:100223.)

Keywords: Private equity; Physician employment; Acquisitions

Private equity (PE) refers to investing in part of a business or company that is usually not publicly traded or listed. Institutional investors such as university endowments, high net worth investors, and others may combine their resources in a PE fund to purchase or form a business/company. Although both venture capital and PE raise capital from investors or 'limited partners,' the former typically invest in private, early-stage companies, whereas PE entities typically invest in both private and public companies. The other difference is that private capital is used almost entirely, at least initially, for venture capital, whereas debt is the primary source of funding PE with a 'leveraged buyout,' collateralized by the target's operations and assets.

PE firms have been attracted to health care in the United States (U.S.) because of the vast amounts of money involved, with over \$ 4.5 trillion spent on health care in 2022, an aging population that will require a projected further increase in spending, and an opportunity to cut costs in a somewhat fragmented and bloated health care system¹ (Figs 1 and 2). Advocates of PE suggest that more capital entering health care is value added and benefits patients and physicians alike. Without it, inefficiencies may prevail, the latest technologies and devices will not be procured, and patients will ultimately suffer.

The typical financing of a PE fund consists of debt financing from banks (70%-80%) and investors (20%-30%). The PE manager generally contributes about 2% of the fund's money.² The PE manager hopes to earn a significant return in a "2/20" model, meaning 2% management fees on the fund's investment annually plus 20% profits upon the sale, and management and consulting fees when they acquire other practices or VS groups.² PE entities are incentivized by some advantages not afforded to many businesses. Thus far, PE is allowed to treat their profits at the capital gains rate, which is lower than taxation of ordinary income. Another advantage is that because they fall below the lower federal reporting transactional threshold of most transactions, the majority of PE transactions are exempt from federal regulatory review.³

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The editors and reviewers of this article have no relevant financial relationships to disclose per the Journal policy that requires reviewers to decline review of any manuscript for which they may have a conflict of interest.

2949-9127

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<https://doi.org/10.1016/j.jvsvi.2025.100223>

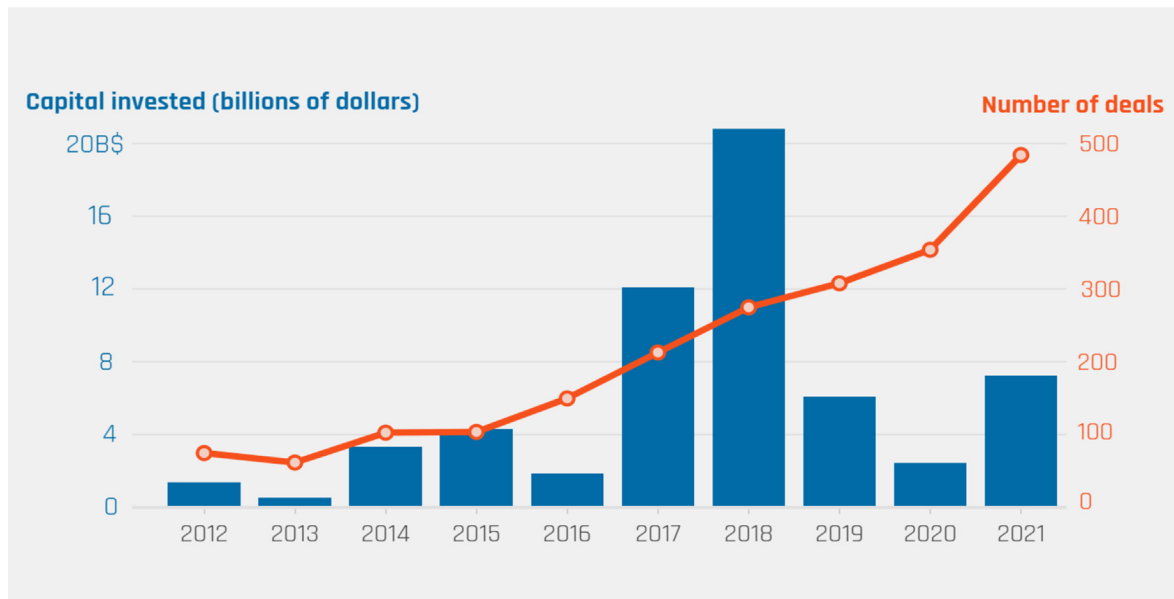


Fig 1. This figure represents Private Equity (PE) deals and capital invested from 2012 through 2021 in all outpatient clinics, excluding veterinary, physical therapy, behavioral, and dental care. The total capital invested in outpatient clinics is estimated to be \$60 billion. Courtesy and permission of American Antitrust Institute. https://www.antitrustinstitute.org/wp-content/uploads/2023/07/AAI-UCB-EG_Private-Equity-I-Physician-Practice-Report_FINAL.pdf.

