# The Private Equity Wave in Health Care

By Carmen Lee, MD, MAS | on September 3, 2024 | 1 Comment

Print-Friendly Version




Hahnemann University Hospital in Philadelphia closed in 2019, a year and a half after it was acquired along with St. Christopher's Hospital for Children by private equity (PE) firm Paladin Healthcare Capital for 170 million dollars. Of that total, 120 million dollars were new loans taken out against the assets of the hospitals with interest rates around 10 percent.[1] Immediately after the purchase, the real estate

holdings of the hospitals were spun off into a separate company owned by Paladin and other PE investors.[2] Former employees and administrators described the period that followed as chaos: it included diminished staffing levels, delayed equipment and building maintenance, closures of entire departments, and a hastily-executed emergency department renovation designed to increase volume that quickly stalled due to poor design and a failure to obtain permits.[1,3]

You Might Also Like

EM Physician Appointed to COVID-19 Health Equity Task Force

What Will Hospital, Health Care System Mergers Mean for Emergency Medicine?

Numbers Say Emergency Care Is One of the Best Values in Health Care

Explore This Issue

ACEP Now: Vol 43 – No 09 – September 2024

Executives had been persuaded not to close the residency and fellowship programs at the hospital, only to have the program's 550 training spots liquidated for 55 million dollars in bankruptcy proceedings.[4] St. Christopher's was able to find a buyer prior to bankruptcy but Hahnemann could not. Its real estate, exempt from bankruptcy filings and valued around 120 million dollars, remains held separately by the original private equity investors, who have sought buyers for the valuable downtown property.

Prior to its closure, Hahnemann had served primarily low-income patients from the surrounding Philadelphia community and had struggled to break even under the ownership of the for-profit Tenet Healthcare Corporation. This story has become increasingly common in the health care industry, as hospitals and physician groups flounder in an increasingly complex reimbursement environment and private equity firms have stepped in to infuse capital. Private equity investment in health care has increased more than 20-fold since 2000, with 70 percent of this activity since 2010. From 200 billion dollars that year, the firms that make up the Healthcare Private Equity Association now have over 2 trillion dollars in assets under management.[2] While widespread, these investments have also begun to saturate local markets: a recent study found that, through physician group

acquisitions, the majority of physician market share is controlled by a single private equity firm in 13 percent of metropolitan markets.[5]

Private equity follows a fundamentally different business model from other forms of investment, such as publicly-traded or privately-owned companies. PE firms manage funds in which only large-scale institutional investors and high-net-worth individuals accredited by the Securities and Exchange Commission may invest. These funds are permitted to use high levels of debt to purchase companies in leveraged buyouts in which typically 60 percent to 80 percent of the purchase price comes from new loans against the value or assets of the acquisition. Between 2 to 10 percent comes from the private equity firm itself; the remainder comes from the fund's investors including accredited individuals, endowments, and pension funds.[2,6] As with Hahnemann, the PE firm and its investors do not remain liable for debts incurred during the purchase. These stakeholders are similarly shielded in court when adverse patient outcomes, such as negligent deaths, occur under their management or when the bought-out companies are challenged for anticompetitive business practices overseen by the PE firm.[7-9]

The PE model then aims to sell acquired businesses for a profit within three to six years. To do this, firms must dramatically increase the market value of their portfolio to produce the return on investment sought by the industry, typically around 20 percent, all while also paying off large levels of debt needed to finance the acquisition.[2,6] At the same time, most PE firms engage in common practices that increase costs and overhead for acquired companies beyond the debt incurred in the acquisition. PE firms typically pay the firm and its investors first, often by borrowing additional money in a strategy called dividend recapitalization.[10] Secondly, PE firms also charge the entities that they own for the oversight they provide in the form of management fees.[2,6] Companies acquired with these high debt burdens and saddled with increased costs and are later at a much higher risk for bankruptcy: 20 percent compared with 2 percent for propensity-matched companies with similar size and risk that were not acquired.[11]

