

Private Equity and Healthcare:

Balancing Profit with Wellness

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Executive Summary

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There is a healthcare crisis in the United States. Costs are rising, driven by market consolidation, increased insurance premiums, escalating drug prices and other changes. Many hospitals and healthcare facilities are experiencing staffing shortages. These and other factors mean that the poorest people in the US have worse health outcomes than those in other high-income countries, despite the high level of spending.

One important trend over the last 20 years has been the emergence of private equity investors in healthcare. Private equity firms have invested more than \$1 trillion in debt-financed healthcare deals in the last decade. Often these investors have relied on financial models that negatively affect the quality of patient care. A study of all leveraged buyouts in 2022 found that PE-owned companies maintain dangerously high debt-to-cash flow ratios averaging 7.1, more than double that of public healthcare companies. This is well above the 4.0 threshold that financial regulators consider to be high. Almost inevitably, this level of leveraging leads to reductions in staff, which are likely to compromise the quality of patient care.

On the plus side, private equity firms provide capital and strategic expertise to the entities in which they invest. They can, and often do, improve operational efficiency and offer strategic guidance. These firms operate in many sectors and within each sector deploy a wide range of operating models. In the context of healthcare, some of these firms have adopted responsible practices, suggesting that industry-wide reform is possible. In publishing this report, our goal is not to call for the elimination of private equity firms in healthcare. Instead, we propose a series of reforms to incentivize PE firms to prioritize the quality of patient care in the communities where they operate.

While this report documents significant problems with PE ownership of

healthcare facilities, including hospital closures, reduced staffing, and compromised healthcare services, it also identifies a series of practical reforms that we believe would help to transform private equity’s role in healthcare.

The Evidence Base for Concern

Looking broadly at the effects of private equity investors in the healthcare sector, it is clear there are reasons for serious concern. For example, studies show that PE ownership raises in-hospital complications by 25% and trims hospital staff by 11.6%. In nursing homes, PE ownership correlates with 11% higher patient mortality rates. One study found that PE ownership raises the risk of bankruptcy by ten times. PE healthcare businesses saw 34 bankruptcies in 2023 alone. The resulting closures sometimes leave entire communities without adequate medical access.

The systematic nature of these problems stems from healthcare markets’ unique vulnerabilities. Healthcare consumers face low demand elasticity (because patients have little choice), high information asymmetry (because many consumers are ill-equipped to assess health services), and poor price discipline (because users do not pay their own bills). Private equity’s combination of legal immunity, public anonymity, and financialized ownership creates a culture that often prioritizes investment returns over social impact.

Case Studies in Financial Engineering

The middle section of this report presents a range of case studies drawn from PE-owned hospitals, nursing homes, behavioral health facilities, ambulance and medical staffing firms, wheelchair and ventilator makers, providers of sign language services, and prison health providers. Three sizable hospital chains have recently gone bankrupt after

similar patterns of debt accumulation and sale-leaseback transactions. A major nursing home chain filed two fraud-driven bankruptcies. At least three large PE-backed businesses relied so heavily on surprise medical billing that they declared bankruptcy after Congress passed the No Surprises Act.

The report also examines two operators of homes for troubled youth with documented patterns of abuse, and America's two dominant prison health-

care providers, each of which faced hundreds of lawsuits for negligent medical care. Appendix B identifies the specific PE investors involved in these controversies, with particular attention to public pension funds financing these activities.

The systematic problems illustrated in these small case studies stem from specific, correctable practices that the report recommends and can be addressed through coordinated action across three levels.

Recommendations in Brief

Recommendations to Private Equity Investors

Private equity firms and institutional investors should adopt Responsible Healthcare Investment Policies, and sign Limited Partnership Agreements, that include the following elements:

- 1 Make full and ongoing public disclosures** regarding your healthcare firms' finances—including the private debt on their balance sheets—as well as their owners, employees, patient outcomes, customer satisfaction, and other service quality metrics.
- 2 Refrain from sale-leaseback transactions or debt-funded dividends.** Don't load your healthcare firms with new obligations, whether to service debt or to pay rent on property that was formerly owned, leaving them vulnerable to cyclical dips in revenue.
- 3 Maintain a maximum ratio of debt to cash flow that is appropriate to the subsector,** with the ratio based on consulting a range of subsector experts. Putting a ceiling on the debt level would ease pressure to erode the quality of care by cutting staff or wages and ultimately closing healthcare facilities on which the community depends.
- 4 Refrain from cutting essential health services, closing health facilities, reducing staff, or reducing wages,** except in exigent circumstances with the permission of regulators.

Recommendations to State and Federal Governments

- 5 State legislatures should empower state health regulators to block or condition the acquisition of any healthcare business** in their state, based on broad public interest criteria—preserving the availability, accessibility, affordability, and quality of care.
- 6 States also should use the leverage provided by deal reviews to impose specific conditions.** Indeed, states may use their approval power to demand the same set of patient-centered conditions that PE firms may embrace in Responsible Healthcare Policies, or institutional investors may seek in a Limited Partnership Agreement.
- 7 Both federal and state legislators should discourage new sale-leaseback transactions or debt-funded dividends** by making healthcare businesses that engage in these risky practices ineligible for payments from government healthcare programs.
- 8 Both federal and state legislators should make a controlling entity liable when its portfolio firm commits fraud** against a government healthcare program, so long as the investor was aware of the misconduct and failed to timely report it.
- 9 Congress should require private equity firms to report to the US Securities and Exchange Commission** the financial data for their funds, loans, and portfolio firms, including their investors, fees, returns, and ownership stakes. Private equity firms that do not comply should lose their impending access to 401(k) retirement accounts.

I. Introduction

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Unlike other industries, healthcare involves life-and-death decisions.
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The US healthcare system is in crisis. Americans spend far more on healthcare on a per capita basis than their counterparts in Western Europe, Japan or other highly industrial states, and yet often get worse results.

The system is plagued by high insurance premiums, deductibles and inflated drug prices. At the high end, the system offers outstanding medical care to those most able to afford it. But at the same time, millions of Americans are uninsured or underinsured. This results in many preventable deaths and unacceptable health outcomes. Compared to countries in Western Europe, Australia or Japan, the US ranks low in terms of infant and maternal mortality, and life expectancy. Gaps in funding also have contributed to shortages of nurses and other essential health workers, a problem that is becoming more acute.

Over the last half century, national health expenditures in the US have grown more than tenfold in constant dollars, from less than half a trillion to nearly \$5 trillion in 2023.¹

This is the result, in part, of an uncoordinated and inefficient system funding medical care that includes an unwieldy mix of private insurance companies, employer funded healthcare plans, federally funded programs like Medicare and Medicaid, and a network of

hospitals providing care to military veterans. Other private companies, including those in the pharmaceutical, hospital supply, and investment sectors, are also contributing to the problem.

This report focuses on one group of investors, private equity firms, which now play an increasingly important role in the healthcare industry. We recognize that a number of problems we identify in this report also plague facilities with different funding models, including those owned by publicly traded firms, or by non-profit entities that act like for-profits. Walter Cronkite observed long before the rise of private equity that, “America’s healthcare system is neither healthy, caring, nor a system.”² The Government Accountability Office recently concluded that medical consolidation by any sort of buyer drives up medical prices.³ In spotlighting the private equity sector, we recognize the need for much broader reform in healthcare. Indeed, many of our recommendations in this report apply to healthcare acquirors of all forms.

We focus on private equity because the record shows that, despite some notable successes, all too often the private equity business model, when applied to healthcare, undermines patient care. Unlike other industries, healthcare involves life-and-death decisions where financial optimization must be carefully balanced with patient outcomes and community needs. While some PE investments in healthcare have successfully struck this balance, many others have struggled to deliver on their promises to upgrade performance while safeguarding quality care.

There are some notable examples of private equity investors having a positive impact on healthcare. In some cases, they have enabled significant innovations and expansions that benefit patients and communities. For instance, the medical device maker ev3, backed by Warburg Pincus, created innovative stents and catheters for vascular surgery, generated 1,350 jobs, and built \$2.6 billion in value.⁴ A case study from the West Virginia College of Business found that the urgent care chain MedExpress benefited rural Appalachian communities by lowering healthcare costs and reducing hospital crowding.⁵ The Association for Responsible Healthcare Investment, a private capital trade group, makes a similar argument on behalf of American Family Care’s national chain of 200 urgent care centers.⁶

Some argue that PE ownership allows medical practice groups to lower the price of care by investing in services like imaging and surgery centers outside the costly hospital setting. For instance, company-funded research found that patients of Duly Health and Care—a PE-owned medical practice aggregator in the Midwest—saw a 25% reduction in 2023 Medicare expenditures compared with patients of hospital-affiliated doctors.⁷

Drew Maloney, while CEO of the American Investment Council, argued that PE firms “know exactly where their capital is most useful, whether it involves expanding a physician practice into rural communities, financing innovative medical devices, increasing medical supplies, or financing promising new drug candidates that can treat hundreds of diseases.”⁸

Some experts, like Eileen Appelbaum of the Center for Economic and Policy Research, conclude that private equity investors are more likely to play a positive role in small deals, where they use minimal debt to acquire struggling companies and revitalize them. In larger deals (which paradoxically attract the most capital), PE firms have a history of loading healthcare institutions with significant debt, compromising their ability to maintain critical staffing levels.⁹

This report examines PE’s role across a large swath of the vast healthcare sector: in hospitals, nursing homes, behavioral health institutions, medical staffing and ambulance companies, specialized healthcare service providers, and prison medical providers. However, it does not wade into the controversy over consolidating physician practice groups, where the effect of PE ownership on the quality of care remains to be studied.¹⁰ After examining the theoretical tension between healthcare and the private equity model, we review specific cases to understand when and how PE investments in healthcare struggle to achieve their goals.

The goal of this report is to identify practices that stymie private equity success in healthcare, and to propose concrete recommendations for improving the current business model in ways that would allow private equity investors to meet their stated objectives of improving both financial

performance and patient outcomes. We approach this analysis in the spirit of our Center’s “Pro-business, high standards” approach.

The recommendations in this report are aimed at multiple stakeholders: private equity firms seeking to optimize their healthcare investments, lawmakers designing regulatory frameworks, and institutional investors—including public pension funds—that increasingly direct capital toward healthcare through private equity channels. By understanding what hasn’t worked well, our objective is to harness private equity’s capital and expertise in ways that will make a positive contribution to American healthcare.

II. Background

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The most successful
PE investors will be
those who refine their
approach to prioritize the
quality of patient care.
”

Leveraged buyouts in healthcare have a long history of ending in bankruptcy court, and empirical studies have linked staff cuts to reductions in the quality of care.

The PE model and the health sector are a dangerous mix because remote PE owners enjoy legal immunity and public anonymity, while patients suffer from scant medical knowledge and limited consumer choice. Moreover, PE owners are not bound by the ethical norms that have restrained traditional healthcare owners. The prevalence of funding from public pensions, and soon 401(k) accounts, make secrecy in private equity inapt. Publicly identifying PE investors may encourage them to avoid problematic buyouts, and to exert a salutary influence over portfolio companies.

A. The Private Equity Experience in Healthcare

In the last 20 years, the assets controlled by private equity firms have grown four to five times faster than the full economy. Across all industries, private equity firms now control 21,000 US companies and contribute \$2 trillion to annual GDP.¹¹

Private equity firms started pouring money into the US healthcare sector about 20 years ago. Their rate of

investment accelerated to [more than \\$1 trillion in debt-financed deals over the past decade](#).¹² In the decade ending in 2023, over half of healthcare deals in Massachusetts featured PE firms, accelerating to 64% from 2021 to 2023.¹³

Bain Capital Partners, KKR, and Merrill Lynch Private Equity set the trend in 2006 with a \$21 billion deal to privatize the largest US hospital chain, the Hospital Corporation of America. The PE owners burdened the hospitals with \$2 billion in new debt in 2010 in order to pay investors a \$2 billion dividend—a practice known as a dividend recapitalization. Bain emerged in 2011 with a tenfold profit,¹⁴ and in this instance, the healthcare business remained healthy.

But a second bellwether deal augured troubles to come: the Carlyle Group's 2007 purchase of the nursing home giant HCR ManorCare for \$6 billion. Carlyle recouped its money early with a \$6 billion “sale-leaseback” of HCR's real estate—a strategy that requires portfolio firms to sell buildings they own and pay rent moving forward.

Like a dividend recapitalization, this practice allows PE owners to extract value, but it burdens the underlying institutions with new obligations. Indeed, Carlyle's sale of HCR's real estate left the nursing homes with debt and rent payments that proved hard to sustain after Congress cut Medicare reimbursements under the Affordable Care Act. As the residential elder care business hit headwinds, Carlyle lost control in 2017. HCR's nursing homes, then numbering 1,500, fell into bankruptcy the next year amid media reports of deteriorating care quality, including a *Washington Post* account citing records from courts and state regulators. "The lack of care had devastating consequences," the Post reported.¹⁵

The HCR ManorCare case illustrates broader patterns that merit attention across the healthcare industry. Large PE firms commonly burden their

acquisitions with significant debt and rent payments, while making profits through fees and dividends. An examination of all leveraged buyouts in 2022 found an average debt-to-cash flow ratio of 7.1, more than double the rate of public healthcare companies.¹⁶ While leverage can provide capital for growth and improvements when managed appropriately, these levels exceed benchmarks that financial regulators consider prudent. The International Monetary Fund considers a debt-to-cash flow ratio above four to be high, and above six elevated.¹⁷ Likewise, a ratio above six "raises concerns for most industries," according to the joint guidance of the US Federal Reserve, the Federal Deposit Insurance Corporation, and the Office of the Comptroller of the Currency.¹⁸

When market conditions deteriorate, high leverage leaves PE-owned enterprises particularly vulnerable to financial distress. A [study](#) from

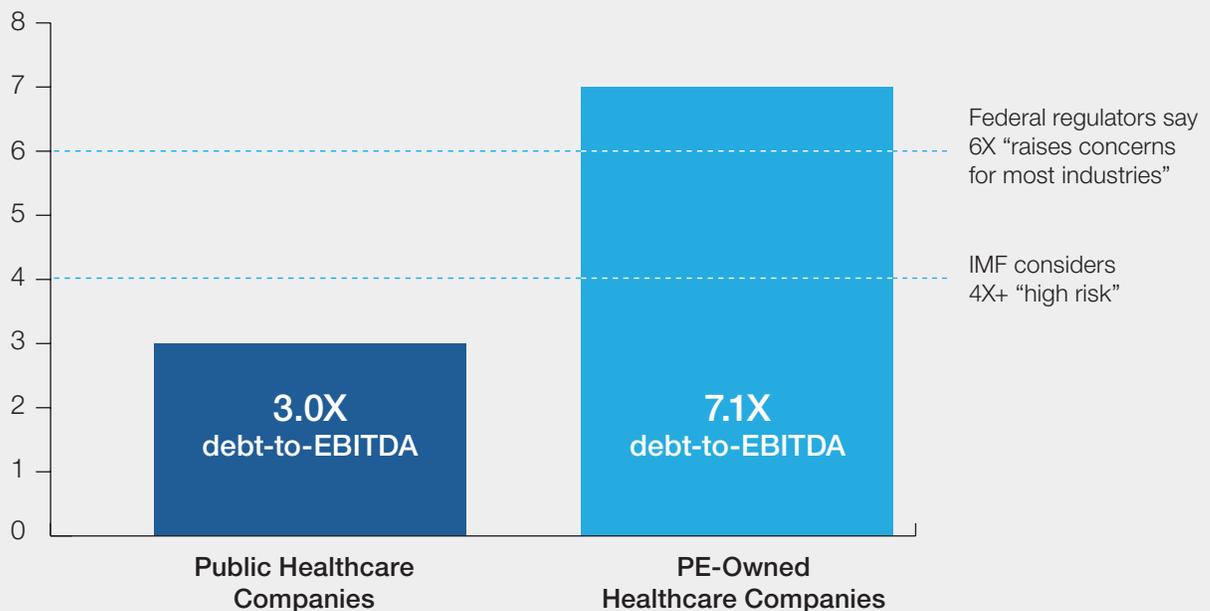
California State Polytechnic University found that public-to-private-equity buyouts raise bankruptcy likelihood by ten times, from 2% to 20% over the next decade—a risk profile that demands careful consideration in essential healthcare services.¹⁹

The sustained wave of debt-laden PE healthcare deals has generated concerning results. By November 2023, PE controlled **93% of medical companies with speculative debt ratings**. Over the next two quarters, PE-owned businesses accounted for nearly **two-thirds of billion-dollar US bankruptcies** across all sectors. In healthcare specifically, there were 26 large PE bankruptcies from 2023 through mid-2024.²⁰ In the healthcare sector alone, private equity accounted for seven of the eight largest bankruptcies of 2024.²¹

These failures sometimes create broader consequences. A Harvard

PE Ownership Debt Levels

2X higher than public companies



Sources: Private Equity Stakeholder Project, "Private Equity Healthcare Bankruptcies are on the Rise" (April 2024); Gabriel Lip, "Net Debt/EBITDA Ratio" (Corporate Finance Institute); Board of Governors of the Federal Reserve System, et al., *Interagency Guidance on Leveraged Lending* (March 21, 2013).

study documented 51 PE bankruptcies [abandoning pension obligations](#) to the government-backed Pension Benefit Guaranty Corporation, affecting retirees who had no involvement in the investment decisions.²²

Even when companies avoid bankruptcy, high debt levels can create operational pressures that may compromise the ability to make improvements to a healthcare institution. Research suggests several troubling patterns that responsible PE healthcare investors can work to address.