WHY PE IS AN OPTION FOR PHYSICIANS, INCLUDING VASCULAR SURGEONS

With continuing regulatory and administrative roadblocks, combined with reimbursement cuts, some physicians may be forced to look at alternatives to self-employment. Most physician employers are hospitals and, more recently, large insurance companies that have stepped in to employ large numbers of primary care physicians.^{4,5} The new entrants (PE and insurers) believe they can squeeze waste and inefficiency out of the U.S. health care system to generate enough profits and reward their shareholders, partners, and executives.

PEs' sales pitch to vascular surgeons (VSs) has several components. First, management will create efficiencies; negotiate with private insurance companies to increase reimbursement (when possible); manage administrative tasks such as human resources, billing, accounting, etc; and allow the VSs to concentrate on quality patient care. Second, management will prepare the practice ready for new models of care, such as value-based reimbursement or accountable care organizations. Third, they may expand or merge with other VS practices to increase market share and exert more influence on payers, becoming a 'platform practice.' A platform practice often refers to the initial large physician practice acquired by the PE entity, often serving as the foundation for future acquisition or "add-ons" to expand its market share or geographic reach. Alternatively, PE entities can "build" a platform practice by aggregating multiple smaller to mid-size VS practices to generate the size/market share attractive for acquisition by a larger entity. Finally, when

they sell the larger platform practice to another entity (often another PE firm), marking the "exit" point of their investment (which usually happens within 3-7 years), VS often receive a portion of the profits generated through the sale based on the equity they hold in the platform practice.

When a VS is presented with another option for sustaining independent practice through a third-party providing capital, taking over administrative tasks, and offering an exit strategy with additional cash at the end, it is not hard to at least consider the choice. The reasons why VSs are approached by or initiate selling their practice to PE vary. Older and younger VSs may have different views when they are faced with rapidly changing circumstances and are cash-poor from decreasing reimbursement, increasing overhead, cost of professional liability insurance and information technology, or inadequate resources to effectively negotiate with payers. Although VSs nearing retirement may be hoping to cash out, usual options for VSs entering practice or looking to continue practicing have been private group practice or hospital employment. Younger VSs are increasingly choosing not to be in debt when starting a practice or joining one, opting for a different lifestyle and are disinterested in administrative functions; these physicians may also be attracted to PE.⁶

HOW DOES PE WORK FOR THE VS?

The goal of PE is typically to be a 'first mover' into a market, where it enters and then consolidates by taking over or partnering with several similar or complimentary