The playbook to quickly grow margins enough to meet these new financial obligations can start to feel familiar, according

to emergency physician Ellana Stinson, MD. In her congressional testimony this year, she described working for PE-owned and publicly traded entities including Envision, Team-Health, Steward Health System, and Tenant as following a familiar script. “I began to realize how resources were being dwindled down and pulled from each facility … and Quincy Hospital was taken down to bare bones before its ultimate closure. Not having blood products, respiratory therapy on certain days, or certain specialty services no longer felt like I was able to provide safe or quality care.”[12]

A common first move is often staffing cuts, since labor amounts to more than half of costs for many health care companies.[13] Cost cutting may also include, as in the case of Hahnemann, postponing maintenance on existing equipment, decreasing inventory or cost of supplies, and shuttering departments. It also frequently includes substituting the physician labor force with advanced practice practitioners (APPs) such as physician assistants and nurse practitioners. Studies have found that while both physician and non-physician staffing turnover occurs at significantly higher rates at PE-owned firms, APPs are also hired at much higher rates, implying replacement of physicians with other types of clinicians.[14]

Dr. Stinson remembers what it was like to work for a PE-owned hospital early in her career. “I walked into a hospital and [the APP] was fresh out of nurse practitioner school, had never worked in the ER before as the primary caregiver of a patient, had no training or anything, they just threw her out there. It was my first week in the facility, and I’m still trying to just figure out where the bathroom is, and I’m like ‘This can’t be safe that we’re the only two people here!’ But they needed bodies, and they’re putting NPs and PAs also in very challenging positions.”

Another common tactic is the sale-leaseback strategy, in which an acquired entity’s real estate is sold off to a third party who then charges it rent to use the land and facilities with the proceeds from the sale funneling back to the PE firm. In the widely publicized example of Steward Health Care, a PE-acquired hospital network with 30 hospitals across multiple states currently facing bankruptcy, sales of its real estate to Medical Properties Trust covered the entire purchase price for the PE owner Cerberus and created 800

million dollars in additional profit. Cerberus then sold the heavily indebted entity back to a group of its own doctors, and Steward is now failing to meet both rent and debt obligations.[15]

The same playbook seen across many industries with PE investment can have especially negative effects on the health care workforce. “Private equity is generally highly leveraged, profit focused, and has a short-term mindset,” explains Jim Dahle, MD of the White Coat Investor. “Good docs tend to be driven elsewhere, burnout levels tend to increase, and capital is used for profit rather than investing in the long-term viability of the business. Undercapitalized hospitals don’t pay their vendors, don’t maintain and purchase needed equipment and supplies, and run overly lean staffing models.” Indeed, when 156 private equity-acquired hospitals were compared to 1,560 matched controls, they lost 24 percent of their capital assets over the first two years after acquisition.[16]

Proponents of the private equity model argue that it can be used to identify and increase economies of scale, yet a growing body of evidence finds that both hospital and physician costs increase after private equity acquisition, and that these costs are typically passed on to the patient.[6,17-18] In a 2023 systematic review, no studies showed decreased costs to patients or payors, and the effect of PE ownership on quality of care measures was “mixed to harmful,” a pattern that has continued in subsequent studies.[19,20] The more granular effects of acquisitions on physician pay, for example, can be hard to quantify, as contracts, business practices, and revenues are often shrouded in secrecy.

A statement from Envision argued that their internal data shows that Envision clinicians exceed national quality benchmarks. “Our physician-led teams are guided by the delivery of high-quality, clinically-appropriate evidence-based care,” the Envision statement said. “They make hiring decisions locally in partnership with hospitals based on communities’ needs. All clinicians—no matter the stage of their career—undergo a rigorous screening process and are hired by local physician leaders if they and the clinician believe it’s a fit.”