Pressure to Raise Prices: PE-owned medical enterprises may dramatically increase bills to private insurers, contributing to broader healthcare cost inflation. A [study](#) from the MIT Sloan School of Management found that bills sent by hospitals to private insurers rise by nearly a third after a PE takeover—potentially undermining long-term relationships with payers and communities.²³

Compliance Challenges: High leverage may push some firms toward billing practices that pose legal risks. According to federal disclosures compiled by the Private Equity Stakeholder Project, twenty-five PE-backed healthcare firms paid [\\$570 million in fraud settlements](#) from 2013 to 2020 for allegedly overbilling programs like Medicare and Medicaid.²⁴ This is a pattern that damages the industry’s relationships with regulators, and its wider reputation too.

Pressure to Cut Staff: High debt service creates incentives to reduce labor costs, with tragic results in businesses where staffing impacts patient outcomes. A large cross-sector study found that [average employment falls 12%](#) when a company goes from public to PE ownership (with more equivocal effects in private-to-private deals).²⁵ In the healthcare sector, a review of five studies concluded that there is evidence for reduced nurse staffing levels or a shift towards lower nursing skill mix under PE ownership.²⁶ A new [study](#) shows

hospital staff falling 11.6% after PE buyouts, though evidence of such a decline is not uniform at either hospitals²⁷ or nursing homes.²⁸

The measurable impacts of PE ownership on patient care represent the most serious challenge for PE healthcare investment. Though, again, the literature does not speak with one voice,²⁹ two highly-respected studies have been especially influential.

At nursing homes, a 2024 [Review of Financial Studies](#) article found perturbing correlations. Patients who transferred from hospitals to nursing homes were 11% more likely to die if they went to a PE-owned facility—equivalent to more than 20,000 premature deaths over 12 years. The researchers, Atul Gupta, Sabrina T. Howell, Constantine Yannelis, and Abhinav Gupta, attributed this mortality increase to “a systematic shift in operating costs away from patient

care.” To compensate for lower staffing levels, PE nursing homes were 50% more likely to use anti-psychotic medication, which may have further contributed to the higher death rate.³⁰

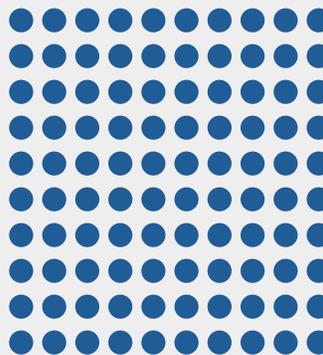
Similar patterns emerge in hospital care. A [landmark 2023 Journal of the American Medical Association](#) study, analyzing nearly 5 million hospitalizations, found that in-hospital complications, like infections or falls, rise by 25% after hospitals are acquired by PE firms.³¹ “We believe [these findings are] largely explained by staffing cuts,” said lead author Zirui Song of Harvard Medical School.³²

These research findings present a critical challenge for the private equity industry: how to maintain the financial discipline and operational improvements that PE can bring to healthcare while ensuring that cost optimization doesn’t compromise the patient care that is healthcare’s fundamental

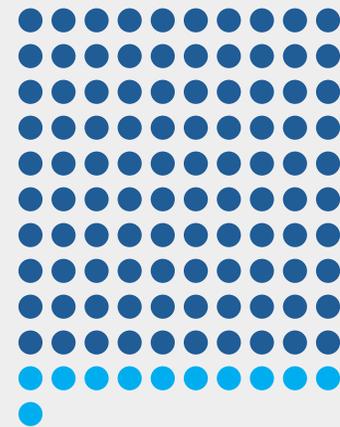
Nursing Home Mortality Impact

Over 12 years: Equivalent to 20,000+ premature deaths

Non-PE Nursing Homes



PE-Owned Nursing Homes



● 11% mortality increase

Source: Patul Gupta, Sabrina T. Howell, Constantine Yannelis, and Abhinav Gupta, “Owner Incentives and Performance in Healthcare: Private Equity Investment in Nursing Homes,” *37 Review of Financial Studies* 1029 (April 2024).

mission. The most successful PE healthcare investors will be those who find ways to achieve both objectives simultaneously.

B. Why Healthcare Demands that Private Equity Adapt

Both the nature of healthcare markets and the nature of private equity make it imperative for PE firms to modify their approach when entering the sector. Highly effective in many industries, the standard PE tools here need to be calibrated. Understanding these dynamics is crucial for PE firms to satisfy their dual mandate of generating strong returns and healthy patient outcomes.

In many sectors outside of healthcare, market forces and norms will constrain a firm from imposing negative outcomes on their customers. However, healthcare is prone to several market distortions that increase a company's ability to unduly raise prices or cut costs and quality without repercussions.

Limited Consumer Choice: Healthcare markets have low demand elasticity because healthcare consumers often lack meaningful alternatives. A patient suffering a heart attack has no opportunity to comparison-shop as the ambulance arrives. In many cases, reduced consumer choice means healthcare markets may not automatically punish overreaching businesses in the way other markets do.

Third-party Payment Systems: Healthcare consumers are also less likely to exert price discipline for a second reason: because government programs like Medicare cover so many of their payments. Again, this dynamic can reduce natural market constraints on pricing.

Information Asymmetry: Unless they've gone to medical school, healthcare consumers lack enough information to properly judge the quality of the services on offer. Even after

treatment, patients lack the knowledge to assess whether they've been under- or over-treated.³³

Evolving Ownership Norms: Healthcare institutions were traditionally owned by public or nonprofit entities, and managed by medical professionals who adhered to ethical codes like the Hippocratic Oath. As finance scholar Sabrina T. Howell, recently of NYU Stern, has noted, these traditional healthcare owners operated under an implicit contract. In exchange for state subsidies and community support, they would provide quality medical care at a reasonable price, without maximizing profits. Businesses are more likely to inflict costs on society when self-restraining norms are removed.

These traits of the healthcare sector interact dangerously with the private equity model. At publicly-traded businesses, legal or reputational costs sometimes deter strategies that harm society, and align profit motives with social benefits. However, private equity itself has several qualities that weaken the likelihood of being held accountable by either laws or consumers.

Legal Immunity: Private equity partners are insulated from legal consequences because their corporate structure severs control from liability to an unusual degree. If a portfolio firm acts criminally or negligently, only the portfolio firm will pay the price. By the time that business suffers the fallout, the PE investors may well have collected their profits and exited the scene.

Public Anonymity: Private equity owners are less visible than traditional healthcare owners, partly because they face minimal disclosure requirements, leaving many citizens unaware of who controls their local hospital, let alone who are the beneficial owners.

Remote Ownership: Private equity investors are also shielded from reputational costs because they are

usually based in a financial center, far removed from the patients who may suffer because of degraded care, staff who may be laid off to improve profits, or communities that may be weakened by the closure of vital institutions. Together with legal immunity and public anonymity, remote ownership may foster a climate of impunity.

A final characteristic of PE—financial and legal expertise—may sometimes combine with the climate of impunity to encourage a socially harmful business strategy. Because PE firms are the most active repeat players in the market for corporate control, they have nurtured a level of financial and legal expertise that enables them to optimize capital structures, ideally boosting the creation of value.³⁴ The danger is that such skills may also tempt PE firms to increase profits by means other than creating real value—like gaining market dominance, exploiting regulatory advantages, or manipulating bankruptcy law. All of these issues are raised in the healthcare cases examined later in this report.

Harvard professor John Coates contends that private equity buyers are more prone than traditional buyers to transform businesses in ways that have negative social consequences.³⁵ Arguably, private equity's characteristics can foster a general culture of prioritizing investment returns over social impact. Private equity represents a potentially dangerous mix with healthcare markets, unless the industry makes a renewed commitment to social responsibility.

As private equity becomes an ever-larger presence in healthcare, the industry needs to develop new frameworks for balancing financial performance with healthcare's social mission. In the long term, the most successful PE healthcare investors will be those who recognize the sector's unique dynamics and refine their approach to prioritize the quality of patient care.

Such an evolution will present both challenges and opportunities for private equity firms entering healthcare markets. Those who develop deep healthcare expertise, careful oversight mechanisms, and a more cautious financial strategy, can and do create significant value for all stakeholders. Those who apply standard PE approaches without adapting to healthcare's special context may encounter the pitfalls documented in this report's various case studies.

C. The Strategic Role of Investors in Healthcare Private Equity

In a typical private equity buyout fund, a PE firm (the "general partner") aggregates money from dozens of institutional investors (the "limited partners") to buy majority stakes in a handful of established businesses. While collecting management and performance fees, the PE firm commonly controls the board of each of its "portfolio companies," until exiting after three to seven years or more. Understanding this ecosystem reveals opportunities for improving healthcare outcomes through transparency and enhanced collaboration among all investors.

Limited partners—who often invest hundreds of millions of dollars in a buyout fund for five to 10 years—could also hold considerable sway if they choose to engage more actively with general partners on responsible investment.

The composition of PE's funding base reveals why the industry's impact on public health matters to a broad range of stakeholders. Pension funds now constitute the largest category of private equity investors, accounting for over a quarter of PE investment.³⁶ Sovereign wealth funds contribute over 10% of PE investment, and non-profit endowments an additional 5%.³⁷ Nearly 90 percent of US public pension funds participate, with the typical fund investing 14% of its assets in

private equity, versus 42% in public equities.³⁸ This means that teachers, firefighters, and other public employees—along with universities, union members, and the citizens of various nations—are all among the beneficial owners of private equity healthcare investments.

The large role played by public and public-minded investors in private equity underscores the need for greater transparency. Currently, the public knows little about these investments because PE firms operate under minimal reporting obligations. Even for PE firms that trade publicly (which include the very largest), financial details about individual funds and their portfolio companies typically remain confidential. Perhaps most alarmingly, no one knows the amount of private debt that PE firms or their portfolio companies carry on their balance sheets.

The lack of PE disclosure poses an ever greater risk to the economy as the market for private debt rockets past **\$2 trillion**—with PE firms participating as major lenders, and their portfolio companies participating as major borrowers. Both the [International Monetary Fund](#) and JPMorgan CEO [Jamie Dimon](#) have warned [repeatedly](#) that the secrecy surrounding private debt could lead to a new financial crisis.³⁹ The data void makes it impossible to detect which businesses are dangerously overleveraged, and which lenders are exposed to them.

This level of secrecy is inappropriate, given that much of "private" equity derives from public pension funds and sovereign wealth. Secrecy will become even less apt as PE starts to tap the \$12 trillion mass market of 401(k) retirement accounts, held by over 90 million Americans of varying levels of wealth and sophistication.⁴⁰

For problematic PE investments in any sector, sunshine can encourage investors to honor their more

responsible instincts. Consider Platinum Equity, which controls prison phone provider Securus Technologies (now part of Aventiv Technologies). When Securus faced public scrutiny in 2018 for pricing practices that were seen as exploitative of prisoners and their families, the nonprofit group Worth Rises led a stakeholder engagement campaign that brought public pressure to bear on both Platinum and its institutional investors.

The campaign produced constructive results. Platinum CEO Tom Gores pledged to reduce prisoners' calling costs, committed to giving away his personal profits, and donated \$3 million to prison causes.⁴¹ On the institutional investor side, Pennsylvania's pension fund withdrew from a reported \$150 million investment with Platinum. A pension trustee explained the decision: "I've been on this board for about 20 years, and I've never seen the amount of negative press on a firm that I've seen here today." The trustee's greatest fear was that the PE firm might invest in another "messed up" business "that we're not going to know about."⁴²

The research presented in Part II and Appendix B identifies, where possible, the specific PE investors involved in controversial healthcare investments, with particular attention to public pension funds. This information is intended as a foundation for more informed dialogue among all stakeholders about how to optimize private equity's role in improving American healthcare.

The transparency gap represents an opportunity for the private equity industry to demonstrate the positive impact of their healthcare investments. Some PE-backed healthcare companies have achieved improvements in patient care—and these success stories deserve greater visibility. Enhanced transparency could help distinguish successful healthcare investors from those whose track records are more problematic, providing a competitive advantage.

III. Case Studies

A. Private Equity and Hospitals

Private equity investments in hospitals have produced a range of outcomes. In recent years, three sizable PE-owned chains—Steward Healthcare, Prospect Medical Holdings, and Pipeline Health—have all filed for bankruptcy. The larger LifePoint Health chain, though financially healthy, has seen several high-profile local scandals, and has employed some of the same strategies that contributed to financial difficulties at other systems.

1. Steward Health: When financial engineering proves unsustainable

The Steward Healthcare case provides an example of how private equity financial strategies can interact with health-care operations in ways that ultimately prove unsustainable for all stakeholders involved.

Cerberus Capital Management launched Steward Healthcare in 2010. Over time, Steward sold \$6.6 billion of property to a real estate investment trust called Medical Properties Trust.⁴³ The company used these proceeds to distribute nearly \$800 million in dividends to investors and to acquire additional hospitals, expanding the chain's reach. Cerberus exited Steward between 2020 and 2021, [having quadrupled its investment](#) over the decade-long period. Unable to find a conventional buyer, Cerberus transferred control to a Steward physician leadership group led by cardiac surgeon Ralph de la Torre. As part of the transition, Steward distributed a \$111 million dividend to the new owner group. Following this transaction, de la Torre purchased [a 190-foot, six-bedroom yacht](#), which provoked public outrage when this later came to light.

The financial structure that enabled Cerberus' successful exit ultimately proved incompatible with continued operations. Weighed down by debt and liabilities totaling \$9 billion, Steward implemented cost reductions, including staff cuts. Between 2019 and 2024, [The Boston Globe documented 15 patient deaths that the newspaper linked to inadequate care at Steward hospitals](#). In one tragic instance, a new mother died of internal bleeding at St. Elizabeth's Medical Center after the hospital's embolism coil had been repossessed by the manufacturer due to unpaid bills.

The financial pressures led to systemic failure across the chain. In the six years leading up to bankruptcy, Steward closed at least six hospitals across the country, and laid off at least 2,650 workers. When the system entered bankruptcy in May 2024, it operated 31 hospitals, employed 30,000 workers, and provided care for 2 million patients. Since the bankruptcy filing, Steward has closed at least five more hospitals, in Ohio, Florida, and Massachusetts, resulting in another 2,400 layoffs.

The impact on healthcare access for the affected communities is generally harder to quantify, but no less real. Perhaps the most significant occurred with Steward's 2022 closure of Texas Vista Medical Center, which left half a million people in San Antonio dependent on a single 110-bed hospital. That's a ratio of only 0.2 beds per thousand people, or one-twelfth the national average.⁴⁴

STEWARD HEALTHCARE



PE Firm: Cerberus Capital Management (2010-2021)

Investors in Cerberus Institutional Partners International included Pennsylvania Public School Employees' Retirement System (\$200 million), California State Teachers' Retirement System (\$151 million), and Michigan State University. [See Appendix B for more ownership information].

Financial Engineering:

- \$6.6 billion sale-leaseback with Medical Properties Trust
- \$800 million dividend to investors
- \$9 billion total debt and liabilities

Patient Impact:

- At least 11 hospitals closed across country, resulting in over 5,000 layoffs
- 15 patient deaths attributed by Boston Globe to poor care (2019-2024)

Current Status: Bankruptcy (May 2024)

A. Private Equity and Hospitals

2. Prospect Medical: Challenges in safety-net hospital operations

In 2010, the PE firm Leonard Green & Company began consolidating hospitals serving economically distressed communities across six states under the banner of Prospect Medical Holdings. A \$1.55 billion sale-leaseback deal with Medical Properties Trust significantly increased the system's rental obligations in 2019. By 2020, *ProPublica* reported that investors had received \$400 million in fees and dividends, with an additional \$222 million in compensation flowing to Prospect's top two executives. During this same period, *ProPublica* reported operational challenges across Prospect's facilities, including broken elevators, dirty surgical gear, bedbugs, and feces on walls.⁴⁵ [A bipartisan 2025 Senate report](#) concluded that Prospect's operations damaged the vulnerable communities their hospitals were meant to serve.

Again, the financial structure proved unsustainable. In 2025, the Prospect system filed for bankruptcy and closed the last two of its four Crozer Health hospitals in Pennsylvania. That brings the total number of safety-net hospitals closed under PE ownership in the Philadelphia region to at least five in the last six years.⁴⁶

Safety-net hospitals serve low-income areas such as Chester, which suffers the state's highest infant mortality rate. Chester's 33,000 residents now lack both hospital services and private practice primary care physicians in their community. City Health Commissioner Dr. Kristin Motley expressed concern about the health implications: "People are going to literally die."⁴⁷

PROSPECT MEDICAL HOLDINGS



PE Firm: Leonard Green & Company (2010 - 2021)

Investors in Green Equity Investors IV included CalPERS (\$150 million), Michigan Department of Treasury (\$100 million), Oregon Public Employees Retirement System (\$100 million), Washington State Investment Board (\$100 million), and New York State Common Retirement Fund (\$75 million). [See Appendix B for more ownership information].

Target: Safety-net hospitals serving depressed communities

Financial Engineering:

- \$1.55 billion sale-leaseback with Medical Properties Trust
- \$222 million to top two executives

Patient Impact:

- Broken elevators, dirty surgical equipment, bedbugs reported, feces on walls
- Multiple hospital closures in underserved areas
- Chester, PA (33,000 residents) left with no hospital

Quote: "People are going to literally die," Chester City Health Commissioner Dr. Kristin Motley.

Current Status: Bankruptcy (2025)

3. Pipeline Health: Regulatory commitments vs. operational realities

Pipeline Health consolidated safety-net hospitals in low-income areas of Illinois, California, and Texas in 2018 and 2019, working with investment partners Stanton Road Capital, Davidson Kempner Capital Management, and Deerfield Management.

In obtaining approval for its Chicago acquisitions, Pipeline committed to Illinois regulators that it would maintain operations at its local hospitals for at least two years. However, as later [reported by Crain's Business](#), the purchase contract simultaneously provided for closing Westlake Memorial Hospital within months of acquisition. Pipeline announced Westlake's closure one month after completing the purchase and closed the facility six months later. In 2020, Pipeline paid \$1.5 million, without admitting wrongdoing, [to settle a suit](#) by the surrounding village for fraudulent misrepresentation.