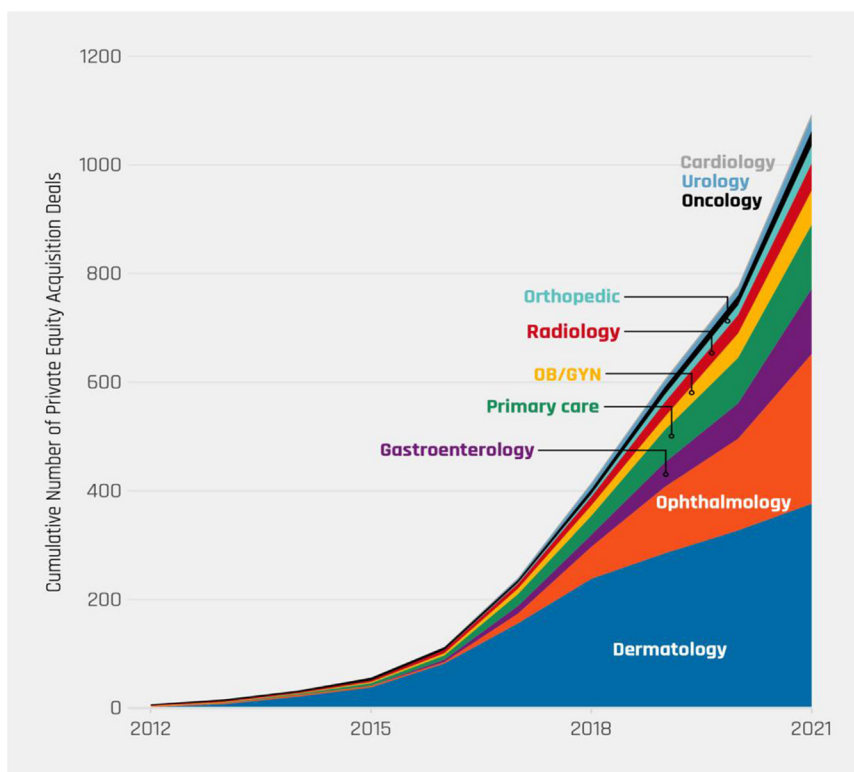


Fig 2. Cumulative number of Private Equity (PE) acquisition deals of physician practices by specialty, 2012 through 2021. There is lack of reliable public information about the number of vascular surgery practices affiliated with PE. Courtesy and permission of American Antitrust Institute. https://www.antitrustinstitute.org/wp-content/uploads/2023/07/AAI-UCB-EG_Private-Equity-I-Physician-Practice-Report_FINAL.pdf.

specialties, rolling them up into a single entity, making them larger and more profitable (and in turn, more valuable), and then exiting by selling the amalgamated practices. Typically, upon purchase of an independent, well-established VS practice, PE will plan a “platform and add-on” approach.⁷ Following this plan, PE may proceed to establish market power by subsequently acquiring smaller, additional practices (barring any anticompetitive concerns).^{2,7–9} This consolidated market power allows PE to negotiate better terms with insurers and vendors, contributing to their strategy of making the practice profitable enough for another buyer to purchase the consolidated entity resulting in profits for the PE and physician investors.

Even though the clinical practice itself may be ‘owned’ by the physicians, the PE entity will manage the non-clinical aspects of the practice, through an existing or newly formed management services organization (MSO) that manages physician practices. This is to avoid state corporate practice of medicine laws that ban physicians in most states from working for non-physician owners/corporations. These laws are the reason why MSOs (which may be owned by physicians or non-physicians) are used in PE transactions—rather than

owning the practice, they simply manage, and pull all revenue out of, the practice through management services fees. The practice is owned by the physicians, in a “friendly Professional Corporation” model (intended to shield the independent medical judgment of physicians), and the PE firm owns the MSO to avoid these issues. The MSO then manages and charges the practice fees for its management services, including managing all non-clinical aspects of the practice such as human resources, administration, billing, accounting, legal, marketing, payer negotiations, etc.

PE investors calculate a practice’s enterprise value through Earnings Before Interest, Taxes, Depreciation, and Amortization (EBITDA). EBITDA is a financial metric used to assess a company’s financial performance. By excluding the effects of financing decisions (interest), tax environments (taxes), and non-cash accounting items (depreciation and amortization), it allows for comparisons between companies in the same industry, as it eliminates the effects of capital structure and tax rates. Although EBITDA has limitations (eg, it may not fully represent a company’s cash flow situation or financial health), investors and analysts often use EBITDA as a proxy for cash flow or operational health when valuing

a company. It can indicate a company's ability to generate profit from its operations, making it useful for assessing operational efficiency.

As part of the acquisition, most practices will receive a cash infusion, albeit with a decrease in compensation, with the premise that if successful, there will be a "second bite of the apple" (ie, an additional, larger amount for the owners in a few years at the sale of the practice [the PE exit event]). The initial infusion is based upon a negotiated EBITDA. Valuation of private companies, like VS practices, are based upon 'multiples' of EBITDA. This EBITDA 'multiple,' depending on net earnings of the practice and other factors prior to acquisition, may be 10 or more times EBITDA. It is important to understand that when a VS or practice is considering a sale, they are generally expected to work for 4 to 5 years for the new enterprise or risk forfeiting part or all their class A stock sale for cash, because this transaction is in essence a trading of compensation in exchange for a cash multiple upfront from the PE buyer.

A higher EBITDA enables the practice and the managers to sell the concern later for a higher price. The task of the PE manager is to increase the EBITDA by increasing revenues and cutting costs. The former can come from strategies such as increasing referrals and VS productivity by bringing in higher reimbursing activities, better marketing, boosting insurance reimbursement through negotiations with payers, or increasing working hours. Decreasing expenses may involve cutting unnecessary high-volume supplies (stents, sutures), laying off highly paid workers, and negotiating pricing with vendors.

