Private Equity Investments Continue to Shape the Healthcare Industry

Written By Laura Carabello

Private equity's focused rollout across the American healthcare industry is one of the most defining and consequential business stories in recent memory.

While the number of health services deals dipped in the first half of 2026, a midyear outlook report from PwC states that deal value has "remained resilient" as strategic acquirers and dealmakers "reprice risk." Analysts highlight how health services deal activity is evolving amid market pressures, emphasizing strategic focus, technology and portfolio optimization.

Amid geopolitical dynamics, policy, reimbursement uncertainty and ongoing pressure from the “SaaS apocalypse,” the health services market is feeling the weight of skyrocketing costs, labor shortages and compressed margins. While deal volume softened in Q1 as investors demand more proof points before committing, total value remained strong due to large transactions.

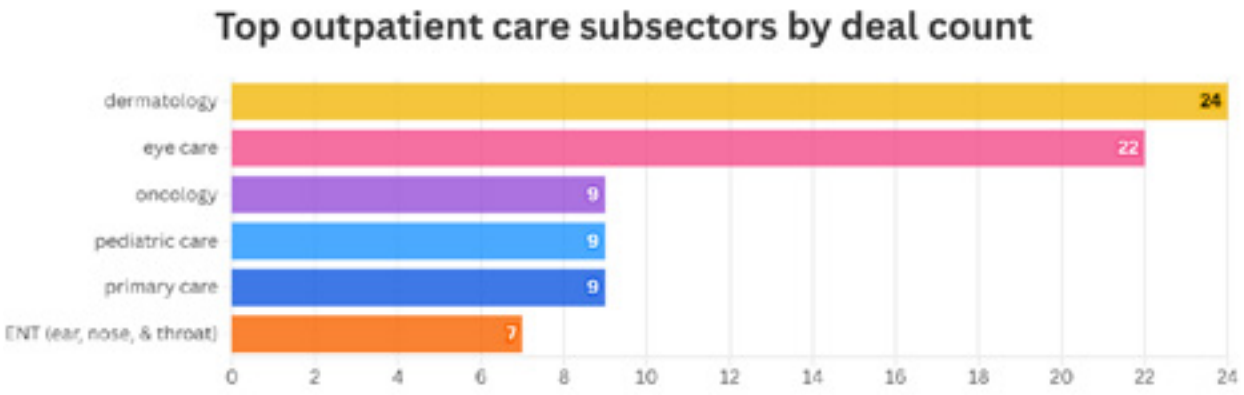
In the hospital space alone, by early 2024, private equity (PE) owned at least 386 hospitals — approximately 30% of all for-profit hospitals in the United States. What began as opportunistic investment in distressed hospitals has expanded into organized acquisitions of thousands of physician practices, urgent care chains, nursing homes, ambulatory surgical centers, emergency departments, hospices, behavioral health facilities, dental networks and more.

The Private Equity Stakeholder Project (PESP) recently documented that more than 500 healthcare facilities have joint ventures with PE-linked companies and anticipates more of those partnerships to be announced. Additionally, in its latest quarterly M&A report, healthcare advisory firm Kaufman Hall tallied 18 new hospital transaction announcements from April through June. This momentum is well ahead of the eight logged in the same window last year and comfortably above the average posted by the sector across the 2020s.

Overall investment dollars and transaction numbers for the broader healthcare marketplace are compelling:

- PESP reports that in 2025, PE firms completed 1,029 private equity-backed healthcare deals in the United States, consisting of 151 leveraged buyouts, 664 add-on acquisitions, and 214 growth investments, involving 420 platform companies and 708 investment firms. The most active healthcare subsectors they tracked included health IT (151 deals), dental care (149 deals), outpatient care (148 deals), medtech (117 deals), and behavioral health (56 deals). Home health and hospice, pharma services, and disability services also remained areas of notable private equity investment activity.
- Between 2000 and the present, the Center for American Progress reports that private equity investment in U.S. healthcare has grown from roughly $5 billion annually to an estimated $104 billion in 2024.

- PitchBook relates that elder care megadeals dominated Q1 2026 healthcare services PE activity.



Source: 2025 Private Equity Stakeholder Project

As in prior years, PESP recounts that add-on acquisitions accounted for the majority of healthcare deals, reflecting private equity firms' continued use of consolidation strategies to expand platform companies. In addition to buyouts, add-on acquisitions, and growth investments, PE firms increasingly relied on joint ventures with nonprofit health systems as a growth strategy, providing access to established brands and geographic markets they might not otherwise readily access.

A recent survey of leaders of private equity firms by McDermott Will & Emery and WSJ Intelligence, part of The Wall Street Journal, found that 40% of respondents had the most interest in investing in healthcare IT and telehealth in the next three years, followed by 37% interested in partnerships with large health systems. More than 30% were interested in investing in pharmaceuticals and biotechnology and physician practice management.

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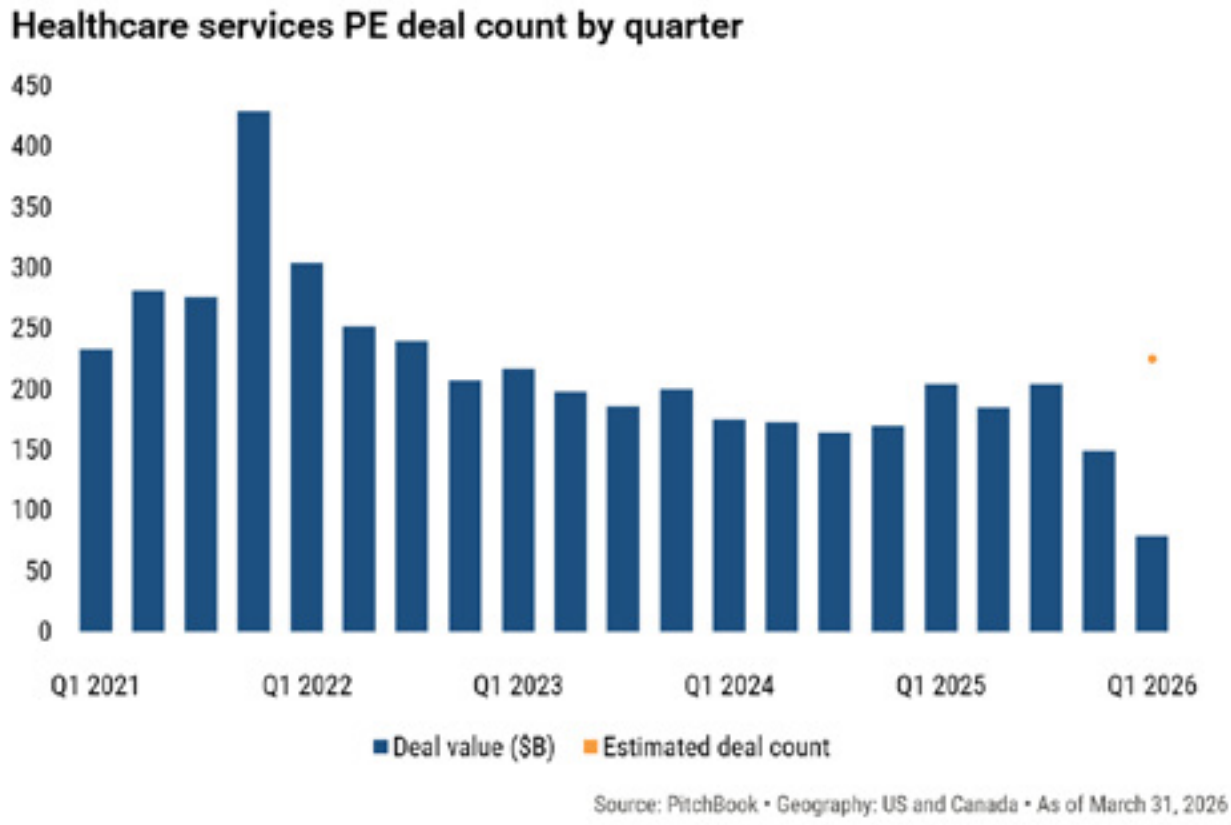