The saga surrounding balance billing in emergency medicine illustrates the influence of private equity on the specialty. During the legislative fight to pass the federal *No Surprises Act* of 2020, it was asserted that most balance billing in the U.S. was due to two large physician groups, TeamHealth and Envision. Both groups, with a collective employment of nearly 90,000 physicians, had recently been acquired by private equity firms and are alleged to have instituted the balance billing strategy to enhance profitability.[2]

In the case of Envision, balance billing was reported to be such a fundamental part of its plan for increased revenue and meeting debt obligations that the passage of the *No Surprises Act* and subsequent disputes with insurers resulted in multiple downgrades of the quality of its corporate bonds. This was cited as a cause for its eventual bankruptcy.[2,5,18] Envision had been acquired for 9.9 billion dollars in one of the largest leveraged buyouts since the 2008 financial crisis, of which over 7 billion dollars was new debt obligation.18 Two months after Envision's bankruptcy, PE-owned American Physician Partners (APP) also folded under the weight of its 630 million dollars in debt despite consistently rising revenues.[21,22]

TeamHealth Chief Medical Officer and emergency physician Jody Crane, MD argues that blame for any increased cost or perceived impact on quality should be placed on insurance companies, referring to long-running legal battles with private insurers over payments for its services. "The harsh reality is that physician groups, regardless of ownership model, have very little control over reimbursement," Dr. Crane said. "While scale can improve a physician practice's ability to negotiate with insurers and hold them accountable for fair payment, at the end of the day healthcare premiums continue to increase year over year and physician reimbursements continue to decline. Insurers leverage laws, like EMTALA or the *No Surprises Act*, to drive down payments…. This is not about private equity driving up costs, this is about unchecked insurer fraud and abuse."

Still, this wave of private equity acquisitions in emergency medicine has come crashing down on the heads of many early-career physicians. As of 2022, 1 in 4 emergency departments in the United States were staffed by a private equity-owned physician group.[23] The emphasis on lower-cost

labor results in heavy recruitment of recent graduates to place downward pressure on wages. Dr. Stinson said, “There have been [PE] facilities where I worked where a third to a half of the staff are all new residents. Usually, they’ll get two or three every now and then, but if everybody is fresh, who’s teaching who?” While secrecy surrounds the operations of many PE-owned groups, Envision serves as a case study. During the pandemic they “cut pay and benefits for emergency room doctors and other medical workers” while “continuing to spend millions on political ads” to counter the *No Surprises Act*, according to reporting from ProPublica.[18,24]

When reached for comment, TeamHealth and Envision both said their companies now have a policy against balance billing. “Envision fully supports the patient protections under the *No Surprises Act* and, before it was passed, had a policy prohibiting balance billing,” the Envision statement said. “Meanwhile, some health insurers improperly deny and underpay claims for care provided to their members. The 2023 ruling by an independent arbitration panel stating UnitedHealthcare owes Envision more than 91 million dollars for underpayment of essential medical care is a clear example of this.” At the same time, there is evidence that declining reimbursements by insurers, including UnitedHealthcare, may also be a strategy driven by private equity investment.[25]

Wesley Barnett had heard disturbing stories about the firm staffing his hometown critical-access ED as he was nearing the end of residency at the University of Kentucky, so he founded an independent physician group to try to take back the contract. He was shocked when the hospital CEO took him up on it, but a year later, volumes increased 30 percent with his emphasis on quality rather than cost-cutting. He explained what he feels is the trap set for early career physicians this way: “Say you’re paying 200 dollars an hour to a physician to see 2 patients an hour. If that number is now 4 patients an hour, instead of keeping safe staffing models, we’ll give you incentive pay, making 300 dollars an hour. Before they were paying you 100 dollars a chart, now they’re paying you 75 dollars a chart, and you just got had. You’ve taken on the additional liability and more money for more pain.” Because young physicians are often walking into these

situations fresh, he says, “They’re just happy they’re making more than in residency.”