The following year, Pipeline raised additional capital through a \$215 million sale-leaseback transaction, selling its Los Angeles hospital real estate in 2021 to Medical Properties Trust, the same real estate investment trust that bought property portfolios from Steward and Prospect.

In 2022, Pipeline also sold the parking lot of Chicago's Weiss Memorial Hospital to a luxury residential developer, over objections from the community. These capital strategies proved insufficient. In 2022 and 2023, the entire Pipeline group passed through bankruptcy protection.⁴⁸

After Pipeline's two remaining Chicago hospitals were sold to Resilience Healthcare, Weiss Memorial has continued to struggle. In summer 2025, Weiss's air conditioning failed during a heat wave, and the federal government [revoked its eligibility for Medicare](#) payments based on findings of inadequate physical environment, nursing services, and emergency services.

PIPELINE HEALTH



PE Firms: Stanton Road Capital, Davidson Kempner, Deerfield Management (2018 - 2023)

Investor Information: Not available

Target: Safety-net hospitals in Illinois, California, Texas

Financial Engineering:

- \$215 million sale-leaseback with Medical Properties Trust
- Promised regulators 2-year commitment, secretly planned immediate closure

Community Impact:

- Westlake Memorial Hospital closed within months of acquisition
- Hospital parking lot sold to luxury developers
- Multiple hospital closures despite public commitments

Current Status: Emerged from bankruptcy in 2023, remaining Chicago hospitals sold

4. LifePoint Health: Scale and stability in rural hospital operations

Apollo Global Management represents the largest private equity player in the hospital industry, operating about 220 US hospitals under the ScionHealth and LifePoint Health brands. In contrast to the other cases examined, Apollo's approach has achieved relative stability. The company points out that "at a time when many rural hospitals are under pressure, LifePoint has not had to close a single hospital." Indeed, Apollo invested over \$1.6 billion in capital improvements for its hospitals from 2019 to 2024. This track record distinguishes Apollo's PE hospital investments from those that have resulted in closures and bankruptcies, yet significant issues remain.

Iowa's Ottumwa Regional Health Center exemplifies the challenges of Apollo's approach to rural hospital management. When Apollo bought LifePoint for \$5.6 billion in 2018, it issued [\\$5 billion in new debt](#). LifePoint later completed a \$700 million sale-leaseback deal covering Ottumwa and nine other hospitals with Medical Properties Trust.⁴⁹

According to a [recent Senate report](#), this financial structure has created operational pressures at Ottumwa, with the facility carrying debt service and rental obligations that strain its operating budget. Employee feedback at Ottumwa reflects the resulting challenges. Typical employee survey responses included concerns about staffing levels, compensation, work schedules, and patient loads: "We are constantly understaffed, underpaid, have to work crazy hours, and deal with multiple patients." Since Ottumwa was first acquired by a PE firm (originally by Warburg Pincus), emergency room wait times have increased from approximately 2 to 3 hours. Staff have also reported roof leaks, peeling wallpaper, and ambulances with over 300,000 miles of service. Patient satisfaction metrics have reflected these challenges, with one measurement ranking the facility sixth-lowest in the nation.

These operational pressures contributed to a tragic security breakdown. In 2021 and 2022, an Ottumwa nurse sexually assaulted nine female patients before taking his own life. The 2025 Senate report linked these criminal acts to understaffing patterns that compromised patient monitoring and facility security.

Apollo states that LifePoint has invested over \$22 million in capital improvements at Ottumwa since 2019, and raised salaries by [\\$2.6 million](#) in 2023-2024. In 2025, the time it takes to see a provider in the ER fell by about half from the prior year, Apollo added, and the hospital is performing better than the national average on five healthcare quality metrics. LifePoint also told Senate investigators that it doesn't plan to close or sell Ottumwa.

Regardless of good intentions, Senate investigators raised concerns that high debt creates a cycle of underinvestment that may force a sale or closure when business conditions deteriorate.⁵⁰ These concerns gained urgency when Congress enacted huge Medicaid reductions as part of the One Big Beautiful Bill Act of 2025. Experts warn that [190 rural hospitals were already at risk of closure](#) in the states set to suffer new funding cuts.⁵¹

Apollo's approach demonstrates both the potential and the limits of private equity in rural healthcare. While LifePoint's operational record compares favorably with the Steward, Prospect, and Pipeline chains—which suffered multiple hospital closures and bankruptcies—the system still exhibits the characteristic pattern of high leverage and sale-leaseback financing that has created challenges elsewhere. LifePoint operated with a 7.9 debt-to-cash flow ratio in 2023, though both [Moody's](#) and [S&P Global](#) have since upgraded the company's bond ratings.

The company's financial performance benefited from about [\\$1.6 billion in pandemic stimulus funds](#). Arguably, that enabled Apollo in 2021 to transfer the hospitals from one fund to another, providing the original investors with a payout of about \$1.6 billion. Apollo denies that there is any connection between the two similarly sized payments.

The LifePoint case raises broader questions about sustainable financing for rural healthcare. While Apollo has maintained operations where others have failed, its challenges suggest an ongoing tension between financial optimization and healthcare delivery. The fundamental question is whether current private equity models can be refined to better balance investor returns with the unique operational and social requirements of rural hospital systems.

LIFEPOINT HEALTH



PE Firm: Apollo Global Management (2018-present)

Investors in Apollo Investment Fund VIII (owner of Apollo hospitals from 2018 to 2021) included public pension plans from Texas (\$850 million), Oregon (\$625 million), New York City (\$500 million), New York State (\$400 million), Connecticut (\$250 million), Illinois (\$250 million), Kansas (\$220 million), Maryland (\$220 million), North Carolina (\$220 million), and Florida (over \$200 million). Investors in Apollo Investment Fund IX (owner, 2021 - present) included public pension plans from California (\$850 million), New York City (\$650 million), New York State (\$480 million), Pennsylvania (\$310 million), Maryland (\$270 million), Connecticut (\$250 million), Illinois (\$250 million), Ohio (\$225 million), Florida (over \$200 million), and Colorado (\$200 million). [See Appendix B for more ownership information].

Apollo Hospital Holdings: ~220 US hospitals, including both LifePoint and ScionHealth

Financial Engineering at LifePoint:

- \$5.6 billion acquisition with \$5 billion new debt
- \$700 million sale-leaseback of 10 hospitals with Medical Properties Trust
- 7.9 debt-to-cash flow ratio at 2023 peak

Patient Impact at Ottumwa Regional Health Center:

- 9 patients sexually assaulted by nurse in 2021-22; understaffing, safety failures
- 3+ hour emergency room wait times in 2023
- 6th-lowest patient satisfaction nationally by one 2023 measure

Current Status: The hospital chain remains healthy, but the financial sustainability of some facilities is questioned

B. Strategic Bankruptcy in the Elder Care Industry

Nursing homes combine complex regulatory requirements, constrained reimbursement models, and vulnerable patient populations. Studying these challenges may help to identify the conditions necessary for successful operations that serve all stakeholders effectively.

The Atlanta-based PE firm Formation Capital began consolidating nursing homes in 1999. By 2012, it operated nearly 200 care centers under the names Consulate Healthcare and LaVie Care Centers, including Florida's largest network of nursing homes.

Consulate has a long history of regulatory compliance failures. *USA Today* found that multiple Consulate facilities had received the lowest federal quality ratings, and eight of its Florida homes accumulated over 100 regulatory violations each in a five-year period.⁵²

According to *Stat News*, Consulate operated through multiple corporate layers, and maintained "paltry" insurance coverage. *Stat News* concluded that the complex corporate structure and inadequate liability insurance were designed to evade or limit legal payouts.

These structural choices became consequential when regulatory compliance issues escalated to lawsuits. In 2020, a US court held Consulate affiliates liable for a quarter billion dollars for overbilling Medicare. Consulate responded by placing the six implicated nursing homes into bankruptcy proceedings, shortly after paying its CEO \$2 million in bonuses. Then, Consulate prevailed on the bankruptcy court to slash the fraud judgment by 98%, to under \$5 million. The restructuring reportedly resulted in creditors recovering less than a penny on the dollar, while allowing Consulate insiders to reacquire their former nursing homes, with debts discharged.⁵³

Still more controversy lay ahead. In 2023, the US Department of Justice alleged that LaVie Care Centers benefited from more than \$30 million in false tax credits during the pandemic. As the DOJ sought to recover these funds, LaVie closed or sold over 90 nursing homes, then placed its remaining 43 homes in bankruptcy. Nearly a hundred plaintiffs who won judgments for negligent care have claimed that the company shifted ownership of several homes ahead of bankruptcy to avoid liability. While the lawyers argued over the bankruptcy, a court monitor reported that some seniors were forced to skip meals. The surviving nursing homes emerged from bankruptcy in June 2025 under the operation of Avardis Health.⁵⁴

LAVIE CARE CENTERS / CONSULATE HEALTHCARE



PE Firm: Formation Capital (1999 - 2024)

Investor Information: Not available

Peak Size: Nearly 200 care centers

Accusations of Financial Gamesmanship:

- Complex corporate structure
- Grossly inadequate liability insurance
- \$250+ million fraud judgment
- \$30+ million in allegedly falsified pandemic tax credits
- Two bankruptcies filed, purportedly to dodge legal claims

Current Status: Recently emerged from second bankruptcy proceedings

C. Regulatory Evolution in Medical Billing

Surprise billing is the colloquial term for patients receiving unexpectedly high charges from medical providers outside their insurance network. This practice has historically been common in billing for ambulance pickups and emergency room visits, both situations where consumers frequently have no choice.

1. Historical context

The scope and impact of surprise billing gained national attention through journalism reports, including a 2016 *New York Times* investigation titled “[When You Dial 911 and Wall Street Answers](#).” That investigation highlighted practices at companies like Rural/Metro ground ambulance service, which was owned by PE firm Warburg Pincus before entering bankruptcy in the early 2010s. Internal company materials revealed aggressive billing strategies, including training flyers that encouraged staff to persistently seek patient consent for out-of-network billing. “Almost always, if the patient is alert, they will be able to sign,” advises a model employee on company posters. “They’ll sign,” the employee says, “because I don’t give up.”⁵⁵

Research documented the financial impact of these practices across different emergency medical services. A [study](#) by the USC-Brookings Schaeffer Initiative for Health Policy found significant price increases following private equity acquisitions of air ambulance firms. PE-acquired helicopter ambulance bills grew by 79% between 2012 and 2017, reaching \$48,350—over seven times the fee structure used by Medicaid. PE-acquired airplane ambulance bills grew by 65% in the same period to \$58,750, or nearly nine times the Medicaid rate.⁵⁶

Similar patterns emerged in emergency medical staffing. A [study by Yale health economists](#) analyzed the impact on hospital billing of staffing companies like TeamHealth (bought by Blackstone in January 2017) and the EmCare unit of Envision Healthcare. The research found that after TeamHealth began staffing emergency rooms that previously had low rates of out-of-network billing, the out-of-network rate rose by nearly one-third. When EmCare entered similar hospitals, the out-of-network rate rose by over 80%.⁵⁷ “It almost looked like a light switch was being flipped on,” the study’s lead author told the *New York Times*.⁵⁸ (Blackstone states that TeamHealth had a longstanding policy against surprise billing.)

The prioritization of profit over clinical considerations sometimes created operational tensions. EmCare faced controversy after terminating a Kansas emergency room physician who had complained that understaffing levels were putting patients at risk. When forced to work alone in the emergency department, the physician raised concerns about dangerous conditions. An EmCare

executive explained that “staffing decisions are financially motivated” and “profits are in everyone’s best interest.”⁵⁹ A jury subsequently awarded \$26 million in damages.

2. Congressional action and market impact

Despite the growing controversy around surprise billing, private equity funds were increasingly attracted to firms that employed these strategies. KKR acquired leading airplane ambulance firms to form Global Medical Response in 2015. American Securities acquired leading helicopter ambulance firm Air Methods in 2017. Between 2017 and 2018, KKR expanded its healthcare portfolio by acquiring Envision’s ground ambulance operations (which included the Rural/Metro unit mentioned in the *New York Times* investigation) and then purchasing the remainder of Envision, including EmCare, for nearly \$10 billion.

Industry lobbying efforts initially delayed a public response to surprise billing. However, mounting political pressure eventually led to legislative action. Through the “No Surprises Act,” Congress banned surprise billing in most healthcare settings as of 2022.

The ban on surprise billing significantly reduced revenues at firms whose business models had incorporated these practices. KKR’s Envision, American Securities’ Air Methods, and Brown Brothers Harriman’s American Physician Partners each entered bankruptcy in 2023. Industry observers attributed these bankruptcies partly to “regulatory headwinds” that fundamentally altered revenue models.⁶⁰ Other affected companies managed to avoid bankruptcy. KKR’s Global Medical Response completed a \$4 billion debt restructuring. Blackstone’s TeamHealth arranged a series of refinancings, despite a temporary downgrade to a CCC credit rating by S&P Global.⁶¹

But in some settings, surprise billing continues, and PE firms continue to benefit. Industry lobbying carved out an exception to the No Surprises Act for ground ambulances, despite a 2021 study showing that ground ambulances generated surprise out-of-network bills for half of privately insured patients.⁶² One beneficiary is the American Medical Response division of KKR’s Global Medical Response. That KKR business now includes the Rural/Metro ground ambulance unit, the original poster child of surprise billing.

SURPRISE BILLING

Key PE Firms: KKR, American Securities, Brown Brothers Harriman, Blackstone

Investors in KKR Americas Fund XII (owner Envision Healthcare, 2018 - 2023) included CalPERS and CalSTRS (more than \$1 billion). Investors in KKR North American Fund XI (owner, Air Medical and Global Medical Response) include Oregon Investment Council and Employees Retirement System (\$750 million), and the Teacher Retirement System of Texas (\$500 million). Investors in American Securities Opportunities Fund III (owner Air Methods, 2017 - 2023) included Massachusetts Pension Reserves Investment Management (\$100 million) and Teachers' Retirement System of Louisiana (\$75 million). Investors in Brown Brothers Harriman BBH Capital Partners V (owner American Physician Partners, 2017 - 2023) included the Merseyside Pension Fund of Liverpool and the New England Teamsters and Trucking Industry Pension Fund. TeamHealth was owned by Blackstone Capital Partners IV from 2005 to 2013, and reacquired in 2017 by Blackstone funds, alongside the Caisse de dépôt et placement du Québec, the Canadian Public Sector Pension Investment Board, and the National Pension Service of Korea. [See Appendix B for more ownership information].

Examples of Business Model:

- Rural/Metro ground ambulances: Aggressive patient consent tactics
- Air ambulance bills: 79% increase (helicopters), 65% (airplanes)
- EmCare ER staffing: 80%+ increase in out-of-network billing

Legislative Response:

- “No Surprises Act” (2022) banned most surprise billing
- Ground ambulances exempted from ban

Outcome:

- Numerous personal bankruptcies due to surprise medical bills
- Multiple corporate bankruptcies attributed to congressional ban on the business model

D. Private Equity in Behavioral Health

Private equity investments in behavioral health have produced varied outcomes. Sequel Youth and Mentor Networks both represent extreme cases, with understaffing contributing to fatalities, and fatalities triggering regulatory action. Though the Center for Autism and Related Disorders did see a decline in staff training, the consequences were nowhere near as extreme. In that case, critics charge that the PE owners let CARD's high standards fall, and unnecessarily shut many autism centers that were decently profitable, with disregard for families' needs.

1. Severe consequences in residential youth care

In 2017, Altamont Capital Partners gained control of Sequel Youth & Family Services, which operated residential facilities for foster children, juvenile offenders, and youth with mental health challenges.⁶³ Sequel co-founder Jay Ripley articulated the apparent business strategy: "You can make money in this business if you control staffing."⁶⁴

Understaffing, combined with under-training and under-paying staff, can have severe consequences in homes for troubled youth. A year-long 2020 [investigation by American Public Media](#) documented serious incidents across Sequel facilities, with state regulators finding instances of assault, sexual abuse, child abuse, and substandard living conditions. The investigation revealed a tragic incident, [captured on video](#), where Sequel staff responded to a 16-year-old boy throwing a sandwich by restraining him for 12 minutes. Cornelius Frederick Jr. died two days later from what the medical examiner determined was homicide by asphyxiation.⁶⁵

The regulatory response was significant. Four states, including California, discontinued placements of children in Sequel facilities. In the next two years, at a time when it was under pressure from state regulators, non-profit organizations, and the media, Sequel closed about half of its treatment centers. Most of the remaining facilities were subsequently sold to Vivant Behavioral Healthcare, a new company established by Sequel co-founder Jay Ripley.⁶⁶

An Altamont spokesperson states that, between 2018 and 2020, Sequel invested \$2 million in compliance and quality control, enhancing training and raising wages to the industry standard. Altamont attributes the closures following 2020 to the pandemic, rather than regulatory pressure or reputational damage. "Staff controls were never part of the business strategy under Altamont's ownership of Sequel," states the spokesperson.

SEQUEL YOUTH & FAMILY SERVICES



PE Firm: Altamont Capital Partners (2017- 2021)

Investor Information: Not available

Target: Residential facilities for foster children, juvenile delinquents, troubled youth

Sequel founder's motto: "You can make money in this business if you control staffing."