Healthcare services PE deal count declined 16% YoY in Q1 2026 from robust Q1 2025 levels, though analyst expects volumes to improve as the year progresses.

DEFINING PRIVATE EQUITY (PE) IN HEALTHCARE

PE is a form of for-profit ownership reflecting investment in healthcare facilities by private parties. PE firms use investor capital and borrowed funds to purchase healthcare facilities, with the goal of generating a high return on their investment by improving the facilities' operations and increasing their value before reselling, typically within three to seven years.

These acquisitions usually involve significant cost-cutting, management changes, and prioritization of revenue-generating services as key strategies to increase profitability and value. This short-term investment strategy is different from the strategies employed by venture capital firms, which typically invest earlier in a company's lifecycle and take a longer-term approach.

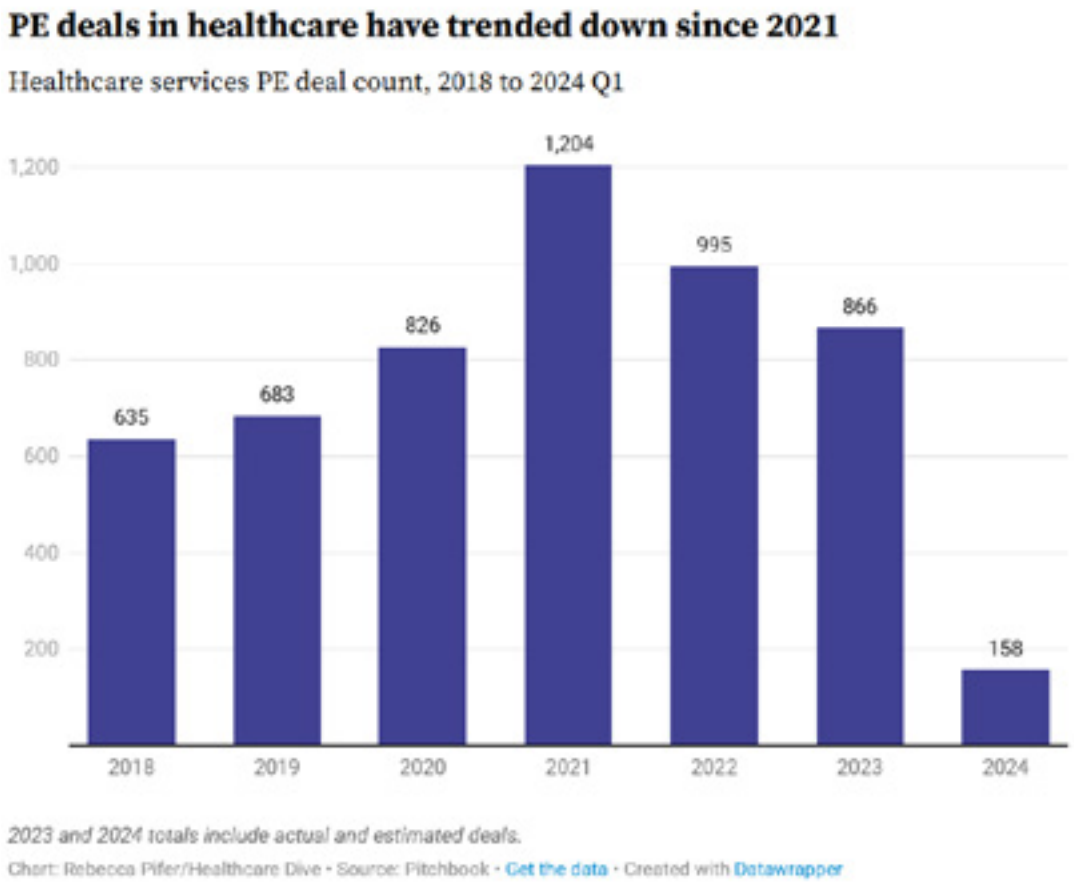
Source: 2025. The growth of private equity in US healthcare: Impact and outlook. NIHCM Foundation.

Health policy analysts at the Arkansas Center for Health Improvement cite several reasons that the healthcare sector is an attractive investment area for PE firms:

- It is often viewed as "recession-proof," meaning that healthcare systems are less vulnerable to the negative consequences of economic downturns than other industries because the demand for healthcare services will always exist.

- Many types of healthcare services also generate predictable and high-volume revenue streams, particularly in outpatient settings such as urgent care clinics, behavioral health facilities, and specialty physician practices.
- Many aspects of the healthcare sector have historically been fragmented into many small or independently owned providers. This fragmentation presents opportunities for private equity firms to consolidate these independent practices into larger, more efficient systems to generate increased revenue.
- Regulatory gaps and limited ownership transparency have fueled the growth of private equity transactions in healthcare, allowing these transactions to occur with minimal oversight at the state and federal levels.

The debate over PE in healthcare is fierce, often partisan and rarely nuanced, as the cumulative effect on self-insured employers who bear the direct financial risk of their employee health plans is rigorous, measurable and accelerating. The typical PE playbook is consistent across specialties as industry pundits say the goal is to generate high returns for investors in the fund, not necessarily to build long-term value. In a fund's portfolio, any one investment target need not survive in the end as long as the overall portfolio generates significant returns for its investors.