The higher the practice's EBITDA, the more likely it is that older surgeons closer to retirement will be favorably inclined to acquiesce to this arrangement. Because younger VSs are needed to replace the older ones over time, PE firms may need to buy the senior partners out of their shares so they can incentivize the younger VSs by offering them cash, stock, or some ownership incentives.¹⁰

In return for the changes, and for the cost of the cash and minority shares received, physicians will be expected to take a cut in their income (salary/bonus) of about 20% to 30% in addition to contributing any income-generating assets such as the vascular laboratory or office-based labs (OBLs) to the new owner or management. The VSs should expect, in general terms, that the PE fund will turn around and sell the practice(s) in 3 to 7 years.^{11,12}

CASE STUDY

PE acquisitions of physician practices can be complex for a number of reasons (eg, corporate practice of medicine laws, and debt structure). For the sake of clarity, Fig 3 below shows a (relatively) simplistic example of PE investment without inclusion of required legal structures

(MSO), debt financing, or continued rollover equity after repeated PE buyouts (ie, "third bite out of the apple").

In the ensuing example (Fig 3), the physician group (VS Practice), consisting of three VSs (VS Physicians), generates revenue from hospital surgical procedures, OBL procedures, and a vascular ultrasound diagnostic lab. The practice wholly owns the OBL and the vascular ultrasound lab. The total EBITDA, based on fiscal year (FY) 2021 data, is \$1,484,357; however, adjustments (add backs) such as removing profit sharing, payroll taxes, and auto expenses are needed. VS compensation, as shown in Fig 3, is arbitrarily set at 35% of collections (or typically \$350,000 or 50% of Medical Group Management Association compensation post transaction) because the PE buyer views this as the replacement value in case the VS quits. The annual compensation drop can vary but is substantial unless the new enterprise delivers on its operational efficiencies.

These adjustments are subtracted from the total EBITDA to produce an adjusted EBITDA of \$702,655 and an adjusted EBITDA margin of 13.8% (Fig 3, Box A).

Comment: Single specialty group private practices trade at a 5 to 7× multiple of adjusted EBITDA. In this case study, a 5× multiple is assumed to calculate the group's enterprise value of \$3,513,274 by a PE platform investor (Fig 3, Box C). If the investor is successful in acquiring additional groups (Add-On Practices) and applying economies of scale on the revenue and expense side (operational efficiency), it may attempt to exit in 3 to 7 years at a multiple of 10 to 14× by selling to an even larger buyer. Consequently, the original group's 30% roll-over equity could then be valued at \$9,600,000, assuming a 12× exit (Fig 3, Box N), for a total payout of \$12,059,293 (Fig 3, Box Q).

CAUTIONARY CONSIDERATIONS

The PE-operated practices may have an adverse impact on the local community. PE firms try either to find underperforming practices and improve their efficiency, maximize revenue, and consolidate with similar practices, or to approach practices with already high operating margins and improve them further. However, selling practices does lead to a loss of physician continuity for the communities affected unless some physicians choose to stay with the new owners. Consolidation into large practices also has the potential to drive small VS practices already under pressure out of the community.

Detractors claim that profit-focused PE companies will 'strip their assets' out of practices, leaving the practice with debt, communities in distress, and employees without jobs while quality of care deteriorates and, in the meantime, generating huge profits for their investors.¹³ The recent example of the PE-owned 33-hospital Steward health system declaring bankruptcy is often cited.¹⁴