Patient Impact:

- Death of Cornelius Frederick Jr. (16) - homicide by asphyxiation
- Documented assault, rape, child abuse across facilities
- Half of facilities shut down under public scrutiny (2019-2021)

Current Status: Most of remainder sold to new firm founded by original co-founder

2. Severe consequences in foster care services

In 2019, Vestar Capital Partners sold to Centerbridge Partners and Vistria Group a provider of foster care and residential services called Mentor Networks (now Sevita Health). Mentor's operations had previously attracted regulatory attention during its ownership by Vestar. A 2015 *BuzzFeed News* investigation reported that Mentor cut costs by hiring fewer and less qualified social workers, with sometimes fatal results.⁶⁷ The journalism prompted a series of bipartisan Senate investigations into the company's operations. The Senate's initial report documented that 86 foster children had died while in Mentor's care between 2005 and 2015, representing a rate 42% above the national average.⁶⁸

Follow-up Senate reports at the end of 2020 identified ongoing patterns of substandard care at Mentor facilities in Iowa and Oregon serving individuals with intellectual and developmental disabilities. State regulators closed the Oregon facility due to multiple regulatory violations.⁶⁹ In 2020, the new PE owners, Centerbridge and Vistria, roughly doubled Mentor's spending on quality of care and compliance to \$10 million. In February 2021, the two PE firms completed a debt-financed dividend distribution of \$375 million, bringing their total dividend recapitalization to approximately half a billion dollars.⁷⁰

MENTOR NETWORKS (NOW SEVITA HEALTH)



PE Firms: Vestar Capital Partners (2006 - 2019); Centerbridge Partners and Vistria Group (2019 - present), Madison Dearborn Investments (25% stake since 2022)

Investors in Vistria Group included the state pension plans of Maryland, New York, and Illinois. [See Appendix B for more ownership information].

Financial Engineering:

- \$375 million debt-fueled dividends (February 2021)
- Total dividend recapitalization: ~\$500 million

Community Impact:

- 86 foster children deaths (2005-2015), 42% above national average
- Substandard care for disabled individuals in Iowa and Oregon
- Oregon facility shut by regulators

Current Status: Operating as Sevita Health under continued PE ownership

3. Disappointment all around in the field of autism care

By the end of the last decade, the disability rights movement had persuaded all 50 US states to mandate that autism spectrum disorder be covered by medical insurance. Private equity funding swiftly followed, with PE firms accounting for 85% of acquisitions in the field from 2017 to 2022. When Blackstone acquired control of the Center for Autism and Related Disorders in 2018, CARD held a leading market position, with a pioneering curriculum and training program that had been admired by families for over 25 years.

The [Center for Economic and Policy Research](#) faults the new managers for damaging CARD's culture by reducing investment in its training program to cut costs. Then, in mid-2022, CARD closed 90 treatment sites across 10 states, disappointing hundreds of its autistic clients and their families. Blackstone notes that CARD faced a variety of unexpected challenges in the pandemic economy. But at the time, CARD attributed these closures to state reimbursement rates that did not meet Blackstone's profit targets. In the Center for Economic and Policy Research's view, Blackstone's profit targets were unnecessarily lofty, and the closures were avoidable. In 2023, CARD went through bankruptcy, emerging with about half the sites and fewer than half the employees.⁷¹ A group led by CARD's founder bought back the company for less than \$50 million, compared to a valuation of \$600 million when Blackstone entered the market.⁷²

**CENTER FOR AUTISM
AND RELATED DISORDERS
(CARD)**



PE Firm: Blackstone (2018 - 2023)

Investors in Blackstone Strategic Capital Holdings included the Alaska state wealth fund (\$500 million), the University of California (\$200 million), Michigan Retirement Systems (\$125 million), and the Ohio Teachers' Pension Fund (\$100 million). [See Appendix B for more ownership information]

Market Position: Largest and most venerable autism care provider

Service Impact:

- Accused of hollowing out training program to cut costs
- Closed 90 sites in 10 states (2022)
- Emerged from bankruptcy with half the sites and employees
- Disrupted services for thousands of autistic children

Current Status: Founder bought back company at bargain bin price

E. Private Equity and Specialized Healthcare Services

Companies that provide and service specialized medical equipment must navigate an intricate regulatory maze while meeting the customized needs of patients who depend on reliable service for essential daily functions. Consolidation among wheelchair providers has created both opportunities for operational efficiency and challenges in maintaining timely service. The case of Apria Healthcare, a leading provider of home respiratory services, shows the need for robust compliance processes to ensure proper billing practices.

Sign language interpretation for deaf Americans is a very different market that might be classified under specialized healthcare services, and has attracted PE investment. The biggest controversy there arises over the proper allocation of rising revenue between capital and labor.

1. Frustration in the market for wheelchairs

Private equity has consolidated much of the US market for supplying and servicing motorized wheelchairs under the companies Numotion and National Seating & Mobility. High debt has led to understaffing and poor service for customized wheelchair users, according to [reporting by Mother Jones](#) and [STAT News](#), as well as [research by the National Disability Rights Network](#) and the Private Equity Stakeholder Project. One field technician reported that workforce reductions sometimes resulted in individual technicians being responsible for servicing up to 2,000 customers. According to the critics and legal opponents, these staffing constraints have contributed to extended delays in wheelchair repairs and maintenance, sometimes lasting months. For customers who depend entirely on specialized wheelchairs for daily mobility, such delays can force them to choose between being uncomfortable or homebound, and result in muscle cramps or bed sores. One legal plaintiff described the impact: “I’d try to use it, but after 20 minutes, I would be in spasms.”

The companies respond that extended service delays are exceptional rather than routine. Senior executives told *Mother Jones* that delays primarily result from external factors, including insurance bottlenecks, as well as labor shortages and supply-chain disruptions.⁷³

Operational challenges have led to legal consequences. Numotion has faced more than 30 personal injury lawsuits since 2015. Additionally, the company paid over \$20 million in 2023 and 2024 to resolve federal allegations of Medicaid and Medicare billing fraud.⁷⁴

numotion®

NUMOTION / NATIONAL
SEATING & MOBILITY



PE Firms: AEA Investors, Leavitt Equity Partners, Crescent Capital (Numotion, 2018 – present); LLR Partners (Numotion, 2011 – 2022); Cinven Partners (National Seating & Mobility, 2019 – present)

Investors in LLR Equity Partners IV (which exited Numotion in 2022) included public pension plans from Pennsylvania (\$250 million), Ohio (\$200 million), and Colorado (\$100 million), as well as the St. Andrew’s School of Delaware. Investors in Leavitt Equity Partners II include the Apex Foundation and Semnani Foundation philanthropies. Investors in the Seventh Cinven Fund include New York State Common Retirement Fund and Teachers Retirement System (\$425 million), Canada Pension Plan (\$320 million), Washington State Retirement System (\$293 million), Teacher Retirement System of Texas (\$220 million), Oregon Public Employees Retirement System (\$200 million), and Tennessee Consolidated Retirement System (\$150 million). [See Appendix B for more ownership information].

Business: Providing and servicing motorized wheelchairs

Patient Impact:

- Months-long repair delays reported for customized wheelchairs
- Allegations of bodily harm and bedsores for paralyzed patients
- 30+ personal injury lawsuits against Numotion since 2015

Patient Quote: “After 20 minutes, I would be in spasms.”

2. Overbilling for ventilators

Blackstone controlled medical equipment provider Apria Healthcare from 2008 to 2022. In 2020, Apria paid the Justice Department \$40.5 million to settle allegations of Medicare and Medicaid billing fraud for respiratory care. In an unusual step, the company acknowledged the alleged behavior, although it did not admit that any of its conduct was illegal or improper.

Apria admitted that from 2014 to 2019, it had routinely sought reimbursement for non-invasive ventilators, in circumstances that the DOJ regarded as illegal. In some cases, Apria requested payment while willfully failing to check whether patients were still using the machines. In other cases, Apria kept billing the federal government despite actually knowing that patients were no longer using the devices.⁷⁵ Blackstone stresses that DOJ did not allege any impropriety or awareness of Apria's conduct on the part of the PE firm.

The case illustrates the importance of robust compliance systems for companies operating in healthcare markets with complex reimbursement requirements.

APRIA HEALTHCARE



PE Firms: Blackstone, with Carlyle's Alpinvest division as a passive co-investor (2008 to 2022)

Investors in Blackstone Real Estate Partners V included Pennsylvania Public School Employees Retirement System: \$200 million. [See Appendix B for more ownership information]

Business: Home respiratory equipment provider

Alleged Fraud Pattern:

- Sought improper reimbursement for ventilators (2014 to 2019)
- Failed to check if patients still used machines
- Billed despite knowing patients weren't using equipment

Legal Resolution:

- \$40.5 million settlement (December 2020)
- Company acknowledged alleged misconduct
- Corporate Integrity Agreement with US Dept. of Health and Human Services

3. Labor complaints in the market for sign language interpretation

Under the Americans with Disabilities Act, the US government covers the cost of sign language interpretation for phone calls by deaf Americans. Two PE-backed companies, ZP Better Together and Sorenson Communications, largely consolidated the resulting market for video-relayed sign language interpretation services. The interpreters who work for the two companies have contended that ZP and Sorenson are failing to give their labor force a fair share of the revenues they are earning from their advantageous regulatory and market position.

In 2023, the Federal Communications Commission hiked rates for the services by 30% to 49%. The FCC projected that these rate increases would enable interpreter compensation to rise by 65% within five years. Yet, despite the regulatory rate adjustments, significant improvements in compensation and working conditions have not materialized, according to a survey by the Office and Professional Employees International Union. Meanwhile, the interpreters surveyed continue to report high levels of occupational stress and low levels of mental health support.⁷⁶

ZP BETTER TOGETHER / SORENSON COMMUNICATIONS



PE firms: Sorenson Communications is controlled by Ariel Alternatives, with minority stakes retained by KKR and Blackstone Credit. ZP Better Together was owned by Kinderhook Capital Partners from 2015 to 2025.

Investors in Kinderhook included Arizona State Retirement System: \$40 million. [See Appendix B for more ownership information].

Business: Video-relayed sign language interpretation for deaf Americans

Regulatory Scenario:

- FCC increased rates 30-49% (2023)
- Projected 65% pay increase over five years

Worker Complaints:

- Significant pay/benefit improvements not yet realized
- High stress, poor mental health support reported

Current Status: ZP sold to digital service provider Teleperformance (2025)

F. Private Equity in Prison Healthcare

Prisoners and patients share a limited ability to exercise consumer choice when the quality of services declines. The business at the intersection between these two sectors has been attractive to PE investors, and has been prone to allegations of abuse. Prison healthcare is chronically underfunded. And its contractual structure—where providers are typically paid on a per-prisoner basis—creates financial incentives that can lead to underinvestment in care. This payment model distorts medical decision-making under any ownership structure, and it needs to be seriously reconsidered. The two leading players in this space, Wellpath and YesCare, have long histories of private equity control. Each was driven into bankruptcy by a torrent of medical malpractice claims.

1. Wellpath: Over 1,500 lawsuits alleging substandard care

H.I.G. Capital formed Wellpath in 2018 by merging Correction Care Solutions with Correction Medical Group Companies. Each of its predecessors had an active legal docket, and Wellpath continued this pattern. In Maine, a class action filed in 2019 alleged that Wellpath denied hepatitis C medication to over 500 inmates. In New Mexico, the family of Frankie Graham alleged that he died in an Albuquerque jail cell in 2022 after spending nearly a week caked in vomit and excrement. US Justice Department investigations in Massachusetts and California during 2020 and 2021 concluded that Wellpath had failed to properly monitor prisoners experiencing mental health crises, and sometimes denied treatment in favor of solitary confinement. The accumulated pressures of these and other legal claims could not be sustained indefinitely.

With over 1,500 pending lawsuits for poor medical care, Wellpath filed for bankruptcy in late 2024. The bankruptcy proceedings revealed [an unusual and complex set of insurance arrangements](#) that the nonprofit Worth Rises argues was wholly inadequate. In spring 2025, Wellpath agreed to pay a \$15.5 million settlement to junior creditors, including those who alleged they received substandard medical care, and exited bankruptcy. Junior creditors now own a one-third stake in the company, with H.I.G. Capital retaining majority control.⁷⁷

The fundamental question raised by cases like Wellpath is not whether private entities can provide prison healthcare, but rather how to structure contracts, insurance, oversight, and funding mechanisms that ensure adequate care for prisoners under any operational model.

WELLPATH



PE Firm: H.I.G. Capital (2018 - 2024)

Investor Information: Not available

Quality Issues:

- 1,500 pending malpractice suits at bankruptcy
- Denied Hepatitis C medication to 500+ Maine inmates
- Justice Department probes found violations of prisoners' rights

F. Private Equity in Prison Healthcare

2. YesCare: Over 1,000 lawsuits alleging substandard care

Wellpath's primary competitor in correctional healthcare, YesCare, has experienced similar challenges. Under its previous name of Corizon Health, YesCare was owned by a series of PE firms: Flacks Group (2020 to 2023), Blue Mountain Capital (2017 to 2020), and Beecken Petty O'Keefe & Company (2008 to 2017). Controversy has stalked the company under every owner.

To take one extreme example, New York state investigators concluded that Corizon's care contributed to twelve inmate deaths at the Rikers Island jail in the years leading up to 2015.⁷⁸ To take another, Corizon provided only [a single psychiatrist for 400 mentally ill detainees](#) at a Georgia facility. The accumulation of bad publicity resulted in Corizon losing 60% of its contracts between 2015 and 2021. By the end of 2021, it faced over 1,000 lawsuits for substandard care.

In 2022, the company restructured, placing its viable assets and contracts into an entity called YesCare, while consolidating its debt and legal liabilities under the name Tehum Care Services. Tehum subsequently entered bankruptcy in 2023 in Texas. Nine Democratic senators attacked YesCare for employing this form of restructuring, widely known as the "Texas two-step," arguing that it would shield the company from full accountability for mistreating incarcerated patients.

In March 2025, a bankruptcy judge [approved a plan](#) under which Tehum will pay at least \$25 million to medical claimants, while allowing 12 medical claimants to opt out of the deal and continue pursuing their lawsuits against YesCare.⁷⁹ Given the situation he inherited, the judge described the plan as an innovation that would benefit the medical claimants. But policymakers need to think hard about a system that generated over a thousand malpractice claims against each of the market leaders in prison healthcare.

**YESCARE
(FORMERLY CORIZON HEALTH)**



PE Ownership:

- **Flacks Group (2020-2023)**
- **Blue Mountain Capital (2017-2020)**
- **Beecken Petty O'Keefe & Company (2008-2017)**

Investor Information: Not available

Quality Issues:

- Over 1,000 pending malpractice suits at bankruptcy
- 1 psychiatrist for 400 mentally ill detainees (Georgia)
- Contributed to a dozen deaths at Rikers Island jail

"Texas Two-Step" Bankruptcy:

- Healthy assets moved to YesCare (2022)
- Debt/liabilities kept under Tehum Care Services
- Tehum entered bankruptcy (2023) to avoid accountability

Current Status: Owned since 2024 by family office Perigrove Capital

IV. Solutions

“Responsible investment is a uniquely powerful tool in private equity—for both general and limited partners.”

The systematic problems documented in our case studies make a compelling case for reform that harnesses PE capital and expertise while keeping the focus on patient care.

We begin this section by examining the design of the most prominent federal and state legislation. Then, after a respectful review of the PE industry’s lobbying record, we brainstorm legal approaches that don’t rely on new legislation, including some tactics that are newly established and some that are aspirational. Finally, we discuss the crucial role that may be played by the many private equity firms and institutional investors who are genuinely committed to responsible investment.

The Legislative Landscape

Federal Bills. At the federal level, two proposals offer frameworks for improving accountability in healthcare investments, though both face political headwinds in the current environment.

The “[Stop Wall Street Looting Act](#),” most recently reintroduced in November 2024 by Senator Elizabeth Warren, proposes structural changes to private equity accountability. This bill would restore a more direct link between control and responsibility by making controlling PE firms (but not limited partners) jointly and severally liable for the debt and legal obligations of companies they control.⁸⁰ It would also mandate comprehensive

financial reporting, requiring PE firms to disclose financial data about their funds and loans, including fees and returns.

A companion proposal, the “[Corporate Crimes Against Healthcare Act](#),” was inspired by the experience of Steward Healthcare. This bill aspires to hold PE firms accountable when their financial engineering seriously imperils medical institutions. If a PE firm or its portfolio executives were to take actions that directly contribute to serious financial distress at a healthcare organization, prosecutors could claw back their earnings and impose civil penalties. Executives whose actions lead to a patient’s death could be charged with a crime.⁸¹ The bill would also require health facilities to disclose financial data and report ownership changes.⁸²

Both proposals would address sale-leasebacks by banning Medicare or Medicaid payments to institutions that engage in new sale-leaseback deals—a provision that responds directly to several case studies in this report.

While these ideas currently have limited support, they establish a range of possibilities for future action. In the meantime, Congress has signaled a surprising level of bipartisan interest in healthcare investment oversight.

Bipartisan Federal Oversight.

Hospital closures affect entire communities, and no lawmaker wants their local hospital to close. The Senate Budget Committee offers evidence that the political parties can come together on this issue. Its 2025 report, [“Profits Over Patients: The Harmful Effects of Private Equity on the U.S. Healthcare System,”](#) represents a meaningful step toward collaborative solutions. Overseen by Senators Charles Grassley (R-IA) and Sheldon Whitehouse (D-RI), the report questions the “compatibility of private equity’s profit-driven model with the essential role hospitals play in public health.” But it sees this conflict as surmountable—calling for “reforms to ensure that PE-driven financial strategies in healthcare do not come at the expense of patient well-being or the sustainability” of weak hospitals.⁸³

This bipartisan call is being answered at the state level, for instance by the Pennsylvania House of Representatives, where [nearly a third of Republicans](#) joined the full Democratic caucus in June to pass a PE healthcare reform bill, which now awaits action in the state Senate.