Trey Hinson, Founder, Goliath Sales Strategies, adds this perspective: "Any time you have an organization that gains a competitive position through acquisition or growth, they are going to push for increased reimbursements in this market or almost any other market. I think the maximization of profits, which has to be the goal obviously to your investors, adds to the efforts as well."

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Trey Hinson

With the continuing emergence of these high-performance networks though, there are options for self-funded groups, as he points out, "The largest problem for most TPAs is the effort that it takes to find the right broker distribution partners who are open to leaning into alternatives to the national PPO networks. This means as an industry, we must be stronger in presenting options and ensuring that our distribution channels can convey the reasons as to why this product fit may be stronger for some versus others."

PE CLOSES THE CAPITAL GAP

For those who live and work in the self-insured employer ecosystem, this influx of capital is not a distant Wall Street spectacle, as it is reshaping access, cost and quality of care in real time. Thoughtfully deployed PE investment can deliver genuine benefits to providers, payers and patients, particularly for self-insured stakeholders where flexibility and innovation are paramount.

Early on, PE firms recognized the opportunity to address undercapitalization in healthcare. The provider sector was operating on razor-thin margins, facing diminishing and delayed reimbursements, outdated infrastructure and the specter of compliance requirements.

Rajiv Sood

As Rajiv Sood, General Manager, Insurance & Risk, Evidium, Inc., explains, "This isn't really a story about PE; rather, it's a story about what happens when clinical knowledge isn't computable. When no one can objectively define what appropriate care for a given patient should cost, pricing gravitates toward whoever holds the most leverage. At Evidium, we're focused on changing that foundation. When cost and clinical dynamics are transparent and traceable, patients, employers, and providers can engage in something closer to an honest conversation."

For the provider segments, this translates directly into resources that were not readily accessible through conventional debt markets. Many smaller entities lacked the financial position to invest in Artificial Intelligence (AI) technology or digital health to modernize and improve patient care, streamline daily workflows and optimize financial operations. PE capital solves this dilemma.

Additional pressures on staffing ratios challenged even the most astute market performers. Research published in the Journal of Financial Economics by professors from Georgetown University and Indiana University reveals that PE-backed hospitals employ a higher ratio of doctors, nurses, and pharmacists compared to their non-PE counterparts. While PE acquisitions lead to overall workforce cuts, the core clinical workforce is prioritized.

The American Investment Council (AIC) points out that, "Private equity provides healthcare companies with access to capital markets, lines of credit, pools of managerial skills and experience in turnarounds. This critical investment lets doctors, nurses, and other healthcare providers focus on patient care."

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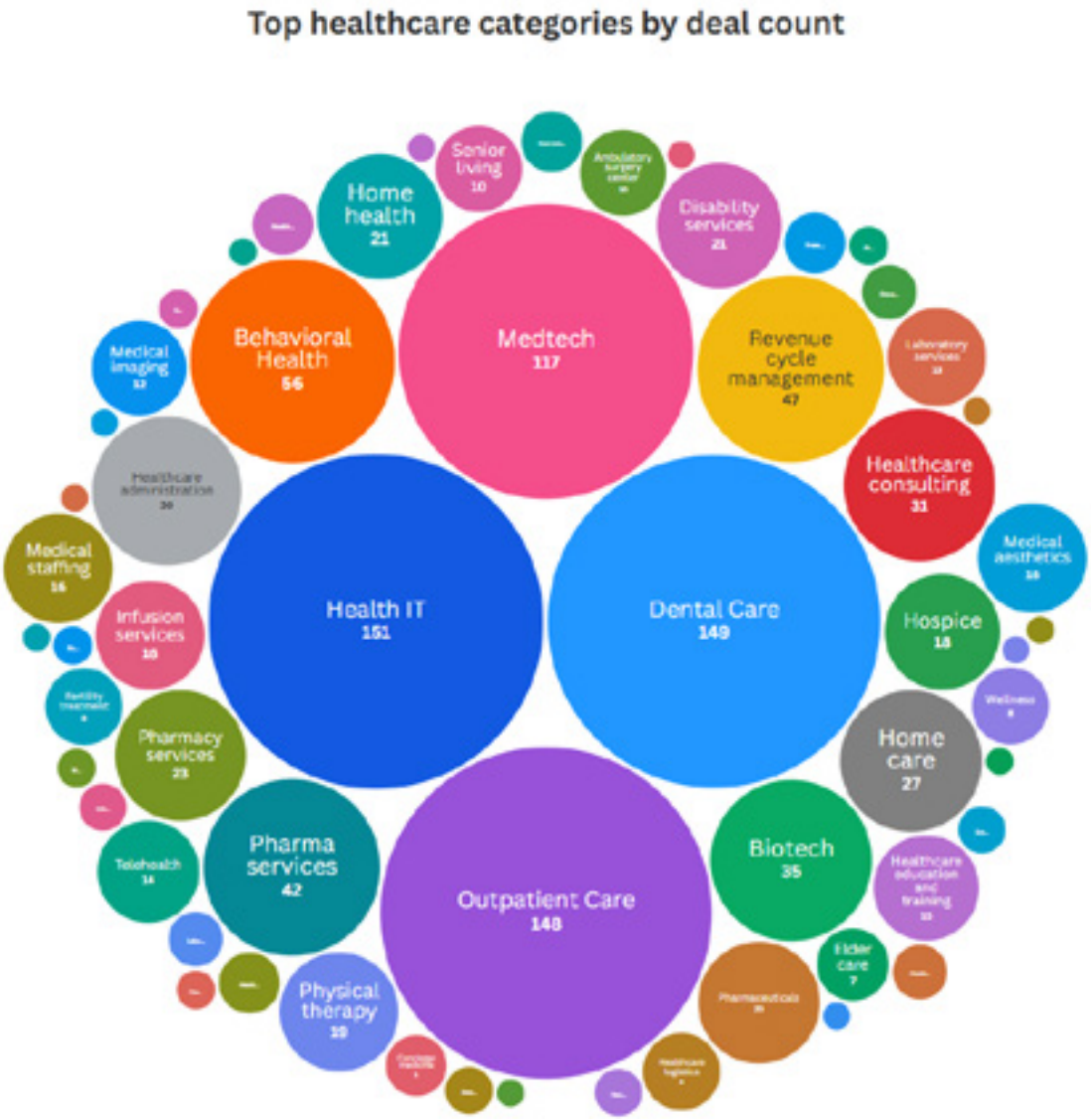

Source: 2025 Private Equity Stakeholder Project

PE-BACKED ORGANIZATIONS ACHIEVE OPERATIONAL EFFICIENCY

The potential for PE to result in less paperwork, more care and reduced administrative waste is largely underestimated. A 2023 estimate from the Center for American Progress acknowledged that PE firms can relieve healthcare providers of administrative responsibilities, infuse capital, enhance revenue cycle management and introduce operational efficiencies.