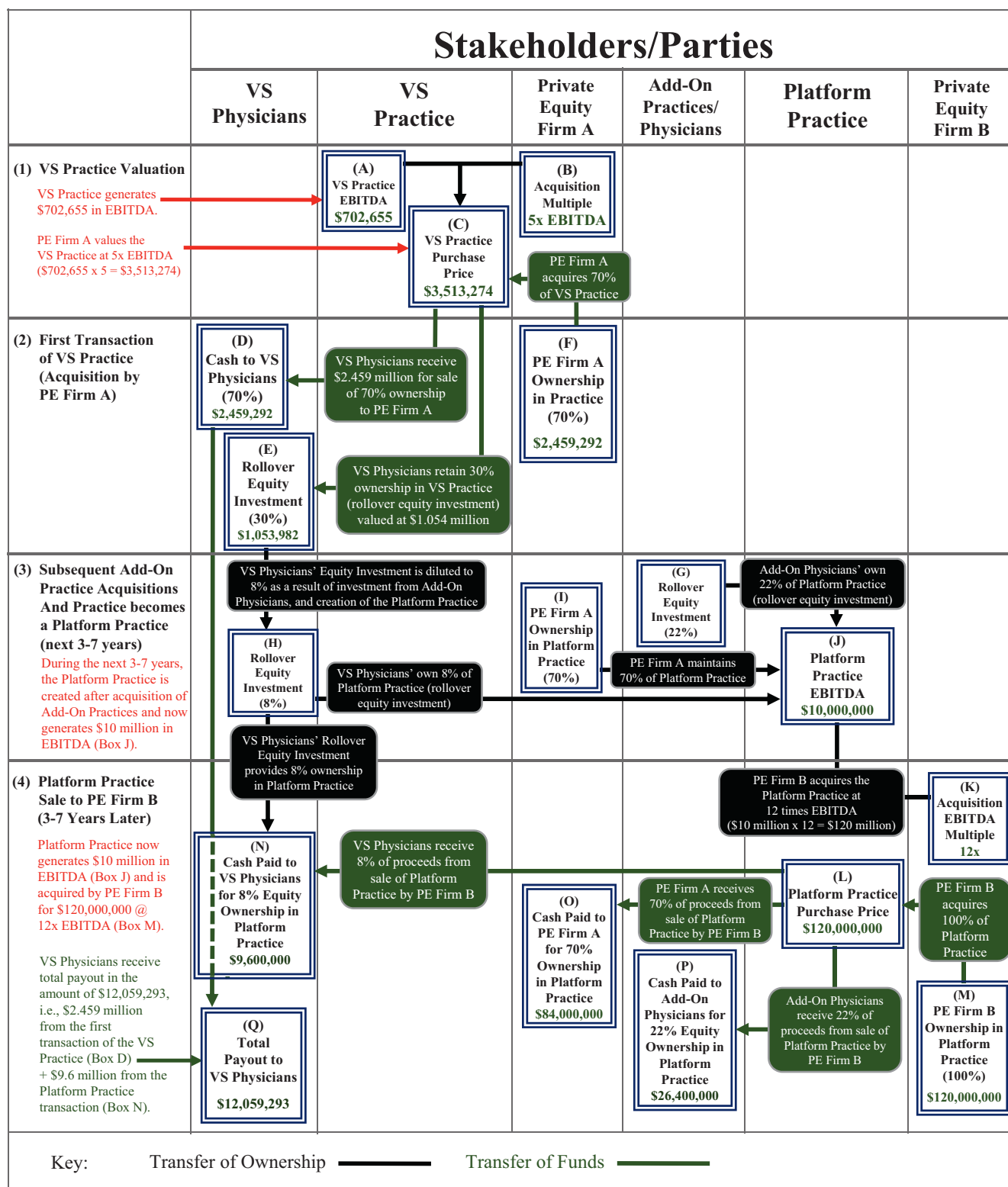


Fig 3. A schematic showing valuation of a vascular surgeon (VS) practice and Private Equity (PE) transactions. EBITDA, Earnings before interest, taxes, depreciation, and amortization.

Physicians are also at a disadvantage due to a lack of understanding of PE operational tactics unless they have an expert at their side. Any practice involved in negotiations with PE firms should be represented by health

care attorneys and advisors with experience in dealing with PE and firms who have expertise in health care valuation. There are several things to consider before signing an agreement with a PE firm. Attention should be paid

to the management fee structure, particularly avoiding any link between the fees as a percentage of practice revenue, rather than a fixed amount supported by fair market value. Productivity and billing metrics must be reasonable, with no appearance of creating any incentives for unnecessary procedures or patient care, which creates a moral hazard for physicians. Although there is not enough data about the impact of PE acquisitions on the quality of care or utilization, price increases have been observed by several studies (Table). Greater market share (larger than 30% by a single firm) has been shown to lead to large price increases, particularly in specialties.² PE may also pressure these practices to sell under duress at lower valuations.

Finally, there is the downside of financial liability for equity partners in addition to the usual malpractice liability for the physicians.

Physician views toward PE are currently negative. Almost 61% of physicians view PE negatively, due to lower professional satisfaction and less autonomy, with possible moral conflicts due to financial incentives compared with non-PE owned practices. Only 10.5% of physicians view PE as a positive participant in health care.³ However, two-thirds of those surveyed were general internists, 70% were salaried employees, and only 5% worked for PE-acquired physician practices.