State-level Innovation. States have emerged as the most promising venues for healthcare investment oversight, with several developing new approaches to balance investment attraction with patient protection.⁸⁴ As of mid-October, the National Academy for State Healthcare Policy tracker of [2025 State Legislation to Lower Health System Costs](#) tallied 48 bills addressing transparency in 30 states, and 102 bills addressing consolidation in 32 states plus the District of Columbia. Of course, interest group lobbying creates significant obstacles—making the bills that succeed in passing, or just miss, of special interest.⁸⁵

In 2021, Oregon pioneered a creative new template for healthcare transaction review. [Oregon H.B. 2362](#) authorized the state health authority to review major healthcare deals in the state, and to block them on broad

public interest grounds, or impose conditions driven by public health policy. This pathbreaking approach only recently survived a federal appellate legal challenge by the Oregon Hospital Association.⁸⁶

By imposing meaningful conditions on healthcare transactions—whether the buyer is a non-profit, a PE consortium, or another for-profit venture—states can improve the quality of care while maintaining access to private capital. Such an approach will create competitive advantages for PE firms that develop expertise in meeting high standards for patient care.

Healthcare deal review laws gathered momentum after the National Academy for State Health Policy issued an updated [model bill](#) in 2024.⁸⁷ The following year, New Mexico enacted this model in an amendment to its [Healthcare Consolidation Oversight Act](#). Now, the New Mexico Healthcare Authority may only approve a significant healthcare deal if the parties prove that the deal will benefit the public and improve health outcomes; will not be on balance anticompetitive; and will not significantly erode the availability, accessibility, affordability, or quality of care. If the deal is approved, the owners must file three annual reports showing they have met any conditions imposed by the state.⁸⁸

Massachusetts passed its own new law following a public outcry over the Steward hospital system’s collapse (and a media outcry over the initial failure to respond to the public outcry.)⁸⁹ Signed into law at the start of 2025, Massachusetts [H. 5159](#) was perhaps most notable for banning future sale-leasebacks of main campus buildings at acute care hospitals, and establishing controlling-entity liability for Medicare or Medicaid fraud. It also increased reporting requirements to the state Health Policy Commission. That commission may seek an impact analysis before any hospital or essential service is closed, or to gauge the impacts of a new deal on healthcare cost, quality and access. Then the health regulators may refer their

findings to the state attorney general to challenge the deal on health policy grounds. While this law represents a compromise—notably, the broad health policy commission did not gain the power to veto a transaction or to cap the ratio of debt to cash flow—it provides a solid foundation to build upon.

Oregon, New Mexico, and Massachusetts are among 17 states that review healthcare deals, and several have recently strengthened that process.⁹⁰ But most states are primarily fortifying their notice and reporting requirements. For now, New Mexico and Oregon are exceptional in giving the power of halting deals to *healthcare regulators*, rather than leaving that power in the hands of an elected attorney general, who may be more susceptible to political influence.

A pair of closely-watched healthcare review bills – both spurred by the Prospect hospital system’s collapse – narrowly failed in California and Pennsylvania in 2024. The Pennsylvania bill passed in the state House, only to languish in the Republican-controlled state Senate. Even more disappointing to reformers, the California bill passed both chambers – only to be vetoed by Governor Gavin Newsom.⁹¹

Ultimately, Gov. Newsom signed a watered-down version in October 2025. California, too, gives a state health policy office the power to review deals and refer its findings to the AG.⁹² But California did not widely expand its AG’s enforcement and monitoring powers, as Massachusetts did. Most crucially, the California AG may not sue to stop a deal on broad health policy grounds.

Reintroduced in 2025, Pennsylvania [H.B. 1460](#) would empower the state AG to block PE and other for-profit firms from buying an interest in a healthcare facility when it’s “against the public interest,” unless it’s the only way to keep the facility open. Deals would be deemed “against the public interest” if they significantly reduce quality of care,

access to care, or competition, if they significantly promote price inflation or deceptive practices—or if they lead to sale-leasebacks. The de facto ban on sale leasebacks shows how the public interest standard in such a bill may be defined flexibly to impose specific conditions on healthcare deals.

Governor Josh Shapiro campaigned for the bill at a visit to Crozer Chester Medical Center a week after the hospital closed, with fiery rhetoric that swept much more broadly than the bill.

“Private equity has no place in our healthcare system,” Shapiro said. “We’ve seen what happens when corporate raiders like Prospect Medical Holdings prioritize profits over patients—families lose access to care, healthcare workers lose their jobs, and communities across the Commonwealth suffer. Private equity raided Crozer, lined their pockets, and gutted the system, leaving Chester

residents and those living in the region without care, putting their lives at risk. We cannot allow for-profit companies to treat our hospitals like piggy banks they can smash and walk away from. We’ve taken action to help those affected—but to protect communities across our Commonwealth, we need to take real action and change the laws that allow private equity to raid our healthcare system and threaten Pennsylvanians’ livelihoods. It’s time to act and get this done.”⁹³

Shapiro’s rhetoric, and the strongly bipartisan vote that followed in the Pennsylvania House, should prod the PE industry to self-regulate, because obstruction will not delay legislation forever. At the same time, reformers should recall that the most aggressive bills have made little progress—whether in Congress, or in Minnesota, where lawmakers failed to obtain a ban on PE in healthcare.⁹⁴ Rachel Linn Gish of Health Access

California blames the narrow failure of her state’s 2024 bill on “the private equity folks” fighting it every step of the way.⁹⁵ Her frustration highlights the need to engage the industry in developing workable solutions.

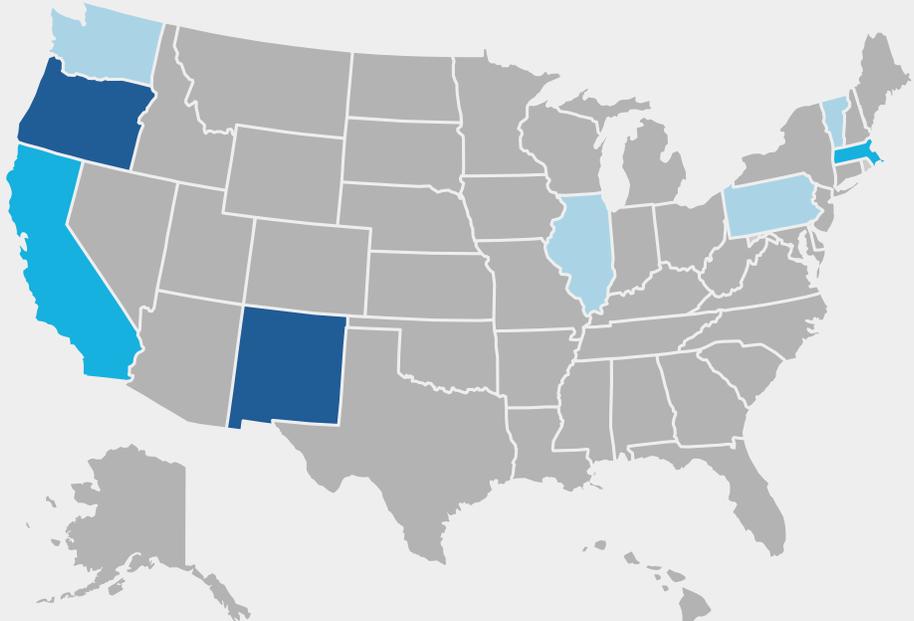
Meanwhile, the fight continues, state by state. Like Pennsylvania, Illinois and Washington are debating whether to give their AGs the power to shut down healthcare deals on broad public interest grounds.⁹⁶ Vermont, for its part, is debating giving such power to its healthcare agency, dubbed the Green Mountain Care Board.⁹⁷ In mid-2025, Maine enacted a one-year moratorium on PE firms or real estate investment trusts buying a stake in a Maine hospital, while it designs a permanent solution.⁹⁸

Political Advocacy. In recent years, partners in the most successful private equity firms have accumulated significant wealth. According to Ludovic Phalippou at Oxford’s Said

State Action Map

States that are taking action on PE healthcare oversight

- States that give their health policy agencies the power to halt healthcare transactions. (NM, OR)
- States that give their health policy agencies the power to review healthcare transactions (MA, CA)
- States that are debating the passage of broad healthcare review statutes (IL, PA, VT, WA)



Sources: Oregon [H.B. 2362](#) (2021); New Mexico [H.B. 586](#) (2025); Massachusetts [H. 5159](#) (2025); California [AB 1415](#) (2025); Illinois [S.B. 1998](#) (2025); Pennsylvania [H.B. 1460](#) (2025); Vermont [H. 71](#) (2025); Washington [S.B. 1881](#) (2025).

Business School, the number of multi-billionaires who made their fortunes in private equity grew from three in 2005 to 22 in 2020.⁹⁹ According to this Center’s research, that number has since jumped to at least 59 in 2025 [see Appendix A]. Like other successful business leaders, some PE industry leaders have used their wealth to participate in the political process.

The private equity industry—like any other—engages in policy advocacy on issues affecting its operations. In an example from outside healthcare, Roark Capital’s Inspire Brands, which franchises the Dunkin’ and Sonic fast food chains, was part of the opposition to [the 2021 effort in Congress to create a \\$15 hourly minimum wage](#).¹⁰⁰ The Private Equity Stakeholder Project found virtually no support in the PE world for a \$15 minimum wage, identifying no PE firms and only one small portfolio company committed to this wage level.¹⁰¹

At the same time, the industry’s lobbyists have protected the generous tax treatment of private equity compensation. The federal tax code allows PE executives to be taxed at lower capital gains rates, rather than ordinary income rates, under the so-called “carried interest loophole.” Polling suggests that [over three-quarters of Americans](#) consider this policy unfair.¹⁰² However, industry advocates have staved off its repeal since 2007, even though Presidents Barack Obama, Joe Biden, and Donald Trump have all favored repeal. As a candidate in 2016, Trump [pledged](#) that “we will eliminate the carried interest deduction and other special interest loopholes that have been so good for Wall Street investors, and for people like me, but unfair to American workers.” Despite Trump [remaining committed to this position](#) in his second term, the “Big Beautiful Bill” excluded carried interest reform in all of its official versions.

In the healthcare realm, PE lobbyists toiled to defeat a ban on “surprise billing,” in an effort to shape public opinion that drew critical press

coverage. *The New York Times* reported that KKR and Blackstone portfolio firms funded an advocacy group on the issue without publicly disclosing their involvement. “Doctor Patient Unity” spent \$54 million on an advertising campaign that characterized surprise billing reform as a “first step toward socialists’ Medicare-for-all dream.”¹⁰³ In the end, such efforts could only forestall and limit surprise billing reform.

More recently, some PE firms have benefited from nursing home advocates delaying a Biden-era rule that healthcare economists believe would save a significant number of lives.¹⁰⁴ [The Penn Leonard Davis Institute of Health Economics](#) projected that a 2024 rule setting a minimum staffing ratio for nursing homes could prevent 13,000 deaths annually.¹⁰⁵ But the enacted version of President Trump’s “Big Beautiful Bill,” influenced by nursing home lobbyists, delayed that staffing mandate by a full ten years.¹⁰⁶ Unsatisfied, nursing home CEOs donated about \$4.8 million to a Trump political action committee; and the administration met the industry’s demand for an outright revocation of the staffing mandate.¹⁰⁷

Industry advocacy reflects democracy in action when it is balanced by public interest advocacy in a transparent policy process. Good policy emerges from the balancing of all valid concerns. Lobbying’s power underscores the importance of transparent policymaking (as opposed to letting donors secretly draft a bill). It also reinforces the wisdom of public interest advocates playing the game and fighting their corner. At the same time, a healthy respect for the PE lobby’s power may motivate some public interest advocates to pursue legal solutions that don’t rely on new legislation. We explore a few such approaches below.

Other Legal Approaches

Enforcing Competitive Markets.

Antitrust provides regulators with flexible tools to allay market concen-

tration through the interpretation of existing legal frameworks. This approach enabled the Biden administration to reset industry expectations for the consolidation of medical practices by PE firms. A pair of pathbreaking settlements show how antitrust can guard against market dominance without undermining beneficial investment.

JAB Consumer Partners reached an agreement with the Federal Trade Commission to divest some veterinary clinics as a condition of acquiring the Ethos veterinary network, and to seek approval for future such purchases.¹⁰⁸ Similarly, Welsh, Carson, Anderson, & Stowe agreed to limit its board supervision of U.S. Anesthesia Partners and obtain approval before acquiring additional anesthesia practices.¹⁰⁹ These healthy precedents allow PE firms to pursue their investment strategy while keeping markets competitive.

Enhanced Investor Accountability.

The US Department of Justice has pushed for PE accountability in healthcare cases where evidence demonstrates significant firm involvement in portfolio company misconduct. Between 2020 and 2022, DOJ sought to hold PE investors liable in at least three healthcare cases. In each instance, strong evidence linked the PE firm to its portfolio firm’s compliance failures. And in each case, the PE firm agreed to pay a portion of its portfolio firm’s settlement.

The most instructive example involves H.I.G. Capital and South Bay Mental Health Centers. According to the DOJ, the PE firm discovered fraudulent medical billing before buying the business but did not fix the problem for two years.¹¹⁰ H.I.G. Capital and H.I.G. Growth Partners ultimately paid nearly \$20 million of a \$25 million settlement—showing that PE investors can be held accountable when they have actual knowledge of misbehavior by a business they own.

Enhanced accountability for

directors. There is precedent for a judge to hold portfolio company directors liable for breaching their fiduciary

duties when they place the interests of the PE firm first. The Delaware Court of Chancery has held that [the board of a portfolio company must prioritize the interests of all shareholders](#) over the controlling investment firm's narrow interests.¹¹¹ This ruling arose in a venture capital context. But the principle of protecting minority shareholders might readily form the basis for damages suits against directors who favor PE owners over non-PE owners.¹¹²

Of course, this precedent is of no use when a PE fund holds a 100% stake in a company. Under current corporate law, a company's directors generally owe a fiduciary duty only to shareholders. Some lawmakers and legal scholars advocate for extending fiduciary duties to protect customers, employees, and communities, particularly in essential service sectors like healthcare. Absent legislation, common law judges should consider broadening the fiduciary duties of company directors over time to encompass the interests of all stakeholders.

Corporate Structure and

Accountability. Traditional corporate structures that shield parent entities from portfolio company liabilities face growing scrutiny in the health-care context. Current standards for "piercing the corporate veil" require plaintiffs to demonstrate exceptionally close ties between corporate entities, with courts typically interpreting liability shields narrowly.¹¹³

State legislatures could establish more appropriate liability frameworks for healthcare investments, while common law could gradually develop more flexible veil-piercing standards. These changes would encourage PE firms to develop stronger operational oversight systems rather than hiding behind structural liability protections.

Having brainstormed all sorts of legal approaches, we come now to the crucial arena of voluntary, investor-led solutions.

Investor-led Solutions

Healthcare Investor Responsibility.

Responsible investment is a uniquely powerful tool in the field of private equity—for both general and limited partners—because PE firms often control portfolio firms, and PE firms often depend on institutional investors.

A responsible PE firm must obviously use due diligence and monitoring to avoid buying or operating firms with harmful business models (like billing fraud). But then comes the hard part. In healthcare, a responsible PE firm must also moderate its own business model. Above all, it must avoid financial strategies that may erode the quality of care, or bankrupt a vital institution.

Pension funds also play a key role in values-based PE investment, and they have already begun to tighten their ethical standards in PE spheres outside healthcare. Last year, the New York State Common Retirement Fund adopted "[Responsible Workforce Management Policy and Principles](#)," calling on PE firms to encourage their portfolio companies to respect international labor rights.¹¹⁴ For its part, CalPERS has incorporated labor principles into its [Governance & Sustainability Principles](#), including commitments to eliminate child and forced labor.

A CalPERS managing director [told Pensions & Investments](#) that labor concerns have driven it to cut some funding commitments by up to 70% or decline a new PE investment altogether—demonstrating how pension funds can drive industry improvement.¹¹⁵ Now investors need to take similar steps in the domain of PE healthcare investment.

Developing healthcare-specific

investment standards. Institutional investors can drive healthcare investment excellence by establishing sector-specific guidelines in their Limited Partnership Agreements. These standards can encourage PE

firms to develop specialized health-care expertise while maintaining focus on sustainable returns.

Healthcare investment commitments should address financial sustainability, quality care maintenance, community benefit, and stakeholder engagement, creating competitive advantages for firms that develop genuine health-care expertise.

In the recommendations section, this report outlines the framework that PE firms and their investors should develop in a Limited Partnership Agreement designed for the health sector.

Industry leadership opportunities.

The most sustainable path forward involves collaboration between responsible PE firms and institutional investors to develop industry standards that work for all stakeholders. Forward-thinking PE firms have opportunities to demonstrate leadership by embracing enhanced accountability mechanisms, developing specialized healthcare expertise, and supporting reasonable oversight frameworks.

This approach creates competitive advantages for firms committed to healthcare excellence while encouraging industry-wide improvement. Rather than viewing enhanced standards as constraints, responsible PE firms can position themselves as leaders in sustainable healthcare investment, attracting institutional capital from investors seeking both strong returns and positive impact.

The goal is to create an ecosystem where PE's capital and operational expertise genuinely serve healthcare's fundamental mission of improving patient outcomes and community health, supported by oversight and accountability mechanisms that benefit all stakeholders.

V. Conclusion and Recommendations

“
The sustainability of
PE in healthcare depends
on choosing proactive
collaboration over
reactive resistance.”
”

This report documents the tension between healthcare's public service mission and investment strategies that prioritize financial optimization. The documented consequences—including nursing home mortality increases and hospital closures—demonstrate the human cost when healthcare is treated purely as a financial commodity, without adequate safeguards.

The central challenge going forward is to develop private equity approaches to healthcare that successfully balance investor returns with patient welfare and community benefit. Current financial engineering practices—like sale-leasebacks, dividend recapitalizations, and strategic bankruptcies—often deplete the resources needed for quality medical care. These practices require fundamental modification in healthcare contexts.