For plan sponsors, administrative efficiency in provider operations is not merely a clinical concern; it is a direct cost driver. Cleaner claims, faster processing, lower error rates and better documentation reduce friction across the entire payment chain.

Sood believes there's a version of PE in healthcare that actually works for patients, for providers, and for the long-term investor, and it looks like this: using data and computational intelligence to identify where better care today prevents a catastrophic cost tomorrow.

"The problem is that most operators are still making staffing and resource decisions with tools that can only see last quarter, not next year," he states. "Clinical quality and financial performance aren't in tension; they're actually the same variable measured at different points in time, and that's the insight we're operationalizing. When a PE-backed operator can project a patient's clinical trajectory in real time, they stop seeing care investment as a cost center and start seeing it for what it actually is — the single most effective cost containment strategy available."

SALVAGING, REVITALIZING AND STRENGTHENING HEALTH SYSTEMS

PE investment has repeatedly performed economic and operational rescues, stepping in where other capital sources have failed to preserve jobs, maintain services and keep facilities open in communities that would otherwise lose access to care entirely. Systemic overhauls that reform, restructure and transform the health system serve to stabilize the health system network and modernize patient care.

As an example, the 2010 conversion of the Caritas Christi Catholic hospital system in Massachusetts into Steward Healthcare under Cerberus Capital's ownership was cited for years as a model of PE rescuing near-bankrupt institutions and maintaining community services.

For rural and underserved communities, AIC reports that PE-backed staffing companies have used growth capital to scale nurse and healthcare professional deployment in markets chronically short of clinical talent.

Furthermore, in behavioral and mental health, one of the most critically undersupplied specialty areas in American medicine, PE has funded expansion. In fact, one report found that 60 percent of all PE deals since 2018 have involved behavioral health organizations.

In a recent study examining the distribution of PE-owned behavioral health facilities, 6.2 percent of mental health agencies and 7.1 percent of substance use agencies were owned by PE firms. Some states, such as North Carolina and Colorado, reported 25 percent of their behavioral health facilities as privately owned.

In another study published in JAMA Psychiatry, PE firms claim to be investing in the behavioral health sector for the purpose of fixing the broken system. Beyond behavioral health and substance use facilities, the American Psychological Association reports that PE firms have also purchased behavioral health technology and apps which can bring mental health treatment to more individuals, including persons living in rural areas.

Trevor Colhoun

Reflecting on this pressing need, Trevor Colhoun, CEO, TPN.health, the operating system for behavioral health, says, "Private equity's role in healthcare is a net positive when success is measured the right way. These investments push the industry toward better efficiency. In behavioral health specifically, it's injecting real energy into a space that's needed it for a long time."

Invigorating provider entities with capital infusions matters enormously for self-insured plans and their members. It is especially important for employers that operate in regions where specialty access is severely limited, and their employees face longer wait times, challenges that result in delayed diagnoses and greater reliance on expensive emergency services. PE-backed consolidation of service providers can meaningfully expand in-network options for plan members, reducing out-of-network exposure and the downstream claim volatility that afflicts self-insured plans.

But many analysts concur that the reason hospital prices are so high is hospitals' accumulation of market power, which brings them more bargaining power when they negotiate prices with insurers. The Department of Justice (DOJ) and Federal Trade Commission (FTC) use the Herfindahl-Hirschman Index (HHI) to measure hospital market concentration, where >1,800 is highly concentrated, 5,000-7,500 is where a few firms hold substantial market power, and >7,500 is a near monopoly, where a single firm holds absolute (or near absolute) price-setting autonomy. The hospital market is heavily concentrated and has an average HHI score of 5,273, with 97% of markets being at least heavily concentrated and 64% being near or complete monopolies.

From Sood's perspective, "When clinical dynamics are computable and transparent, consolidation that truly improves care gets rewarded by patients who trust it, by employers who choose it, and by a market that can finally see the difference. The PE firms that lean into that transparency will have a durable competitive advantage. The ones that depend on opacity are building on borrowed time."

VALUE OF HEALTH IT INVESTMENT

Management consultants at Bain and Company attest that healthcare IT remains a top-performing segment for investors, outpacing the rest of healthcare and most other industries. Deal volumes have remained robust, accounting for nearly 20% of healthcare transactions in 2025 compared with 15% in 2021, underscoring increasing investor interest. Emerging technologies offer opportunities to streamline back-end processes to achieve cost savings and facilitate new product development to drive revenue expansion.

Advisors maintain that leading investors are achieving 'Rule of 60' outcomes, an evolving financial benchmark used primarily in the AI and Software-as-a-Service (SaaS) industries. It states that a high-performing company's combined Year-over-Year (YoY) revenue growth percentage and Free Cash Flow (FCF) margin should exceed 60. Consistent, disciplined focus on value creation, from underwriting to exit, sets apart the highest-returning deals, with Generative AI offering top- and bottom-line value creation opportunities for healthcare IT providers. Incumbent health IT firms will likely have to add generative AI tools, or they could lose their market position to other AI-native companies.

These investments are significant for employers as healthcare costs continue to rise amid a growing focus on alternative and tech-driven health plans to remain financially sound. Self-insured entities rely on these PE-backed solutions to optimize their bottom line without compromising employee health benefits.

PE also fuels the growth of data and analytics platforms that help employers dig into their specific claims data. This visibility allows companies to identify cost drivers, forecast expenses, and prevent overcharges before they hit the balance sheet. Capital accelerates opportunities for buying or scaling cost containment vendors that use advanced software to reprice claims, audit medical bills for inaccuracies and apply out-of-network solutions to lower hard-dollar medical spend.

In addition, PE cash infusion optimizes pharmacy benefit optimization by supporting the development of robust software solutions that negotiate lower drug prices, track specialty drug utilization. and audit pharmacy rebates for greater transparency. These funds are also critical for building captive management software that helps employers manage catastrophic claims and optimize their stop-loss policies.