Amid high-profile failures of hospitals and physician groups, legislatures are looking to limit private equity investment in health care. In California, a recent bill has been introduced and has sparked a lobbying battle pitting physicians’ and nurses’ associations against PE-funded groups.[26] In the United States Senate, Senator Elizabeth Warren (D-MA) has introduced legislation that would make it easier to hold PE firms and health care executives accountable for the negative consequences of leveraged buyouts, including criminal liability for the wrongful deaths of patients.[27]

Private equity acquisitions tend to target hospitals and physician groups financially struggling to survive and those with a significant proportion of government-insured patients. Dr. Stinson is concerned about the potential to exacerbate disparities. “Most of these private equity firms are in lower-income, under-resourced places already because they come in with a promise to turn the books around. But maybe that was never the intention,” she speculates. “They leave the area deprived of access.” Low Medicaid and Medicare reimbursement, which according to the American Medical Association have “declined greatly between 2001 and 2023 after adjusting for inflation in practice costs,” increase the financial strain on providers of health care including both hospitals and physicians. The AMA found that administrative burden of reimbursement and low rates were the most frequent factors in physicians’ decisions to sell their practices.[28]

Dr. Crane sees acquisitions as a way to help physician practices survive: “The singular focus the house of emergency medicine in America, big or small and regardless of ownership model, should rally around is fair reimbursement.” Yet the advice may differ for newer physicians versus more seasoned ones. In a cautionary tale for young physicians, Dr. Dahle warns, “The only benefit I see to any private equity involvement is for a doctor at the end of her career to have an additional buyer for a practice.”

*This article contains additional reporting from Medical Editor-in-Chief Cedric Dark, MD, MPH, FACEP, and ACEP staff.* ACEP Now *reached out to Paladin, the Healthcare Private Equity*

*Association, Cerberus, Steward Health System, and Tenant for comment but did not receive any in time for press. The views expressed in this article do not represent an official position of the American College of Emergency Physicians."*

---

**Dr. Lee** is a second-year resident in emergency medicine at Highland Hospital in her hometown of Oakland, California. Her primary interests are in ultrasound, machine learning, and health justice.

## References

1. Pomorski C. **The death of Hahnemann Hospital**. *The New Yorker*. Published May 31, 2021. Accessed August 25, 2024.

2. Appelbaum E, Batt R. **Private equity buyouts in healthcare: who wins, who loses?** *Center for Economic and Policy Research (CEPR)*. Published March 15, 2020. Accessed August, 2024.

3. D'Mello K. Hahneman's closure as a lesson in private equity healthcare. *J Hosp Med*. 2020;15(5):318-320.

4. Barrish C. **Bankruptcy judge approves 55 million sale of Hahnemann residency program**. *WHYY*. Published September 5, 2019. Accessed August 25, 2024.

5. Sheffler RM, Alexander L, Fulton BD, et al. **Monetizing medicine: private equity and competition in physician practice markets**. *American Antitrust Institute (AAI)*. Published July 10, 2023. Accessed August 25, 2024.

6. Cai C, Song Z. **Private equity in Health Care: Prevalence, Impact, and Policy Options for California and the U.S. California Health Care Foundation (CHCF)**. Published May 7, 2024. Accessed August 25, 2024.

7. Justia. Filing 45. **Salley et al v. Heartland-Charleston of Hanahan SC LLC et al**. Accessed August 25, 2024.

8. Stempniak M. **Private equity firm, accused of trying to build a monopoly in radiology, dismissed as defendant in FTC lawsuit**. *Radiology Business*. Published May 15, 2024. Accessed August 25, 2024.

9. Herman B. **Private equity escapes FTC in court, but anesthesia group doesn't**. *STAT*. Published May 20, 2024. Accessed August 25, 2024.

10. Dubner SJ. **Are private equity firms plundering the U.S. economy?** Freakonomics Radio. Published November 15, 2023. Accessed August 25, 2024.