The encouraging news is that solutions exist at every level. Federal legislation could establish clearer accountability by linking PE firms more directly to their portfolio companies' obligations. State governments can implement transaction review processes and transparency requirements. Antitrust enforcement can prevent excessive market consolidation while preserving opportunities for efficient investment. Most importantly, PE firms and their institutional investors can adopt ethical guidelines, and public pensions can proactively adopt healthcare-specific standards that create competitive advantages while ensuring patient protection.

The private equity industry stands at an inflection point in healthcare investment. The case studies presented in this report demonstrate both the

risks of applying standard PE practices to healthcare without modification and the potential for developing specialized approaches that serve all stakeholders effectively.

Healthcare is not like other industries. When private equity fails in retail or manufacturing, companies go bankrupt, and jobs are lost. When private equity fails in healthcare, patients die, and entire communities lose access to life-saving services. This fundamental difference demands a fundamentally different approach.

The most sustainable path forward involves collaboration among private equity firms, institutional investors, healthcare professionals, patient advocates, and policymakers to develop industry standards that work for all stakeholders. The evidence presented in this report provides a comprehensive foundation for action. The regulatory tools, investor leverage, and industry best practices needed to transform private equity healthcare investment already exist or are rapidly developing. The choice facing the private equity industry is whether to lead this transformation by developing specialized healthcare expertise and embracing appropriate oversight, or to wait for external pressure to impose less flexible regulatory constraints.

The health and safety of American patients, and the long-term sustainability of private equity's role in healthcare, depend on choosing proactive collaboration over reactive resistance. This report provides a clear roadmap for action. The evidence is clear, the solutions are available, and the opportunity for positive leadership is immediate.

Recommendations for Patient-Centered PE Healthcare Reform

A. Recommendations to Private Equity General Partners

Private Equity firms should adopt Responsible Healthcare Investment Policies that include the following elements:

- **Make full and ongoing public disclosures** regarding your portfolio healthcare firms' finances – including the private debt on their balance sheets – as well as their owners, employees, patient/customer outcomes, patient/customer satisfaction, and other service quality metrics.
- **Refrain from sale-leaseback transactions or debt-funded dividends.** New financial obligations, whether to service debt or to pay rent on property that was formerly owned, leave portfolio firms vulnerable to revenue downturns, to which the healthcare sector is prone. These practices are the common threads uniting most of the bankruptcies addressed in this report.
- **Maintain a maximum ratio of debt to cash flow that is appropriate to the subsector,** with the ratio based on consulting a range of subsector experts. For context, publicly traded health systems maintain an average debt to cash flow ratio of about 2.2x.¹¹⁶ Non-profit health systems maintain an average ratio of about 4.4x.¹¹⁷ Accordingly, as a starting point for discussion, we would propose a maximum ratio of 5x for hospitals and other healthcare facilities. Putting a ceiling on the debt level would alleviate pressure to erode the quality of care by reducing staff or wages, and ultimately closing the healthcare facilities on which the community depends.
- **Refrain from cutting essential health services, closing healthcare facilities, reducing staff, or reducing wages,** except in exigent circumstances with the permission of regulators. (Buyers of distressed assets may devise a plan to reach profitability in consultation with regulators).
- **Exercise ongoing due diligence** to avoid operating portfolio companies that engage in socially harmful business practices.
- **Set up means of redressing problems when they are identified.** As a matter of best practice, portfolio firms may wish to appoint patient care advocates¹¹⁸ in every relevant facility; and to develop systems for obtaining patient or customer feedback to assess satisfaction with the quality of care or services. Several studies confirm that patient surveys improve the quality of care.¹¹⁹
- **Report back annually to your limited partners, lenders, and insurers** on your adherence to these responsible healthcare policies, your due diligence findings, and your follow-up.

B. Recommendations to Limited Partners, Lenders, and Insurers

There are two ways that limited partners can address the same set of issues. First, they may adopt their own Responsible Healthcare Policies, much as the New York State Common Retirement Fund has adopted a “[Responsible Workforce Management Policy](#),” or CalPERS has incorporated labor principles into its [Governance & Sustainability Principles](#).¹²⁰

Second, before agreeing to participate in a PE fund, institutional investors may seek responsible commitments as a condition of signing their Limited Partnership Agreement, consistent with their fiduciary obligations.¹²¹ Of course, pension trustees will be constrained to some degree by a strict fiduciary duty to maximize financial return, because they are investing retirement funds. To be most meaningful, such commitments should be substantive, sector-specific, and binding throughout the life of the fund.

Lenders may seek similar responsible commitments as conditions of a Loan Agreement that they sign with a private equity group making a healthcare acquisition.

Insurers may seek similar responsible commitments as conditions of a Directors & Officers Liability Agreement signed with a private equity or PE portfolio firm active in healthcare.

Civic-minded PE firms should welcome the negotiation of all agreements or side letters that codify the parties’ pro-social commitments and preserve their reputation in the community.

C. Recommendations to the US Government

The US government should enact a package of laws responding to the most egregious healthcare failures tied to private equity investment. This legislation should include the following general or subsector-specific elements:

General policies

- **Discourage new sale-leaseback transactions or debt-funded dividends** by making healthcare businesses that engage in these risky practices ineligible for payments from government healthcare programs.
- **Make a controlling entity liable for its portfolio company’s violations of the federal False Claims Act** (covering fraud in Medicare, Medicaid, and similar programs), so long as the investor was aware of the misconduct and failed to report it within 60 days.
- **Require private equity firms to report to the US Securities and Exchange Commission** the financial data for their funds, loans, and portfolio companies, including their investors, fees, returns, and ownership stakes. Private equity firms that do not comply should lose the access to 401(k) retirement accounts recently ordered by President Trump.¹²² Private equity funds and portfolio firms are now exempt from reporting obligations, even if a private equity is publicly traded and therefore obliged to disclose at the level of the holding company. The reliance of private equity firms on capital from public pension funds—and now 401(k) accounts—underscores that they are not meaningfully “private,” and they merit greater public scrutiny.

Subsector-specific policies

- **Establish minimum ratios of nurses to patients** in both hospitals and nursing homes, as urged by the American Nurses Association.¹²³ In hospitals, a recent Oregon law provides suitable ratios for each of 12 acute care specialties.¹²⁴ In nursing homes, the standard should be set by the Centers for Medicare & Medicaid Services staffing rule,¹²⁵ which was recently rescinded by the Trump administration (See pp. 29.) According to the Penn Davis Institute of Health Economics, merely restoring the nursing home staffing mandate could save 13,000 lives a year.¹²⁶
- **Close the biggest loophole in the 2020 “No Surprises Act”**—which ended surprise out-of-network bills in most medical contexts—by extending the ban to ground ambulances. Absent federal action, the 36 states that have not yet done so should enact laws to achieve the same goal. This reform has also been urged by the Commonwealth Fund.¹²⁷
- **Fix the worst market distortion in prison healthcare.** Ban government contracts that incentivize under-treatment by paying prison health providers on a *per-prisoner* basis. This would clear the way for contracts that instead align profit with health outcomes.¹²⁸

D. Recommendations to State Governments

States have emerged as promising venues for healthcare investment oversight. Absent federal action, states should adapt local versions of each of the provisions proposed above for Congress. For instance, state legislatures should establish controlling-entity liability for billing fraud under each state False Claims Act, following the lead of Massachusetts.¹²⁹

But a state’s most powerful potential policy lever is the review of in-state healthcare deals. By imposing clear conditions on healthcare transactions, states can improve the quality of care while maintaining access to private capital. Such an approach will create competitive advantages for PE firms that develop expertise in meeting high standards for patient care.

The National Academy for State Health Policy offers a [model bill](#) empowering state attorneys general or health officials to block healthcare deals, updating an approach pioneered by Oregon in 2021.¹³⁰ In 2025 New Mexico adopted a similar law, Massachusetts enacted a relatively strong compromise version, and California enacted a weaker compromise version.¹³¹ Comparable bills are pending in Illinois, Washington, Vermont, and Pennsylvania.¹³² For more details, see pp. 27-28.

State legislatures should empower state health regulators or attorneys general to block or condition the acquisition of any healthcare business in their state, based on broad public interest criteria—for example, preserving the availability, accessibility, affordability, and quality of care. Approval should be needed for any direct or indirect acquisition of a material stake in a state healthcare facility, or healthcare business unit of any kind.

An ideal healthcare review law, as in Oregon and New Mexico, will give the power of vetoing transactions to a state health agency, which is apt to be more expert and less susceptible to political influence. Although most such bills focus on the purchase of healthcare facilities and medical practice groups, an ideal bill will capture the full range of healthcare businesses. Although many such bills target private equity or for-profit buyers, an ideal bill will follow the National Academy for State Health Policy in targeting all buyers—demanding the same conditions from private capital investors, publicly-traded companies, and non-profits.

Recommendations for Patient-Centered PE Healthcare Reform

States also should use the leverage provided by deal reviews to impose specific conditions—in the same way that the Pennsylvania bill defines a deal as “against the public interest” if it would lead to a sale-leaseback. Indeed, states may use their approval power to demand the same set of patient-centered conditions that PE firms may embrace in their Responsible Healthcare Policies, or that institutional investors may demand in a responsible Limited Partnership Agreement. Accordingly, a state’s AG or health agency should make approval of a local healthcare deal contingent on the acquirors’ commitment to:

- **Make full and ongoing public disclosures** regarding their finances, as well as their ownership, human capital, and service quality metrics. The National Academy for State Health Policy offers a [model bill for transparency in hospital systems](#).¹³³
- **Refrain from sale-leaseback transactions** or debt-funded dividends.
- **Maintain a maximum ratio of debt to cash flow** that is appropriate to the subsector, with the ratio based on a consultation with a range of experts in the subsector. As noted in our recommendations for investors, we would propose a maximum ratio of 5x for hospitals and other healthcare facilities, subject to further consultation.
- **Refrain from cutting essential health services**, closing facilities, reducing staff, or reducing wages, except in exigent circumstances with the permission of state regulators.
- **Exercise ongoing due diligence** to avoid operating portfolio companies that engage in socially harmful business practices; and redress problems when they are identified.

If they are allowed to proceed with their purchase, the new owners of the healthcare business should file an annual report showing that they continue to meet the state’s conditions.

Appendices

A. Methodology for Appendix A: Private Equity Multibillionaires

Data Sources

The primary source for constructing the billionaire dataset was the Forbes World's Billionaires List 2025, which provides net worth estimates, country of residence, and principal sources of wealth. To verify the accuracy of billionaire involvement in private equity, secondary sources such as company websites and financial media were consulted.

Data Cleaning and Standardization

- To align with the broader research scope, only US-based billionaires were included in the dataset.
- A cutoff of USD \$2 billion in net worth was applied, excluding individuals below this level to maintain a focus on those with the most significant financial influence. In addition, a cutoff of USD \$2 billion allows for consistent comparison with the base findings published by the Oxford finance scholar Ludovic Phalippou in the Journal of Investing (Dec. 2020). Phalippou counted three PE multibillionaires in 2005, and 22 in 2020.
- Only individuals whose primary business activities center on private equity were included; those whose wealth derives mainly from adjacent industries such as venture capital, hedge funds, or other asset management vehicles were excluded.

Limitations

While the dataset was constructed with careful attention to accuracy, certain limitations remain:

- Forbes' billionaire rankings are based on market valuations, shareholdings, and available disclosures, which may fluctuate daily and may not fully capture private or illiquid assets.
- Not all billionaires' private equity involvement could be independently confirmed; in these cases, only those with verifiable connections were retained in the dataset.
- By focusing solely on U.S.-based billionaires with a net worth of \$2 billion or above, the dataset does not account for ultra-high-net-worth individuals below this threshold or those based outside the United States.

B. Methodology for Appendix B: Investors in Controversial PE Healthcare Deals

Data Sources

The LP dataset was compiled primarily through three industry-standard databases: PitchBook, Bloomberg, and S&P Capital IQ. These sources provide coverage of institutional investors and their commitments to private equity funds. PitchBook served as the central reference point because of its comprehensive coverage of LP commitments, while Bloomberg and S&P Capital IQ were used as supplementary sources to cross-check and enhance data completeness.

Data Cleaning and Standardization

- Where commitment amounts or investor details differed across databases, PitchBook was treated as the authoritative source, as Bloomberg itself frequently cited PitchBook as its underlying reference.
- To ensure the dataset remained comprehensive, LPs listed in Bloomberg but absent from PitchBook were included and marked with an asterisk (*) to denote their source.
- For full transparency, LPs that exited the fund, or entered only after the leveraged buyout occurred have been clearly marked.
- In order to maintain focus, private pension funds and insurance companies were excluded from the dataset. The emphasis was placed instead on public pensions, sovereign wealth funds, endowments, foundations, and other major institutional investors that disclose commitments more consistently.
- All fund commitments have been reported in USD, unless specified otherwise.

Limitations

- Some LP commitments are not publicly disclosed, meaning the dataset may underrepresent private or smaller LPs.
- There may be discrepancies in the investment amounts presented in the dataset, primarily because public pension fund transparency varies significantly across jurisdictions. Data sources used here sometimes rely on secondary reporting and may not be directly confirmed by institutional filings.

Appendix A: Private Equity Multibillionaires

Name	Company	Net worth
Stephen Schwarzman	Blackstone	44.4
Leon Black	Apollo Global Management	14.9
George Roberts	KKR	14.7
Henry Kravis	KKR	13.3
Antony Ressler	Apollo Global Management	11.4
Robert F. Smith	Vista Equity Partners	10.8
Josh Harris	Apollo Global Management	9.9
Michael Kim	MBK Partners	9.8
Orlando Bravo	Thoma Bravo	9.8
Tom Gores	Platinum Equity	9.4
Ramzi Musallam	Veritas Capital	9.2
Jonathan Gray	Blackstone	8.9
Michael Dorrell	Stonepeak	8.5
Marc Rowan	Apollo Global Management	7.5
Justin Ishbia	Shore Capital Management	5.1
Stephen Feinberg	Cerberus Capital Management	5
James Coulter	TPG Capital	4.9
Hamilton James and family	Blackstone	4.6
Carl Thoma	Thoma Bravo	4.4
Steven Klinsky	New Mountain Capital	4.4
José E. Feliciano	Clearlake Capital	4.4
Behdad Eghbali	Clearlake Capital	4.4
Daniel D'Aniello	Carlyle	4.4
Neal Aronson	Roark Capital Group	4.1
William Conway, Jr.	Carlyle	3.9
Scott Crabill	Thoma Bravo	3.8
David Rubenstein	Carlyle	3.8
Seth Boro	Thoma Bravo	3.7
Holden Spaht	Thoma Bravo	3.7
Byron Trott	BDT & MSD Partners	3.7
J. Tomilson Hill	Blackstone	3.5
Jonathan Nelson	Providence Equity Partners	3.4
C. Dean Metropoulos	C. Dean Metropoulos & Co.	3.4
Lawrence Golub	Golub Capital BDC Inc	3.3
Ronald Burkle	The Yucaipa Companies	3.3
Wesley Edens	Fortress Investment Group	2.9
Doug Ostrover	Blue Owl Capital	2.9
Fernando de Leon	Leon Capital Group	2.8
Stephen Deckoff	Black Diamond Capital Management	2.8
Barry Sternlicht	Starwood Capital Group	2.8
Gerald Ford	Ford Financial Fund	2.7
Scott Nuttall	KKR	2.6
David Golub	Golub Capital BDC Inc	2.5
Joseph Bae	KKR	2.4
Bruce Karsh	Oaktree Capital Management	2.4
Bennett Rosenthal	Ares Management	2.3
David Adelman	Darco Capital	2.3
Kenneth Hao	Silver Lake Technology Management	2.3
Egon Durban	Silver Lake Technology Management	2.3
David Kaplan	Ares Management	2.2
Adebayo Ogunlesi	Global Infrastructure Partners	2.2
Howard Marks	Oaktree Capital Management	2.2
Antonio Gracias	Valor Equity Partners	2.2
Alec Gores	The Gores Group	2.1
Mark Lipschultz	Blue Owl Capital	2.1
James Dinan	York Capital Management	2.1
Michael J. Arougheti	Ares Management	2.1
Michael Rees	Blue Owl Capital	2
David Hoffmann	Hoffmann Family of Companies	2