The overall costs for the health care system may increase with or without an appreciable increase in the quality of care (Table).

DISCUSSION

There have been two waves of equity-based investments, a combination of both private and public investors, in physician groups and practices. In the 1990s, both public and private equity and physician management companies were involved. This was later followed by PE alone after the passage of the Affordable Care Act.⁷ By early 2024, more than 50% of physicians and over 70% of employed physicians were hospital employees.² Non-physician entities, such as insurers like UnitedHealth Group and public companies like Hospital Corporation of America, employ about 22% of physicians, and PE-backed 'providers' represent less than 4% of U.S. health care 'providers' by revenue.²⁴ However, PE firms have rapidly bought physician practices, with a six-fold increase from 75 acquisitions in 2012 to 484 practices in 10 years.² (Figs 1 and 2) The revenue of PE-backed health care 'providers' in the U.S. is estimated at \$117.7 billion in 2024, which is less than 3% of overall U.S. health care 'provider' spending of \$4.5 trillion.²⁴

Most of the PE literature is centered on hospitals, nursing homes, and health care information technology. However, because PE tends to focus on practices of various sizes that they can then expand, consolidate, and make profitable before selling, it is focused on certain sectors of the surgery market.²⁴ As far as

specialties, cardiology, with very high Medicare payment recipients, has been a recent focus of PE, especially in the ambulatory surgery center (ASC) setting.²⁵ Between 2012 and 2016, surgical specialties represented by ophthalmology, urology, obstetrics and gynecology, orthopedics, otolaryngology, and general surgery (in that order) constituted about 8% of all medical groups acquired by PE.⁷ There is no reliable public information yet about the number of VS practices acquired by PE, because these transactions may be private. However, Pitchbook reports 14 PE deals in the 'cardiovascular' sector in 2021 and 2022, with an additional six major mergers and acquisitions in 2023.²⁴

Outpatient markets (ASC and OBLs) are an ideal target for PE firms.²⁶ PE is attracted to ASCs because they are usually small, mostly independently owned, have limited capital reserves, and capture almost 60% of all outpatient procedural care.²⁷ Although limited to Medicare patients and only 3 years after PE takeover, one of the few studies of PE-owned ASCs showed no increase in case volumes or treatment cost, nor any change in quality of care.²⁷ In this study, Frack and colleagues state that clinical behaviors remained unchanged in ASCs after PE partnership, although private insurers were noted to avoid these ASCs because of pricing concerns. Because of lower reimbursement from private payers, some ASCs (primarily non-VS) have tried 'direct-pay' models, which eliminates the insurer part of the transaction.²⁸

Another reason for PE investment is the unique features of ASCs and OBLs such as lean operations; skilled physicians, nurses, and technologists; better efficiencies; and a smaller number of physician owners, which makes them susceptible to the 'financial engineering' provided by PE. The typical independent VS physician group practice with an OBL is still a small unit and frequently contracts out or purchases everything, including supplies, procedural supplies, insurance, its revenue cycle, legal services, and information technology. If expansion and consolidation is intended and a partner with capital is needed, a hospital or a PE entity may be an option.

As mentioned earlier, when practices own significant assets, such as real estate (where the practice is housed), PE may push to sell it to share in the profits (known as 'asset stripping').¹³ Because many physician practices do not have real estate or other valuable assets, researchers have pointed to other tactics such as higher prices, pressure on employed physicians causing overutilization of services, and possibly poor quality of care because of an extreme focus on profits rather than on affordable, cost-effective, and high-quality patient care.¹³ Critics say that, unlike not-for-profit hospitals and health systems, the purpose of PE is to generate profits for their investors by turning over to other buyers after a brief holding and growing period, with no intention to improve the quality of care (Table). Critics point to data suggesting that 21% of health care companies filing for bankruptcy in 2023

Table. Review of recent studies of Private Equity (PE)-acquired hospitals, medical practices, and ambulatory surgery centers