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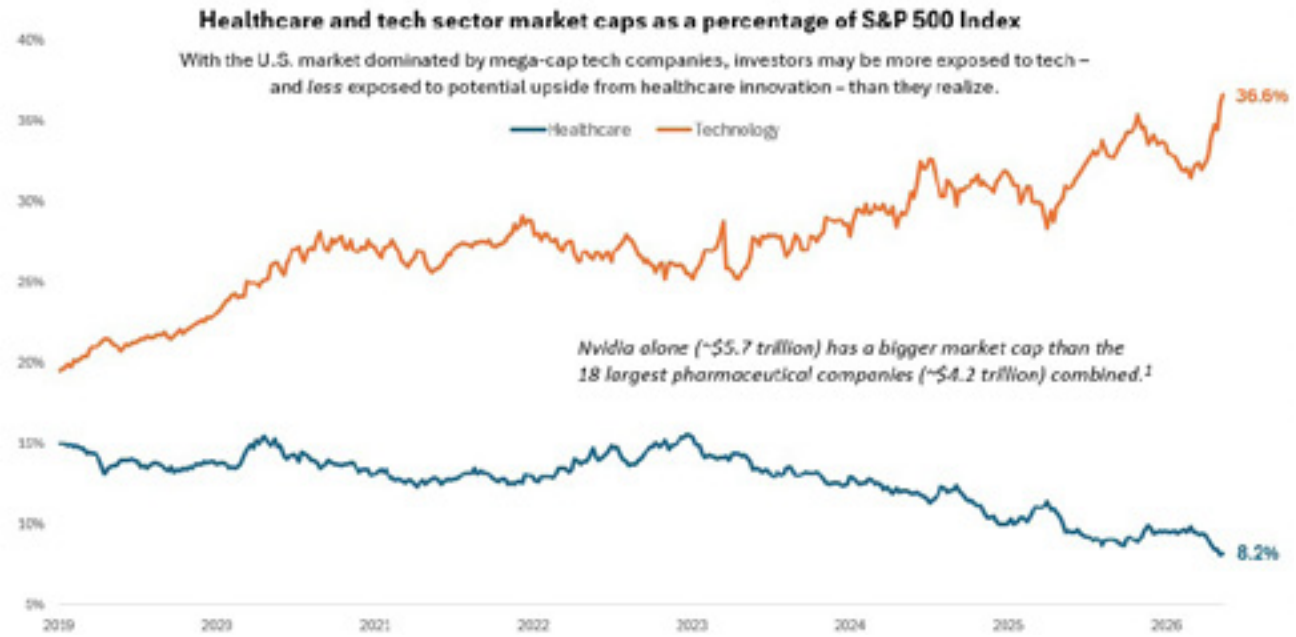

Source: Bloomberg, data as of 1 January 2019 to 14 May 2026. Represents GICS sector market capitalization as a percentage of S&P 500 Index total market capitalization. Healthcare = S&P 500 Healthcare Sector, which comprises those companies included in the S&P 500 that are classified as members of the GICS Healthcare Sector. Technology = S&P 500 Information Technology Sector, which comprises those companies included in the S&P 500 that are classified as members of the GICS Information Technology Sector. Past performance is no guarantee of future results.

VALUE-BASED CARE ALIGNMENT

As PE investors focus heavily on tech-enabled platforms that transition care toward value-based models, they are enhancing the capabilities of companies providing virtual health/telehealth, chronic disease management and primary care networks that lower costs by keeping employees healthier and preventing emergency room visits.

Proponents of PE investments, including industry groups like the Medical Group Management Association, outline several benefits, including access to the necessary capital to upgrade aging facilities, expand into underserved areas and accelerate the development of life-saving medical technology. They tout operational efficiency, streamlining administrative overhead and integrating fragmented electronic health records that allow doctors to focus more on patient care. With an eye on market trends, many modern PE investments target value-based care platforms, incentivizing providers to focus on proactive preventative care rather than fee-for-service volume.

The Bloom Organization commends this focus on predictable, value-based revenue streams, noting that practices that demonstrate consistent cash flow, strong patient retention and quality outcomes data are commanding premium valuations. This shift reflects broader industry trends where payor contracts increasingly reward outcomes over volume.

But pushback from America's Health Insurance Plans (AHIP), the lobbying group for insurance payers, is worth acknowledging. In a recent report, AHIP states that PE firms consolidate smaller healthcare entities to increase their market power and leverage in setting reimbursement rates with payers. AHIP regards

this as a bad thing, pushing for federal scrutiny of even the smallest transactions, and portraying physician practice mergers as a threat to care. In fact, the main threat from these practice mergers is to the massive profits of healthcare payers, like the ones AHIP represents.

AN HONORABLE CAVEAT

The case for PE in healthcare is real, but many thought leaders caution that it is not unconditional. As PE firms focus on short-term revenue generation and investor profit, this approach also can lead them to strip acquired facilities of their assets, force those entities to raise prices through anticompetitive practices, reduce staffing to dangerously low levels, avoid investment in critical infrastructure and eliminate vital services.

Todd E. Archer, CEO, Concierge Third Party Administrator, believes, "The fundamental purpose of PE is to maximize the Return on Investment. A central component of that process (in most cases) is increasing billings either through unit cost increases and/or incremental billings for services. There is no way these increases don't flow through to the patients and plans."

The other central component of any process to maximize Return on Investment is to minimize expenses, as he explains, "The largest single expense category for any business is labor, so it stands to reason that this is where the quickest returns will be generated. When the primary focus of any business venture is to maximize the bottom line (to the exclusion of all else), it will have a detrimental effect on the quality of the product being delivered. You might argue whether the degradation is short-term or long-term, but it will occur. "

Many stakeholders argue that PE stewardship and activities are detrimental to the patients, workers, and entire communities. For this reason, private equity fund ownership is concerning in the healthcare space, where quality of care and patient safety are in the public interest and should be a healthcare entity's highest priority.

Supporting this viewpoint, research from a systematic review conducted by the Columbia Mailman School of Public Health, which examined 55 studies, found that PE ownership was associated with increased costs in 9 of 12 cases and decreased costs in none. Other studies have specifically documented increases in the charged and allowed amount per claim following PE acquisitions of independent physician practices.

Market perceptions persist that PE acquisitions increase negotiated prices that translate into higher cost-sharing for members and are ultimately passed on through taxes or suppressed wages for plan sponsors' own employees. The National Institute for Healthcare Management (NIHCM) Foundation, a nonprofit, nonpartisan organization dedicated to improving healthcare through evidence and collaboration, states that while PE investment in healthcare may improve operational or technological efficiencies, there are concerns about the effects on cost, quality and utilization of care.

Studies specifically document increases in the charged and allowed amount per claim following PE acquisitions of independent physician practices.

Bruce Roffé

Dr. Bruce D. Roffé, P.D., M.S., H.I.A., President and Chief Executive Officer, H.H.C. Group, a healthcare cost containment firm he founded in 1995, cautions, "For healthcare payors, the rise of PE in this field presents significant challenges, including skyrocketing costs and diminishing care quality. Private equity firms operate on a straightforward yet aggressive business model: acquire assets, boost their perceived value, extract profits and eventually sell them off. In the context of healthcare, this approach often means prioritizing financial returns over the well-being of patients and communities."