Appendix B: Investors in Controversial PE Healthcare Deals

Portfolio Company	Investor	Initial Investment Deal Completed Date	Fund	LPs of the Fund with Amount Invested
LifePoint Health	Apollo Global Management	11/16/2018	Apollo Investment Fund VIII	<p>1199SEIU Healthcare Employees Pension Fund (\$11m)</p> <p>Adams Street 2016 US Fund</p> <p>American Electric Power System Retirement Plan (\$25m)</p> <p>American Federation of Musicians and Employers' Pension Fund and Subsidiary (\$10m)</p> <p>American United Life Insurance Company (\$5m)</p> <p>Amitim Pension Funds</p> <p>Anne Arundel County Retirement and Pension System (\$20m)</p> <p>Arizona State Retirement System (\$85m)</p> <p>ATP Private Equity Partners IV (\$50m)</p> <p>Brederode (\$23.7m*)</p> <p>British Columbia Investment Management</p> <p>Building Laborers Local 310 Pension Fund</p> <p>California Public Employees' Retirement System (\$80m)</p> <p>Canada Pension Plan Investment Board* (\$991.8m)</p> <p>Colorado Public Employees' Retirement Association (\$80m)</p> <p>Colorado School Division Pension (\$80m)</p> <p>Colorado Trust (\$5m)</p> <p>Connecticut Retirement Plans and Trust Funds (\$125m)</p> <p>Connecticut State Employees Retirement System (\$125m)</p> <p>David C. Copley Foundation</p> <p>Directors Guild of America - Producer Pension Plan Basic Benefit Plan† (\$8m)</p> <p>Directors Guild of America - Producer Pension Plan Supplemental Benefit Plan (\$8m)</p> <p>Essex County Council Pension Fund (\$15.80m)</p> <p>Florida Retirement System* (\$200m)</p> <p>Florida Retirement System Pension Plan</p> <p>Florida State Board of Administration (\$200m)</p> <p>Forest Preserve District Employees' Annuity and Benefit Fund of Cook County* (\$15m)</p> <p>Fort Worth Employees' Retirement Fund* (\$10m)</p> <p>Goldman Sachs Foundation (\$9m)</p> <p>Greater Kansas City Laborers Pension Plan</p> <p>Griffith R. Harsh, IV and Margaret C. Whitman Charitable Foundation</p> <p>Houston Police Officers' Pension System (\$15m)</p> <p>Hudson-Webber Foundation (\$3m)</p> <p>John Hancock (\$0.30m)</p> <p>Kansas City Public School Retirement System (\$60m)</p> <p>Kansas Public Employees Retirement System (\$160m)</p> <p>Kansas Retirement System for Judges (\$60m)</p> <p>Laborers' International Union of North America (\$12m)</p> <p>Landmark Equity Partners IV</p> <p>LIUNA National (Industrial) Pension Fund (\$12m)</p> <p>LIUNA Staff and Affiliates Pension Fund (\$12m)</p> <p>Los Angeles City Employees' Retirement System (\$40m)</p> <p>Los Angeles Department of Water and Power Employees' Retiree Health Benefits Fund (\$6m)</p> <p>Los Angeles Fire and Police Pension System† (\$25m)</p> <p>Los Angeles Water & Power Employees' Retirement Plan* (\$34m)</p> <p>Louisiana State Employees' Retirement System (\$70m)</p> <p>Lowell Milken Family Foundation</p> <p>Manton Foundation (\$1m)</p> <p>Maryland State Retirement and Pension System (\$220m)</p> <p>Michigan Department of Treasury</p> <p>Municipal Employees' Retirement System of Michigan* (\$100m)</p> <p>Municipal Police Employees Retirement System</p> <p>National Elevator Industry Pension Plan</p>

* sourced from Bloomberg † former investor/exited ‡ joined fund after LBO

Portfolio Company	Investor	Initial Investment Deal Completed Date	Fund	LPs of the Fund with Amount Invested
Steward Healthcare	Cerberus Capital Management	11/06/2010	Cerberus Institutional Partners International	California State Teachers' Retirement System (\$122.25m) Hall Family Foundation Michigan State University* Mitzi and Warren Eisenberg Family Foundation† Pennsylvania Public School Employees' Retirement System* (\$200m) Public Service Enterprise Group Master Retirement Trust Sam and Marilyn Fox Foundation† (\$12m) Sidney E. Frank Foundation Susan & Leonard Feinstein Foundation Teachers Insurance and Annuity Association of America† (\$26m) The Annie E. Casey Foundation The Robert Wood Johnson Foundation*
Prospect Medical Holdings	Leonard Green & Partners	12/15/2010	Green Equity Investors IV	Ardian Bank of America Bessemer Trust Caisse de dépôt et placement du Québec California Public Employees' Retirement System† (\$150m) Conversus Capital LP Danske Private Equity Employees' Retirement System of the State of Hawaii† (\$5.70m) Energy Super* Fire & Police Pension Association of Colorado† Florida Retirement System (\$100m) Florida State Board of Administration† Goldman Sachs Private Equity Partners 2002 (\$14m) Hamilton Lane (\$440m) Howard University Employees' Retirement Plan (\$2m) I.A.M. National Pension Fund† Illinois Municipal Retirement Fund† (\$4.75m) Kentucky Public Pensions Authority (\$67.50m) Kentucky Retirement Systems Insurance Fund (\$7.50m) Lexington Capital Partners Los Angeles Fire and Police Pension System† (\$5.34m) Mesirow Partnership Fund II (\$10m) Michigan Department of Treasury† (\$100m) National Union Fire Insurance Company of Pittsburgh (\$2.40m) New Mexico State Investment Council† (\$25m) New York State Common Retirement Fund† (\$75m) Nordea Thematic Fund of Funds I K/S†* (\$10m) Oregon Public Employees Retirement System† (\$100m) Pantheon International PLC* Permanent University Fund* Philadelphia Board of Pensions and Retirement (\$10m) Philadelphia Municipal Retirement System (\$10m) Public Employee Retirement System of Idaho† (\$20m) Rhode Island State Investment Commission† (\$15m) Robeco Robert Wood Johnson Foundation (\$27m) Saga I K/S* Saga II K/S* Saga IV K/S* shaPE Capital Fund† (\$4.50m) State of Michigan Retirement Systems† State Universities Retirement System† (\$8.60m) StepStone Private Wealth United Food & Commercial Workers International Union - Industry Pension Fund University of Texas Investment Management Company (\$25m) Washington State Investment Board (\$100m) Washington State Retirement System (\$100m)*

* sourced from Bloomberg † former investor/exited ‡ joined fund after LBO

Portfolio Company	Investor	Initial Investment Deal Completed Date	Fund	LPs of the Fund with Amount Invested
LifePoint Health	Apollo Global Management	11/16/2018	Apollo Investment Fund VIII	<p>National Grid USA Companies Final Average Pay Pension Plan</p> <p>National Railroad Retirement Investment Trust</p> <p>New Mexico Educational Retirement Board (\$50m)</p> <p>New York City Board of Education Retirement System (\$20m)</p> <p>New York City Employees' Retirement System (\$140m)</p> <p>New York City Fire Department Pension Fund (\$40m)</p> <p>New York City Police Pension Fund (\$100m)</p> <p>New York State Common Retirement Fund (\$400m)</p> <p>Niagara Mohawk Pension Plan (\$7m)</p> <p>North Carolina Retirement Systems (\$220m)</p> <p>Northwest Center for Reproductive Sciences</p> <p>Oklahoma Law Enforcement Retirement System (\$10m)</p> <p>Oklahoma Police Pension and Retirement System (\$7.50m)</p> <p>OMIGSA International Private Equity Fund of Funds II*</p> <p>Ontario Teachers' Pension Plan Board</p> <p>Oregon Investment Council (\$300m)</p> <p>Oregon Public Employees Retirement System (\$300m)</p> <p>Orgeon Common School Fund (\$25m)</p> <p>Pennsylvania Public School Employees Retirement System (\$220m)</p> <p>PensionDanmark</p> <p>Public Employee Retirement System of Idaho (\$40m)</p> <p>Reading Health System Pension Plan</p> <p>Regents of the University of California (\$75m)</p> <p>Robert Wood Johnson Foundation (\$47m)</p> <p>RWB Global Market Fonds International III*</p> <p>RWB Global Market Fonds International V*</p> <p>San Antonio Fire & Police Pension Fund (\$15m)</p> <p>San Bernadino County Employees' Retirement Association* (\$4.7m)</p> <p>San Francisco Employees' Retirement System (\$50m)</p> <p>Santa Barbara County Employees Retirement System (\$10m)</p> <p>Sheet Metal Works Pension Fund of Local Union No.19</p> <p>Sisters of Charity of Leavenworth Health System Inc*</p> <p>South Yorkshire Pensions Authority (\$12m)</p> <p>State of Michigan Retirement Systems</p> <p>State of Wisconsin Investment Board† (\$150m)</p> <p>State Teachers Retirement System of Ohio (\$100m)</p> <p>StepStone Private Wealth</p> <p>Teacher Retirement System of Texas† (\$850m)</p> <p>Teachers Retirement System of the State of Illinois (\$250m)</p> <p>Teachers' Retirement System of Louisiana (\$125m)</p> <p>Teachers' Retirement System of the City of New York (\$200m)</p> <p>The ATP Group</p> <p>Tower Health (\$5m)</p> <p>United Food & Commercial Workers International Union - Industry Pension Plan</p> <p>UPS Group Trust*</p> <p>Virginia Retirement System (\$230m)</p> <p>William & Elaine Kaplan Family Charitable Foundation</p>

* sourced from Bloomberg † former investor/exited ‡ joined fund after LBO

Portfolio Company	Investor	Initial Investment Deal Completed Date	Fund	LPs of the Fund with Amount Invested
LifePoint Health	Apollo Global Management	6/1/2021	Apollo Investment Fund IX	<p>1199SEIU Healthcare Employees Pension Fund*</p> <p>AlpInvest Partners BV*</p> <p>Amitim Pension Funds</p> <p>Anne Arundel County Retirement and Pension System (\$28m)</p> <p>Arizona State Retirement System (\$90m)</p> <p>ASP 2022 Aspire II</p> <p>ATP Private Equity Partners V (\$50m*)</p> <p>Baltimore County Employees' Retirement System* (\$16m)</p> <p>Banner Health*</p> <p>Brederode* (\$24.2m)</p> <p>California Public Employees Retirement System (\$550m)</p> <p>California State Teachers' Retirement System (\$300m)</p> <p>Cockrell Foundation</p> <p>Colorado Public Employees' Retirement Association (\$100m)</p> <p>Colorado School Division Pension (\$100m)</p> <p>Connecticut Retirement Plans and Trust Funds (\$125m)</p> <p>Connecticut State Employees Retirement System (\$125m)</p> <p>CPP investments† (\$750m)</p> <p>Cummings Foundation, Inc.</p> <p>Directors Guild of America-Producer Pension Plan Basic Benefit Plan</p> <p>Directors Guild of America-Producer Pension Plan Supplemental Benefit Plan</p> <p>Employees' Retirement System of Baltimore County (\$16m)</p> <p>Employees' Retirement System of the State of Hawaii (\$50m)</p> <p>Essex County Council Pension Fund (\$14.76m)</p> <p>Florida Retirement System* (\$200m)</p> <p>Florida Retirement System Pension Plan</p> <p>Florida State Board of Administration (\$200m)</p> <p>Forest Preserve District Employees' Annuity and Benefit Fund of Cook County* (\$16m)</p> <p>Fort Worth Employees Retirement Fund* (\$7.50m)</p> <p>Griffith R. Harsh, IV and Margaret C. Whitman Charitable Foundation</p> <p>Haverford College*</p> <p>Hawaii Employer-Union Health Benefits Trust Fund (\$42m)</p> <p>Hillsdale College*</p> <p>Kansas City Public School Retirement System (\$64m)</p> <p>Kansas Public Employees Retirement System</p> <p>Kansas Retirement System for Judges (\$64m)</p> <p>Kapan Pensioner</p> <p>Keva</p> <p>LIQID Private Equity Vintage I GmbH and Co KG*</p> <p>Los Angeles Department of Water and Power Employees' Retiree Health Benefits Fund (\$11m)</p> <p>Los Angeles Department of Water and Power Employees' Retirement Plan (\$54m)</p> <p>Louisiana State Employees' Retirement System (\$85m)</p> <p>Maryland State Retirement and Pension System (\$270m)</p> <p>Michigan Department of Treasury</p> <p>Municipal Police Employees Retirement System</p> <p>National Elevator Industry Pension Plan</p> <p>National Grid USA Companies Final Average Pay Pension Plan</p> <p>National Railroad Retirement Investment Trust</p> <p>New Hampshire Retirement System (\$40m)</p> <p>New York City Board of Education Retirement System (\$32m)</p> <p>New York City Employees' Retirement System (\$256m)</p> <p>New York City Fire Department Pension Fund (\$52m)</p> <p>New York City Police Pension Fund (\$154m)</p> <p>New York State Common Retirement Fund (\$480m)</p>

* sourced from Bloomberg † former investor/exited ‡ joined fund after LBO

Portfolio Company	Investor	Initial Investment Deal Completed Date	Fund	LPs of the Fund with Amount Invested
LifePoint Health	Apollo Global Management	6/1/2021	Apollo Investment Fund IX	<p>New York State Teachers Retirement System, Inc.* (\$256m)</p> <p>Ohio Police & Fire Pension Fund (\$25m)</p> <p>Oklahoma City Employee Retirement System (\$6.50m)</p> <p>Oklahoma Law Enforcement Retirement System (\$8.50m)</p> <p>Oklahoma Police Pension & Retirement System (\$13m)</p> <p>Ontario Teachers' Pension Plan</p> <p>Oregon Public Employees Retirement Plan (\$480m)</p> <p>Oregon Public Employees Retirement System*</p> <p>Partners Group Global Value</p> <p>Pennsylvania Public School Employees Retirement System (\$225m)</p> <p>Pennsylvania State Employees' Retirement System (\$85.40m)</p> <p>Pension danmark Pensionsforsikring A/S*</p> <p>PFA</p> <p>Public Employee Retirement System of Idaho (\$50m)</p> <p>Reading Health System Pension Plan</p> <p>Regents of the University of California (\$135m)</p> <p>San Antonio Fire & Police Pension Fund (\$16m)</p> <p>Sands Family Supporting Foundation</p> <p>Santa Barbara County Employees Retirement System (\$10m)</p> <p>Shriners Hospitals for Children Inc*</p> <p>Sidney Kohl Family Foundation</p> <p>Sound Retirement Trust</p> <p>South Yorkshire Pensions Authority (\$22m)</p> <p>Southwest Carpenters Pension Trust</p> <p>St Paul's School*</p> <p>State of Michigan Retirement Systems (\$100m*)</p> <p>State Teachers Retirement System of Ohio† (\$225m)</p> <p>StepStone Private Wealth</p> <p>Teachers Retirement System of the State of Illinois (\$250m)</p> <p>Teachers' Retirement System of Louisiana (\$125m)</p> <p>Teachers' Retirement System of the City of New York (\$256m)</p> <p>The ATP Group</p> <p>The Hartford Retirement Plan for U.S. Employees</p> <p>The Spence School†</p> <p>Tower Health</p> <p>United Food & Commercial Workers International Union - Industry Pension Fund</p> <p>UPS Group Trust*</p> <p>Virginia Retirement System* (\$270m)</p> <p>Wartburg College*</p> <p>Wilburg and Hilda Glenn Family Foundation*</p>

* sourced from Bloomberg † former investor/exited ‡ joined fund after LBO

Portfolio Company	Investor	Initial Investment Deal Completed Date	Fund	LPs of the Fund with Amount Invested
Air Medical Group	KKR, Ardian (listed under Global Medical Response)	04/24/2015	KKR North America Fund XI	<p>Astrea III Pte Ltd (\$38.60m)</p> <p>Booth Ferris Foundation</p> <p>California State Teachers' Retirement System (\$170m)</p> <p>Charles J. Lynn Trust</p> <p>CPP Investments (\$300m)</p> <p>Hess Foundation†</p> <p>Hess Philanthropic Fund</p> <p>John Hancock (\$56m)</p> <p>Lincoln M Knorr Residuary Trust 4411206000</p> <p>Maine Public Employees Retirement System (\$30m)</p> <p>Manton Foundation (\$10m)</p> <p>Mary D. Clapham Charitable Trust (\$0.50m)</p> <p>Massachusetts Pension Reserves Investment Trust (\$100m)</p> <p>Michigan Department of Treasury (\$125m)</p> <p>Naomi & Nehemiah Cohen Foundation</p> <p>Oregon Investment Council (\$250m)</p> <p>Oregon Public Employees Retirement System (\$500m)</p> <p>Paul E. Andrews Jr. Foundation (\$1m)</p> <p>Pomona Capital X</p> <p>Public Employee Retirement System of Idaho (\$30m)</p> <p>State of Michigan Retirement Systems</p> <p>Teacher Retirement System of Texas† (\$500m)</p> <p>The Rona Jaffe Foundation</p> <p>Washington State Investment Board† (\$500m)</p> <p>Washington State Retirement System (\$250m)"</p>
Air Methods	Ascribe Capital affiliated with American Securities	04/21/2017	American Securities Opportunities Fund III	<p>American Electric Power System Retirement Plan*</p> <p>American Federation of Musicians & Employers' Pension Fund*</p> <p>American Federation of Musicians and Employers' Pension Fund*</p> <p>Employees' Retirement System of the State of Hawaii* (\$35m)</p> <p>Essex County Council Pension Fund* (\$16.9m)</p> <p>Fire & Police Pension Association of Colorado*</p> <p>Fort Worth Employees Retirement Fund* (\$5m)</p> <p>Greater New York Pension Fund*</p> <p>Healthcare Employees Pension Fund*</p> <p>IAM National Pension Fund*</p> <p>Los Angeles City Employees' Retirement System* (\$30m)</p> <p>Los Angeles Fire and Police Pension System* (\$25m)</p> <p>Massachusetts Pension Reserves Investment Management* (\$100m)</p> <p>Public Employee Retirement System of Idaho* (\$30m)</p> <p>Santa Barbara County Employees' Retirement System* (\$10m)</p> <p>Sound Retirement Trust*</p> <p>Teachers' Retirement System of Louisiana* (\$75m)</p> <p>United Food and Commercial Workers International Union-Industry Pension Fund*</p> <p>Zurich Anlagestiftung*</p>