11. Ayash B, Rastad M. **Leveraged buyouts and financial distress. Finance research letters, forthcoming**. *SSRN*. Published July 22, 2019. Accessed August 25, 2024.

12. United States Senate. **When health care becomes wealth care**. Subcommittee Field Hearing of the U.S. Senate Committee on Health, Education, Labor and Pensions. Published April 3, 2024. Accessed August 25, 2024.

13. Coleman-Lochner L, Church S. **Private equity is no longer a reliable last resort for troubled hospitals**. *Bloomberg*. Published September 12 2023. Accessed August 25, 2024.

14. Bruch JD, Foot C, Singh Y, et al. Workforce composition in private equity-acquired versus non-private equity-acquired physician practices. *Health Aff (Millwood)*. 2023;42(1):121-129.

15. Schooley M, Hager C, Kaplan M. **Steward Health Care files for Chapter 11 bankruptcy**. CBS Boston. Published May 7, 2024. Accessed August 25, 2024.

16. Schrier E, Schwartz HEM, Himmelstein DU, et al. Hospital assets before and after private equity acquisition [published online ahead of print July 30, 2024]. *JAMA*.

17. Singh Y, Song Z, Polsky D, et al. Association of private equity acquisition of physician practices with changes in

health care spending and utilization. *JAMA Health Forum*. 2022:3(9):e222886.

18. Bugbee M. **Envision Healthcare: a private equity case study**. Private Equity Stakeholder Project (PESP). Published December 14, 2022. Accessed August 24, 2025.

19. Borsa A, Bejarano G, Ellen M, et al. Evaluating trends in private equity ownership and impacts on health outcomes, costs and quality: systematic review. *BMJ*. 2023;382:e075244.

20. Kannan S, Bruch JD, Song Z. Changes in hospital adverse events and patient outcomes associated with private equity acquisition. *JAMA*. 2023;330(24):2365-2375.

21. Yerak B. **American Physician Partners files for bankruptcy after shutdown**. *The Wall Street Journal*. Published September 19, 2023. Accessed August 25, 2024.

22. Muoio D. **Hospital, ED staffer American Physician Partners files for Chapter 11 bankruptcy**. *Fierce Healthcare*. Published September 20, 2023. Accessed August 25, 2024.

23. Adelman L. **2023 State of the Emergency Medicine Employer Market**. *Ivy Clinicians*. Published February 2023. Accessed August 25, 2024.

24. Arnsdorf I. **Medical staffing companies cut doctors' pay while spending millions on political ads**. *ProPublica*. Published April 20, 2020. Accessed August 25, 2024.

25. Hamby C. **In battle over health care costs, private equity plays both sides**. *The New York Times*. Published April 7, 2024. Accessed August 25, 2024.

26. Sabalow R. **Doctors vs. hospitals: a bid to regulate hedge funds is dividing California medical groups**. *Cal Matters*. Published April 30, 2024. Accessed August 25, 2024.

27. **Lannan K. Warren seeks consequences for 'corporate crimes' in health care**. WGBH. Published June 11, 2024. Accessed August 25, 2024.

28. Kane CK. Changes in physician practice arrangements: shifts away from private practice and towards larger practice size continue through 2022. American Medical Association (AMA). Physician Practice Benchmark Survey. Published May 16, 2024. Accessed August 25, 2024.

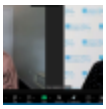


**Topics:** corporate medicine physician union

## Related

GW Residency Union: A Resident's Perspective

December 17, 2024 - 0 Comment



A Conversation with ACEP President Dr. Alison Haddock

December 3, 2024 - 0 Comment

Reader Responds: The Private Equity Wave in Health Care

November 5, 2024 - 0 Comment

## CURRENT ISSUE


**ACEP Now: Vol 44 – No 02 – February 2025**

Read More

## One Response to "The Private Equity Wave in Health Care"