	Scope of study	Cost/Prices	Quality
Kannan et al, ¹⁵ 2023	Studied Medicare Part A claims to examine adverse events and hospitalization outcomes associated with 51 PE-acquired U.S hospitals with matched controls.		PE-acquired hospitals were associated with greater hospital-acquired adverse events. Although less statistically precise, there was a doubling of surgical site infections.
Scheffler et al, ² 2023	Used several databases to study trends and impact of PE on markets where a PE firm had a market share over 30 percent.	PE acquisitions were associated with price increases in 8 of 10 specialties, particularly if a PE entity controlled over 30% of the market. Per-patient expenditure increased for 6 of 10 specialties, ranging from 4% to 16% depending on the specialty.	
La Forgia et al, ¹⁶ 2023	A retrospective cohort study utilizing commercial claim data to compare price paid to anesthesia practitioners before and after contracts with a PE-backed physician management company in an outpatient facility.	Prices paid to anesthesia practitioners increased after hospital outpatient departments and ASCs contracted with the physician management company. Prices were especially higher if the PE had invested in the management company.	
Singh et al, ¹⁷ 2022	A study of three specialties (dermatology, gastroenterology, and ophthalmology) unique patients seen at PE-acquired sites.	2874 control practices were compared with 578 PE-acquired physician practices to evaluate measures of spending and utilization. PE acquisition was associated with increases in health care spending, measures of utilization, and evidence of greater intensity of care in many cases.	Patient risk scores were not significantly different between PE-acquired practices and controls.
Cerullo et al, ¹⁸ 2022	Financial performance of 176 hospitals acquired by PE during 2005 to 2014 were compared with matched control hospitals.	Reported at least a \$432 decline in costs per adjusted discharge and almost a 2 percentage point increase in operating margins in PE-acquired hospitals. Financial performance also improved after acquisition by PE along with patient throughput. However, inpatient utilization increased, and staffing metrics decreased. Non-PE hospitals also had an increase in operating margins but without a change in discharge costs.	
Bruch et al, ¹⁹ 2022	Study of the probability of unplanned hospital visit, total costs, and encounters 3 years before and after PE acquisition of ASCs.	No statistically significant differences in the probability of total costs, or total encounters between those acquired by PE (91) and non-PE (57) entities.	The average unadjusted probability of un-planned hospital visits for PE-acquired vs non-PE entities was not significantly different. No other quality measures were studied.

(Continued on next page)

Table. Continued.

	Scope of study	Cost/Prices	Quality
Cerullo et al, ²⁰ 2022	Patient outcomes (measures of comorbidity, mortality, readmission), length of stay, and spending among Medicare beneficiaries were compared after admission for 1 of 5 acute medical conditions to short-term PE vs non-PE-acquired acute care hospitals.	PE acquisition was not associated with significant differences in spending.	Outcomes were not substantially different between PE-acquired hospitals and non-PE-acquired hospitals. A moderate improvement in mortality (−1.1%) and lower 30-day mortality (−1.4%) among Medicare beneficiaries was noted in hospitalized patients with acute myocardial infarction. However, no significant differences in other measures of quality or across other medical conditions were noted.
Offodile II et al, ²¹ 2021	Review of studies comparing PE-acquired acute care hospitals between 2003 and 2017 vs unacquired ones for financial and operational differences.	Observed higher charge to cost ratios and higher operating margins in PE-acquired sites than non-acquired sites. These types of hospitals tend to receive higher payments from patients and insurers. However, significant limitations of the study are described.	
Braun et al, ²² 2021	Studied impact of PE on dermatology practice prices, spending, utilization, and patient volumes using commercial claims data.	PE firms generally acquired larger practices with more commercially covered patients. At 1.5 years after acquisition, prices for routine visits were 3% to 5% higher in PE practices compared with non-PE practices. The volume of patients was also greater. However, no differences were found in spending or use of common index procedures.	
Bruch et al, ²³ 2021	Using Medicare database, authors compared PE-owned acute care hospitals (138) with similarly sized and located matched non-PE hospitals (688) as to location, financial characteristics, and patient experience.	PE hospitals were more likely to have a lower median household income and patient experience score. PE hospitals, more rural, did not differ from their matched controls on net income per patient discharged, total inpatient charge per inpatient day, total charge-to-cost ratio, or Medicare and Medicaid discharges.	
ASC, Ambulatory surgery center.			

were owned by PE.² Although wealthy investors funding PE vehicles can withstand the financial losses, public stockholders of most insurance companies and local communities (in the case of not-for-profit health systems) and patients, employees, and physicians in those communities may not be able to recover.²⁹

There are others who believe the threat from PE is ‘overblown.’³⁰ Pauly and Burns claim that the current wave of