Roffé says that by consolidating services and creating near monopolies in key areas like anesthesiology or emergency care, PE firms have the leverage to dramatically increase prices, and these inflated costs are passed along to payors, employers and patients. He describes their profit-driven culture shifts from patient care to bottom-line metrics, eroding morale and quality of service.

"This cost-cutting ethos, while boosting short-term profitability, undermines the very foundation of effective healthcare delivery, jeopardizing patient outcomes and straining payer resources," he observes.

Roffé warns that one of the most alarming aspects of PE's foray into healthcare is the absence of federal regulation to curb its practices: "Unlike other industries where antitrust laws and oversight can mitigate harmful consolidation and predatory practices, healthcare remains an open playing field for these investors."

He says the rising costs associated with PE involvement directly impact healthcare payors, increasing premiums and straining budgets for insurers, TPAs and self-insured employers.

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"The ripple effect on healthcare payors is a significant challenge," he continues. "PE-owned ambulatory surgery centers have been documented charging up to 50% more following acquisition — along with more aggressive out-of-network billing, upcoding that inflates claim values, and less pricing transparency."

Hinson believes that when an organization gains leverage through acquisition or growth, they're going to push for higher reimbursements, adding, "That's true in this market and just about every other one. And when you've got investors expecting returns, profit maximization isn't a side effect; it's the mandate."

In response, many advisors suggest the self-insured ecosystem would be well served by a policy framework that distinguishes between PE investments that genuinely improve access and efficiency, and those that are principally designed to extract revenue through pricing leverage. That distinction is not a blanket condemnation or endorsement of PE; it is the point where productive policy conversation should begin.

For providers facing a capital desert, for payers seeking operational partners capable of driving efficiency and for self-insured plan members who need access to expanded care options, PE in healthcare can be a legitimate source of value. The evidence for PE's contributions to health IT innovation, operational professionalization, and access expansion in underserved markets is genuine and documented.

The question for the self-insured community is not whether PE belongs in healthcare. It is whether the structures governing PE investment transparency requirements, antitrust enforcement, network adequacy standards and dispute resolution rules are calibrated to maximize the capital benefits while containing the risks. It is essentially a regulatory challenge, not an indictment of private capital itself.

CONFLICTING STUDIES SPARK DISCUSSION

PE may have generated some negative notoriety when a landmark 2025 study published in the Annals of Internal Medicine found that after PE acquisition, hospitals reduced emergency department salary expenditures by 18.2%, approximately $12.63 per inpatient bed stay. Non-PE hospitals, by contrast, increased pay in the same departments.

The Harvard Medical School-led research team noted that PE hospitals transferred sicker patients at higher rates than non-PE facilities, suggesting the most complex and costly cases are being redirected rather than treated and linking staffing and salary cuts to a measurable increase in patient deaths. The study contends that these actions shift downstream costs onto other providers and ultimately onto plan sponsors.

Another indictment surfaced in a 2024 report from the Stanford Law Review claiming that no study to date has found significant improvements to healthcare quality, efficiency, costs or access as a result of PE's entrance into healthcare. The researchers framed the trend starkly: the drive for rapid revenue generation threatens to increase costs, lower quality and contribute to physician burnout and moral distress.

Yet an additional study found that not-for-profit hospice ownership was associated with the greatest spending on direct patient care services. By contrast, all for-profit ownership models spent significantly less on direct patient care, with PE-owned hospices spending the least. The study estimated that the difference in direct patient care spending between the not-for-profit and the three for-profit models was driven by spending on nursing salaries.

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Counterbalancing these reports, researchers at the Georgetown University School of Business observe that while in the first few years of takeover there is a reduction in both medical and non-medical workers, the number of medical workers quickly recovers and reverts back to pre-acquisition levels within five to eight years. However, the number of administrative employees does not recover, but permanently goes down. This reveals that PE firms do not seek to chase profitability to sacrifice long-term healthcare quality. Consistently, they do not find a significant change in patients' mortality rates after the takeover.

The American College of Surgeons PE extols investment into the healthcare sector, stating that it can result in positive changes regarding workforce shortages, increased access to resources and enhanced patient care. Specifically, PE acquisition can provide capital investment for start-up practices to purchase office space, equipment, and improved electronic health record processes, hire personnel and analyze big data to handle capitated contracts.

But the jury is still out on quality of care, since many studies validate that patients treated in PE-owned hospitals experience more hospital-related adverse events, including bloodstream infections, surgical site infections, and falls. Perhaps most accusatory is the nursing home data: A 2023 study found that nursing homes owned by PE were associated with more than 20,000 additional resident deaths over a 12-year period.

The National Institutes of Health's consolidated research summary is equally sobering: "Overall, research has found that PE involvement in healthcare has led to changes in the workforce, increased costs and utilization, mixed effects on quality of care and a lower percentage of Medicare patient discharges, implying an increase in privately insured patients with higher reimbursement rates."

REGIONAL MARKET CONSOLIDATION

Regional consolidation is better known as a "roll-up" strategy in which PE firms serially acquire competing practices, group by group, until they achieve dominant market share in a specific specialty or geography. Because individual acquisitions are structured to fall below the Hart-Scott-Rodino Act's $119.5 million threshold for mandatory antitrust review, regulators frequently cannot see the full picture until concentration is complete.

For self-insured employers operating in geographically constrained markets, PE consolidation draws criticism for eliminating the competitive alternatives that give TPAs leverage in network contracting. When there is only one PE-owned anesthesiology, radiology or emergency medicine group in a region, employers have no choice but to accept those providers' rates or leave their plan members without in-network access.

Federal and state regulators have responded. In 2025, the FTC, DOJ, and HHS released a joint report confirming. "The American public is dissatisfied with ongoing trends in the healthcare sector," with over 2,000 public comments documenting consolidation harms. The report noted that by 2024, approximately three-quarters of health insurance markets were considered highly concentrated.

REGULATORY HEADWINDS

PE investment in the U.S. healthcare sector faces a complex and evolving regulatory and legislative landscape. Due to mounting concerns over stealthy consolidation and financialization, state and federal regulators are heavily scrutinizing PE transactions in 2026. At least 25 states have tracked or introduced legislation to increase ownership transparency, mandate transaction reviews, and curb anti-competitive practices in healthcare M&A transactions.

Attorneys at Benesch law firm warn that both federal and state authorities are intensifying scrutiny of PE investment, driven by concerns about market consolidation, quality of care, corporate profiteering and lack of financial transparency. As challenges mount, particularly at the state level, PE firms and the healthcare businesses in which they invest must be prepared to adapt their consolidation strategies.