* sourced from Bloomberg † former investor/exited ‡ joined fund after LBO

Portfolio Company	Investor	Initial Investment Deal Completed Date	Fund	LPs of the Fund with Amount Invested
TeamHealth	Blackstone	11/23/2005	Blackstone Capital Partners IV	<p>1199SEIU Greater New York Pension Fund (\$15m) Absolute Private Equity† (\$30.80m) ACP Investment Group Adams Street 2015 Non-US Fund LP* Adams Street 2016 Non-US Fund LP* Adams Street Global Secondary Fund 5 LP* Adams Street Partnership Fund 2007 US (\$0.80m) Adams Street Partnership Fund 2008 US (\$12m) Administrative District Council 1 Pension Fund Alaska Retirement Management Board (\$40m) Bank of America Bessemer Trust Brighthouse Financial (\$7.20m) BVT-CAM Private Equity Global Fund GmbH & Co KG* (\$1.90m) BVT-CAM Private Equity Global Fund II GmbH & Co KG* (\$1.80m) BVT-CAM Private Equity New Markets Fund GmbH & Co KG* Caisse de dépôt et placement du Québec California Ironworkers Field Pension Trust California Public Employees' Retirement System† (\$200m) California State Teachers' Retirement System (\$215m) Carpenters Pension Trust Fund of St. Louis Central pension Fund of the IUOE & Participating Employers CIC Defined Contribution Retirement Plan City of Philadelphia Municipal Pension Fund* (\$20m) Clark University* Co-Op Retirement Plan Colorado Public Employees' Retirement Association† (\$150m) Colorado School Division Pension (\$150m) Conversus Capital LP* CPP Investments (\$200m) CSFB Strategic Partners III† CSFB Strategic Partners III LP* District of Columbia Retirement Board (\$15.23m) EMA Alternatives CalPERS Employees' Retirement System of the State of Hawaii (\$5m) Energy Super* Fire & Police Pension Association of Colorado† Fresno County Employees' Retirement Association (\$20m) General Motors Co* Georgia Tech Foundation* Gerard B Lambert Foundation GIC Private Goldman Sachs Private Equity Partners 2000 (\$12m) Goldman Sachs Private Equity Partners 2000 Management Fund Goldman Sachs Private Equity Partners 2002 (\$9m) Hamilton Lane (\$730m) Harbourvest Partners VI-Buyout (\$64m) HarbourVest Partners VIII-Buyout Houston Firefighters' Relief and Retirement Fund (\$20m) Howard University* Howard University Employees' Retirement Plan (\$4m) Illinois Municipal Retirement Fund† (\$5m) Indiana Public Employees' Defined Benefit Account (\$6.48m) Indiana Public Retirement System (\$6.48m) Indiana State Teachers' Retirement System (\$7m) International Brotherhood of Teamsters Union Local 710 Pension Fund† Invesco Partnership Fund III (\$9m) Iowa Public Employees' Retirement System (\$50m) Johns Hopkins University* JPEL Fund JPEL Private Equity Kansas City Cement Masons Pension Fund† LA84 Foundation Lexington Capital Partners VII Local 73 Retirement Fund</p>

* sourced from Bloomberg † former investor/exited ‡ joined fund after LBO

Portfolio Company	Investor	Initial Investment Deal Completed Date	Fund	LPs of the Fund with Amount Invested
TeamHealth	Blackstone	11/23/2005	Blackstone Capital Partners IV	<p>Los Angeles County Employees' Retirement Association (\$75m + \$5m added in 2012)</p> <p>Los Angeles Fire and Police Pension System (\$4.63m)</p> <p>Lumina Foundation</p> <p>Massachusetts Pension Reserves Investment Trust (\$75m)</p> <p>Medical Trust*</p> <p>Memorial Sloan-Kettering Cancer Center*</p> <p>Mesirow Partnership Fund II (\$10m)</p> <p>Michigan Department of Treasury (\$175m)</p> <p>Minnesota State Board of Investment (\$70m)</p> <p>National Union Fire Insurance Company of Pittsburgh (\$23.90m)</p> <p>NB Crossroads Fund XVIII LP*</p> <p>Nevada Public Employees' Retirement System (\$10m)</p> <p>New York City Board of Education Retirement System† (\$34.42m)</p> <p>New York City Employees' Retirement System (\$40m)</p> <p>New York City Fire Department Pension Fund (\$15m)</p> <p>New York City Fire Department Pension Fund†</p> <p>New York City Police Pension Fund (\$50m)</p> <p>New York City Public Pension Funds (\$135m)</p> <p>New York State Common Retirement Fund (\$300m)</p> <p>New York State Teachers' Retirement System† (\$100m)</p> <p>NG DB MT Alternative Investments Fund</p> <p>ODDO BHF Group</p> <p>Ohio Public Employees Retirement System (\$175m)</p> <p>Old Copper Company*</p> <p>PA Arconic Inc†*</p> <p>Pennsylvania State Employees' Retirement System (\$75m)</p> <p>Pension Benefit Guaranty (\$10m)</p> <p>Philadelphia Board of Pensions and Retirement (\$20m)</p> <p>Philadelphia Municipal Retirement Systems (\$20m)</p> <p>Pipe Fitters Retirement Fund Local 597</p> <p>Plumbers & Pipefitters Local Unions 502 and 633 Pension Trust Fund</p> <p>Pomona College†*</p> <p>Princeton Theological Seminary*</p> <p>Public Employees' Retirement System of Nevada* (\$10m)</p> <p>Rasmuson Foundation (\$9m)</p> <p>Regents of the University of California (\$50m)</p> <p>Retail Clerks Specialty Stores Pension Plan (\$3m)</p> <p>Rhode Island State Investment Commission† (\$25m)</p> <p>Robert Wood Johnson Foundation (\$41m)</p> <p>Sal Oppenheim Private Equity Partners†</p> <p>San Diego County Employees' Retirement Association (\$15m)</p> <p>San Francisco Employees' Retirement System (\$35m)</p> <p>Schroder Private Equity Fund of Funds II PLC* (\$10m)</p> <p>Secondary Opportunities Fund II LP*</p> <p>Security Health Plan of Wisconsin (\$8.40m)</p> <p>SheetMetal Local 36 Pension Fund</p> <p>Sherman Fairchild Foundation*</p> <p>Sound Retirement Trust</p> <p>South Dakota Investment Council†</p> <p>South Dakota Retirement System†</p> <p>State of Michigan Retirement Systems</p> <p>State Teachers Retirement System of Ohio† (\$50m)</p> <p>StepStone Private Wealth†</p> <p>Structural Iron Workers Local #1 Pension Plan† (\$14m)</p> <p>Teacher Retirement System of Texas (\$200m)</p> <p>Teachers Insurance and Annuity Association of America (\$69m)</p> <p>Teachers' Retirement System of the City of New York (\$30m)</p> <p>The California Endowment</p>

* sourced from Bloomberg † former investor/exited ‡ joined fund after LBO

Portfolio Company	Investor	Initial Investment Deal Completed Date	Fund	LPs of the Fund with Amount Invested
American Physician Partners	Brown Bros Harriman Capital Partners, Brentwood Capital Advisors	01/18/2017	BBH Capital Partners V	Louis Calder Foundation* Merseyside Pension Fund* (\$18.60m) New England Teamsters and Trucking Industry Pension Fund* Travelers Casualty and Surety Co*
Envision Healthcare	KKR	10/11/2018	KKR Americas Fund XII	Almenni Pension Fund Ardian Primary Fund VII (\$30m) Ardian Secondary Fund VI (\$146.13m) ASF VI LP* Berco Ltd* (\$200k) Birta lífeyrissjóður (\$6.21m) Blue Coast Private Equity (\$7.50m) Caisse de dépôt et placement du Québec California Public Employees' Retirement System (\$750m) California State Teachers' Retirement System (\$300m) California State University Foundation (\$1m) Carnegie Institute* Celebar Investments (\$5m) Chicago Teachers' Pension Fund (\$25m) Compagnie Financiere Montchoisi (\$12.53m) CPP Investments (\$300m) Credit Suisse Anlagenstiftung 2. Saule (\$8m) Crown Global Secondaries III (\$10m) Domino Invest† (\$5m) Dover Street IX (\$6.26m) Dover Street IX LP* Festa lífeyrissjóður (\$5m) Financiere Moliere (\$1m) Fred L. Emerson Foundation Gemeinschaftsstiftung der Zellweger Luwa (\$5m) Gildi lífeyrissjóður (\$31.32m) Growth Value Securities (\$50m) HSBC Holdings (\$75m) Icelandic State Pension Funds (\$14.40m) Japan Bank for International Cooperation (\$90m*) Kentucky Teachers Medical Health insurance Trust (\$10m) Kentucky Teachers' Retirement System (\$50m) Kieger (Luxembourg) (\$12.53m) Koret Foundation LH PE (\$3.90m) Lífeyrissjóður starfsmanna rík* (\$14.40m) Linda Peace Foundation M. W. Murphy foundation Maine Public Employees Retirement System (\$60m) Manton Foundation (\$10m) Meyer Memorial Trust* Michigan Department of Treasury (\$200m) Minnesota State Board of Investment (\$150m) Misland Capital† (\$20m)

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Portfolio Company	Investor	Initial Investment Deal Completed Date	Fund	LPs of the Fund with Amount Invested
Envision Healthcare	KKR	10/11/2018	KKR Americas Fund XII	<p>Mizuho Bank (\$100m) Negaunee Foundation (\$2m) New York City Board of Education Retirement System (\$16m) New York City Employees' Retirement System (\$158m) New York City Fire Department Pension Fund (\$28m) New York City Police Pension Fund (\$75m) New York State Common Retirement Fund (\$600m) New York State Teachers Retirement Systems Inc* (\$223m) Oberthur Developpement (\$5m) Ocean Wilson Holdings Ophelia International Investments (\$10m) Oregon Investment Council (\$500m) Oregon Public Employees Retirement System (\$500m) Pantheon International (\$1.94m) Pantheon Securities† Partners Group (\$13m) Partners Group Global Value (\$10m) Partners Group Global Value 2014 (\$20m) Pension Fund of Commerce Personalvorsorgestiftung der Arzte und Tierarzte (\$5.50m) PH PE (\$7.10m) Pomona Capital X Primapen (\$20m) Public Employee Retirement System of Idaho (\$50m) Public School Teachers' Pension and Retirement Fund of Chicago (\$25m) Richard King Mellon Foundation Shear Family Foundation Shubert Foundation* Soparexo (\$10m) Stafir lifeyrissjoour (\$5m) Stapi Lifeyrissjoour (\$12.53m) State of Michigan Retirement Systems Sumitomo Mitsui Banking (\$50m) Teachers' Retirement System of the City of New York (\$223m) TfL Pension Fund (\$22m) The Spence School* University of Nebraska Foundation* Vhano-Lux (\$15m) VKR Holding (\$15m) Washington State Investment Board (\$750m) Washington State Retirement System* (\$750m)</p>

* sourced from Bloomberg † former investor/exited ‡ joined fund after LBO

Portfolio Company	Investor	Initial Investment Deal Completed Date	Fund	LPs of the Fund with Amount Invested
Center for Autism and Related Disorders	Blackstone	05/31/2018	Blackstone Strategic Capital Holdings	Alaska Permanent Fund† (\$500m) Forsta AP-fonden Michigan Department of Treasury Regents of the University of California (\$200m) Robert Wood Johnson Foundation State of Michigan Retirement Systems (\$125m*) State Teachers Retirement System of Ohio (\$100m) The Dow Chemical Co.
Sevita Health	Centerbridge Partners & Vistria Group	03/08/2019	Vistria Fund	Healthcare Service Corporation (\$25m) IDP Foundation Illinois Municipal Retirement Fund (\$75m*) Maryland State Retirement and Pension System (\$50m) M2 NY Pioneer Fund (\$15m) National Endowment for Financial Education* New York State Common Retirement Fund(\$15m) Pritzker Traubert Family Foundation Teacher Retirement System of Texas† (\$15m) United Student Aid Funds
Sequel Youth & Family Services	Altamont Capital Partners	08/31/2017	Altamont Capital Partners Fund II LP	Adams Street 2011 US Fund LP* Adams Street 2012 US Fund LP* Adams Street Global Secondary Fund 5 LP*
Numotion	AEA Investors, Ares Capital, Crescent Capital Group, Leavitt Equity Partners, LLR Partners	11/13/2018	Leavitt Equity Partners II	Apex Foundation Inova Health System Services* Semnani Foundation* Sentara Healthcare
Numotion	AEA Investors, Ares Capital, Crescent Capital Group, Leavitt Equity Partners, LLR Partners	11/13/2018	LLR Equity Partners IV	Alaska Retirement Management Board (\$10m) Arizona State Retirement System (\$50m) Colorado Public Employees' Retirement Association (\$50m) Colorado School Division Pension (\$50m) Employees' Retirement System of the State of Hawaii (\$15m) Maryland State Retirement and Pension System (\$75m) Ohio Public Employees Retirement System (\$200m) Pennsylvania Public School Employees Retirement System (\$200m) Pennsylvania State Employees' Retirement System (\$50m) Reinberger Foundation St. Andrew's School of Delaware Inc* The Sherman Fairchild Foundation

* sourced from Bloomberg † former investor/exited ‡ joined fund after LBO

Portfolio Company	Investor	Initial Investment Deal Completed Date	Fund	LPs of the Fund with Amount Invested
Apria Healthcare	AlpInvest Partners, Blackstone	10/28/2008	AlpInvest Partners Fund III - Mezzanine Investments	AlpInvest Partners The Carlyle Group
Apria Healthcare	AlpInvest Partners, Blackstone	10/28/2008	Blackstone Real Estate Partners V	Andrew W. Mellon Foundation Arconic Inc†* AT&T Inc* Blackstone Carnegie Mellon University* Colorado Public Employees' Retirement Association Colorado School Division Pension Commonwealth Fund (\$4m) Denison University* Gerstner Family Foundation Hackensack University Medical Center* Harold Alfond Foundation John R. Oishei Foundation J. Paul Getty Trust† (\$23m) J. N. Pew Jr. Charitable Trust* LA84 Foundation Kentucky Teachers' Retirement System†* Marathon Oil Company Thrift Plan (\$2m) Max M. & Marjorie S. Fisher Foundation (\$2m) Memorial Sloan-Kettering Cancer Center* Medical Trust* Michigan Department of Treasury Minnesota State Board of Investment (\$100m) Missouri State Employees' Retirement System (\$90m) New Jersey Division of Investment (\$75m) New York State Common Retirement Fund New York State Teachers' Retirement System (\$50m) North Carolina Retirement Systems (\$100m) Northwest Center for Reproductive Sciences Ohio Police & Fire Pension Fund (\$25m) Ohio Public Employees Retirement System (\$150m) Pennsylvania Public School Employees Retirement System (\$200m) Pennsylvania State Employees' Retirement System (\$50m) Philadelphia Board of Pensions and Retirement† (\$20m) Princeton Theological Seminary* Public School and Education Employee Retirement Systems of Missouri† Raytheon Co* Regents of the University of California† Robert Wood Johnson Foundation (\$17m) Southern California United Food & Commercial Workers Unions and Food Pension Fund* South Dakota Education Enhancement Trust Fund South Dakota Healthcare Trust Fund South Dakota Cement Pension Trust Fund* South Dakota Investment Council† South Dakota Retirement System† South Dakota School and Public Lands Fund State of Michigan Retirement Systems† State Teachers Retirement System of Ohio† (\$79.66m) St. Louis University* CSFB Strategic Partners III RE† Teacher Retirement System of Texas (\$150m) Teachers' Retirement System of Louisiana (\$75m) Texas Treasury Safekeeping, Co.* (\$1m) The Hearst Foundations (\$13m) The Kresge Foundation* The Pierre and Tana Matisse Foundation The University of South Dakota Foundation* The William Penn Foundation* TWDC Enterprises 18 Corp* United Jewish Communities of MetroWest New Jersey Pension Plan* United States Steel Corporation Plan for Employee Pension Benefits (Revision of 2003) (\$25m) United States Steel Plan for Retiree Insurance Benefits University of Kansas Endowment Association* UPS Retirement Plan (\$31m) Virginia Retirement System* (\$87.80m) Voya Financial† (\$2m) Wellcome Trust Young Men's Christian Association Retirement Fund*

* sourced from Bloomberg † former investor/exited ‡ joined fund after LBO

Portfolio Company	Investor	Initial Investment Deal Completed Date	Fund	LPs of the Fund with Amount Invested
ZP Better Together	Kinderhook Industries	02/05/2015	Kinderhook Capital Fund IV	Arizona State Retirement System (\$40m) Bankers Life and Casualty Company‡ (\$3.80m) Boy Scouts of America Master Pension Trust - Boy Scouts of America Retirement Plan for Employees Broyhill Family Foundation* Colorado Health Foundation Co-Op Retirement Plan Inasmuch Foundation Legacy Plan of the National Retirement Fund† Legacy Plan of The Unite Here Retirement Fund* Max M. & Marjorie S. Fisher Foundation Montana Board of Investments (\$20m) National Automatic Sprinkler Industry Pension Fund (\$4m) "
Sorenson Communications	Ariel Alternatives	04/04/2022	Project Black	Amgen Hobson Lucas Family Foundation JP Morgan Chase Lowe's Companies Merck & Co. Nuveen Qatar Investment Authority Steven Ballmer Walmart"
National Seating & Mobility	Cinven Partners	11/14/2019	Seventh Cinven Fund LP	Berkshire-Taconic Community Foundation* (€1.50m) Canada Pension Plan Investment Board* (€320.1m) Cassa Nazionale di Previdenza ed Assistenza a favore dei Dottori Commercialisti* Farmers Property and Casualty Insurance Co* Fresno County Employees' Retirement Association* (€7.40m) ICG Enterprise Trust PLS* (€200k) Idaho National Laboratory Employee Retirement Plan* Illinois State Board of Investment* (€37.40m) Keva* Landesbank Hessen-Thuringen Girozentrale* New York State Common Retirement Fund* (€281.10m) New York State Teachers Retirement System Inc* (€144.50m) Orange County Employees Retirement System* (€44.90m) Oregon Public Employees Retirement System* (€199.80m) Partners Group Global Value SICAV* Patria Private Equity Trust PLC* Private Equity Holding AG* (€5m) Public School and Education Employee Retirement Systems of Missouri* Santa Barbara County Employees' Retirement System* (€7.50m) School Employees Retirement System of Ohio* (€28.20m) Sherman Family Foundation* Sjatte AP-fonden* South Dakota Cement Pension Trust Fund* South Dakota Education Association* South Dakota Healthcare Association* South Dakota Retirement System* South Dakota School and Public Lands* Teacher Retirement System of Texas* (€220.60m) Tennessee Consolidated Retirement System* (€150.20m) Tredje AP-fonden* (€40m) Washington State Investment Board* (€293.10m) Washington State Retirement System* (€293.10m)

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