PE acquisition is simply a ‘back to the future’ scenario, just like the first wave in the 1990s, and that we should be more concerned with increasing consolidation leading to concentrated market power rather than which entity is doing the consolidation. The authors suggest that the ‘profit seeking’ behavior of PE may be no different than hospitals with employment contracts incentivizing physicians to do more (work relative units) and increase

their take home pay while generating revenue for themselves. Furthermore, advocates point to the recent moves by large, deep-pocketed insurance companies, such as UnitedHealthcare, to own large numbers of physician practices in addition to almost the entire supply chain in health care, which may represent a larger threat to the system.⁵

THE FUTURE

The number of physicians employed by PE entities is a moving target at this time. Health systems are aggressively beginning to directly hire specialists associated with PE-backed companies to deal with workforce shortages and partly to save money by eliminating expenses related to staffing and consulting agencies.³¹ Although insurers have become a large employer of physicians, almost all of whom are primary care physicians, VSs as employees seem to be a harder sell for several reasons, including the longstanding adversarial relationship with commercial insurance companies as payers, recent reports of physician layoffs in insurer-owned facilities, and finally the specter of antitrust investigations.³²

Increasing negative publicity from recent studies, as well as from the media, has led to attention from Congress and state legislators, who have started to hold hearings or have pending legislation to push federal antitrust regulators and state authorities to investigate PE transactions.³³ In December 2023, the U.S. Senate initiated a bipartisan investigation into PE involvement in the health care industry, reaching out to several health care providers and PE groups to request information.³⁴ In July 2024, the *Health Over Wealth Act* was introduced in the U.S. Senate, which would give the U.S. Department of Health and Human Services significantly more power to regulate and block PE deals and to require PE providers to disclose certain financial and operational data and protect consumers if its facility closes.³⁵

The executive branch has also taken several steps to garner more information regarding, and increase transparency related to, PE moves in the health care space, especially as relates to competition.³⁶ The Department of Justice's Antitrust Division, the Federal Trade Commission, and the U.S. Department of Health and Human Services under the previous administration announced the launch of a multi-agency inquiry focusing on the increasing control of PE and other corporations over the health care industry.^{37,38}

In addition to federal oversight and enforcement, 11 states have laws on the books that require some level of review over certain health care transactions.³⁹ Additional states have proposed legislation targeting PE health care investments specifically. Historically, lawmakers, judges, and regulators have found it difficult to scrutinize PE transactions (and the motivations behind them) due to their transactional and organizational

complexity. However, recent efforts to increase transparency in health care may make it easier to decipher—and challenge—these transactions. This emboldened scrutiny at the federal and state levels has resulted in a recent slowdown in the acquisition of relatively smaller medical businesses.

There is value added in terms of capital entering health care, which benefits patients and physicians alike.¹⁷ The investments may aid in provision of the latest technologies and devices, resulting in higher efficiency and outcomes. However, transparency and regulatory oversight is necessary to avoid excessive profit taking endangering the quality of care.

As PE's involvement in the U.S. health care system continues to grow, regulatory scrutiny and enforcement will continue to follow. In a recent strategic move, the tactic by PE firms of acquiring several small practices in the same geographic area and consolidating them into one large company ('rollup') to take advantage of economies of scale and make it easier to sell for a larger profit has slowed down significantly. The industry has lately shifted to investing in information technology, biopharma, and home health and nursing homes.

CONCLUSIONS

As the provision of health care in the U.S. changes, VSs will continue to be faced with new challenges. The choice of employment between independent practice and hospital employment has now been expanded to include new proprietors such as insurance companies and PE. Established as well as younger VSs entering the workforce with different goals and timelines may find something to like about affiliation with PE-backed entities. Caution is required to make well-informed choices in consultation with legal and financial PE professionals in addition to colleagues employed with PE. The recent sharp growth in health care expenses and a push for site-neutral based reimbursement may force health care employers including hospitals to reassess their continued physician employment strategy.⁴⁰

There is a strong need to inform Society members of rapid changes affecting VSs involving newer models of employment through publications and symposia to enable them to choose wisely.

AUTHOR CONTRIBUTIONS

Conception and design: BS, JBW, HR

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Writing the article: BW, JBW, TZ, HR

Critical revision of the article: BW, JBW, TZ, HR

Final approval of the article: BW, JBW, TZ, HR

Statistical analysis: Not applicable

Obtained funding: Not applicable

Overall responsibility: BS

FUNDING

None.

DISCLOSURES

B.S. reports author royalties from McGraw Hill.

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- Submitted Dec 12, 2024; accepted Mar 24, 2025.