While the current administration will likely take actions to spur PE investment and prioritize deregulation, some states could attempt to counterbalance the federal government's approach with additional state regulations intended to address perceived gaps in federal regulation and enforcement. California, which recently enacted legislation that grants the state greater authority to scrutinize PE investments in healthcare providers, as well as Massachusetts, Oregon, and a handful of others, have enacted similar laws. PE firms with healthcare portfolios should expect increased state-level compliance obligations, longer transaction review timelines, and more public scrutiny around outcomes.

But PE ownership can deliver a compliance uplift for self-insured plan sponsors and their TPAs, as Managed Healthcare Executive has reported: "The capital from PE can also help providers adhere to government rules, take steps to reduce fraud and abuse and improve billing. Private equity typically will raise the bar on compliance."

Authors forecast that for stop-loss carriers and TPAs negotiating in an era of increased regulatory scrutiny -- from the Consolidated Appropriations Act's transparency requirements to CMS enforcement of surprise billing rules -- a provider community with stronger compliance infrastructure will mean fewer disputed claims, cleaner audits and more predictable payment processes.

SAFEGUARDING AGAINST RISKS

Writing in the May 2026 edition of the American Journal of Managed Care, thought leaders contend that PE's growing influence on American healthcare has outpaced regulatory oversight and call for stronger policies to safeguard patients, providers and care delivery. Authors maintain, "There is growing political will for reform, driven by regulators who have recognized that PE's outsized footprint makes it an urgent target for policy intervention…robust policy must, at a minimum, shield patients, providers and practices from PE's associated risks, and, at best, position these parties to benefit from private investment."

Their recommendations include:

- Empower antitrust authorities and strengthen existing policies to increase accountability, promote competition, and curb consolidation.
- Pursue novel regulatory solutions, including healthcare–specific PE law, alignment of state and federal oversight, adoption of alternative payment models, and strengthened patient protections against PE-associated risks.

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PE TANGLES WITH THE NO SURPRISES ACT

Passed in 2020 to shield patients from unexpected out-of-network bills, the No Surprises Act (NSA) created an Independent Dispute Resolution (IDR) process for payment disputes between providers and payers. While regulators projected approximately 17,000 disputes per year, the reality has been catastrophic for employers. The Texas Association of Health Plans reports that from mid-2022 through May 2025, 3.3 million IDR disputes were filed – more than 190 times the projected annual volume. In 2024, 39% of all disputes filed were identified as ineligible under the law, yet health plans were forced to pay out nearly half of those ineligible claims.

PE-backed providers have been identified as the engine of this dysfunction.

- In 2023 and 2024, 43% of all resolved line-item IDR claims were filed by just two PE-backed organizations: Radiology Partners and TeamHealth.
- KFF's analysis of IDR performance through mid-2024 found that the top 10 dispute-initiating parties are all providers or their billing consultants, and the top three parties -- all of which are backed by private equity firms -- accounted for 53% of payment disputes from the beginning of 2023 through mid-2024.
- Congressional Research Service documents that for air ambulance services, another specialty dominated by PE-backed operators, Global Medical Response, Air Methods, and Apollo MedFlight collectively initiated 65% to 72% of all disputes in each quarter of 2024.

Christine Cooper

PE-backed providers typically win the disputes. A Health Affairs Scholar study analyzing 2023 emergency medicine IDR data found that providers won 86% of cases overall, with mean decisions averaging 2.7 times the qualifying payment amount (QPA). PE-backed providers won more often and with higher monetary awards than other providers, with PE-backed physician staffing companies winning 90% of their disputes.

Christine Cooper, CEO, aequum LLC, who serves on the Self-Insurance Institute of America's Board of Directors, emphasizes, "The No Surprises Act dispute process was not designed with high-volume, PE-backed operations in mind. The extraordinary volume was overwhelmingly driven by a handful of PE-affiliated providers and revenue cycle companies. The practical consequence is that self-insured employers are absorbing billions in awards that are well above the in-network and QPA rates. Employers who focus on eligibility and methodology rather than individual claim outcomes are better equipped to navigate this overburdened process."

For those who question why PE wins so consistently, KFF explains, "PE-backed provider groups have historically been able to negotiate for above-average contracted rates," and those prior contracted rates become evidence in IDR proceedings that arbitrators are required to consider. The roll-up strategy creates pricing leverage in network contracting, which becomes the basis for winning above-median awards in

arbitration. In the process, the costs are borne by self-insured plan sponsors, their TPAs and ultimately their employees.

There is growing sentiment that PE is pursuing arbitration as a business strategy. The Niskanen Center Think Tank lays blame on arbitrators that consistently side with providers offering rates several times higher than insurers' median in-network payments, resulting in the current IDR framework that creates strong incentives to flood the system with disputes. They say PE-backed provider groups, in particular, are well-positioned to exploit this dynamic: they are highly motivated to generate quick revenue to meet debt obligations and have the financial capacity to absorb arbitration fees.

As a consequence, dispute volumes have vastly exceeded predictions and the IDR system, originally designed as a last resort for genuine disputes, has been transformed into a revenue optimization engine. For self-insured employers, it may not be acceptable to remain passive victims in this landscape but to initiate strategic, coordinated action that can materially improve plan outcomes in NSA disputes and limit PE's leverage over benefit costs.

Hinson expresses that the NSA took the patient out of the crossfire, and credited where it was due. "But the IDR process has become its own arena, and PE-backed groups treat arbitration as a revenue strategy, not a last resort," he explains. "We are struggling to defend the reimbursement protocol, and the PE-backed physicians are enhancing resources to make sure the judgments go their way. As an industry, we must look at this much more aggressively, as treating it as an administrative headache is simply causing most entities to fail in the independent reviews. What will it take for employers to prevail? Showing up

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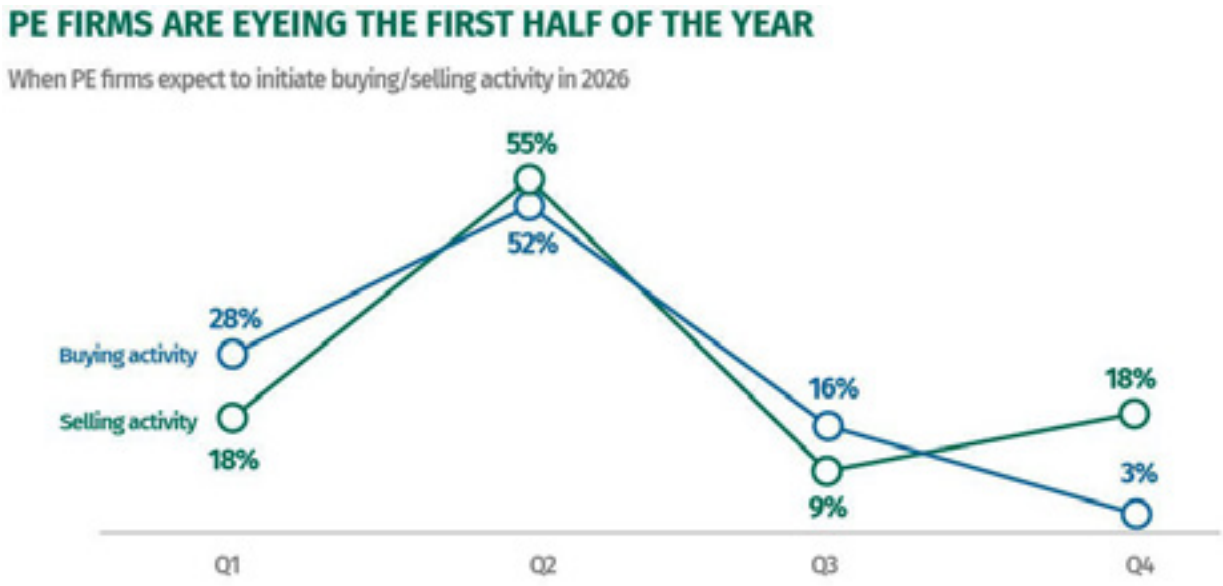
prepared and collectively working together to fight for fairness and leaning into the robust data set we have. Our partners and clients depend on us to take this approach."

Archer contends that things are not going to change in that process, "…until the transparency movement is able to expose the egregious billing practices being used in a manner that is easily accessed and understood by the rank-and-file employee." Sood considers that the No Surprises Act got the patient protection right, with this caveat: "Where it fell short was in anticipating that a small number of highly consolidated, PE-backed provider groups would treat arbitration not as a last resort but as a core revenue strategy — and that the information advantage built through years of roll-up acquisitions would translate almost directly into IDR wins. There's a better version of this system available, and it doesn't require dismantling the law. It requires giving employers, patients and plans the same quality of clinical and financial intelligence that sophisticated provider groups already have."

He clarifies, "When the cost of a patient's care can be grounded in their actual clinical trajectory, and not just comparable rates, arbitration becomes what it was always supposed to be: a genuine dispute resolution process, not a revenue optimization engine. That's the system patients deserve, and it's the one we're working to make possible."

THE VALUATION OUTLOOK

While technology, media and telecommunications participants lead the outlook for valuations in 2026, healthcare lags at the other end of the spectrum. A Citizens Bank survey provides this intelligence: just a quarter of respondents anticipate higher valuations in 2026. The majority expect valuations in healthcare to remain stable, possibly reflecting an already-high level from 2025.

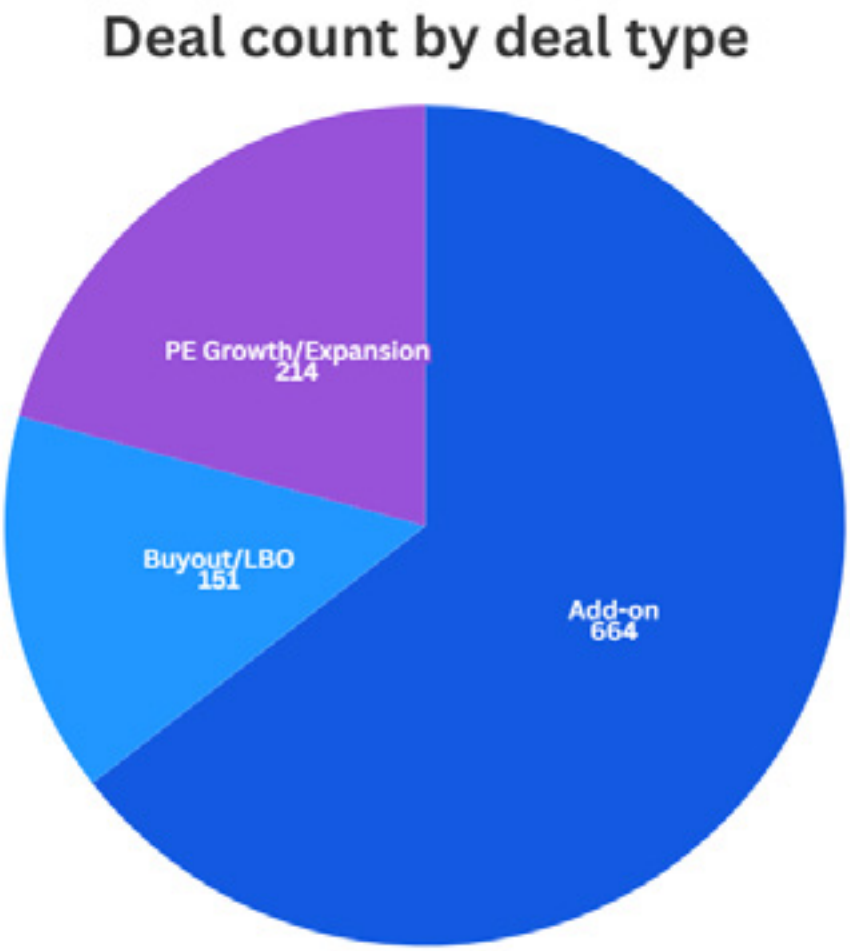


Source: 2026 Citizens Bank

While venture capital investment across the healthcare sector slowed in the first half of 2025, investors are spending on health tech — especially artificial intelligence (AI). The Silicon Valley Bank (SVB) reported that last year, the segment made up about one-third of overall healthcare investment, with just over 60% of health tech funding linked to companies that use some form of AI.

According to SVB, back-office use cases for AI have become a large focus for investment since their processes are outdated and ripe for disruption. Tools aimed at lessening administrative work rather than clinical tasks made up 44% of AI funding.

Fast forward to the SVB 2026 Healthcare Report and commentary from David Crean, Ph.D., managing partner, Cardiff Advisory, who characterizes AI as "One Theme Consumes Half a Market." He projects healthcare AI to reach $22B, which equates to 46% of total healthcare venture capital.



Source: 2025 Private Equity Stakeholder Project

Laura Carabello holds a degree in Journalism from the Newhouse School of Communications at Syracuse University, is a recognized expert in medical travel and is a widely published writer on healthcare issues. She is a Principal at CPR Strategic Marketing Communications. www.cpronline.com