AMERICAN BANKRUPTCY INSTITUTE

Mid-Atlantic Bankruptcy Workshop

Private Equity in Healthcare: How Sick Is the Patient?

Steven Adler, Moderator
Bayard, P.A. | Wilmington, Del.

Erin R. Fay
Wilson Sonsini Goodrich & Rosati | Wilmington, Del.

Christopher A. Ward
Lowenstein Sandler LLP | Wilmington, Del.

Allen D. Wilen
EisnerAmper LLP | Iselin, N.J.

Jonathan W. Young
Troutman Pepper Locke | Boston

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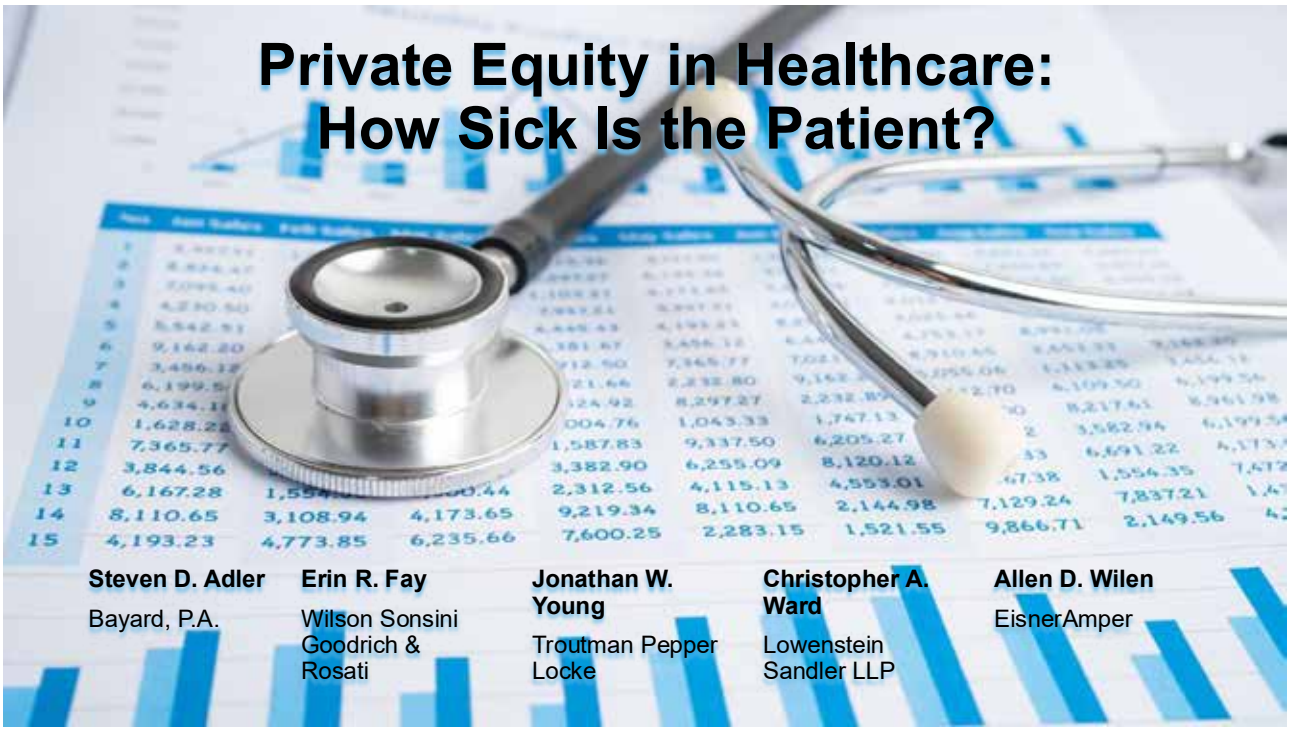


Private Equity Healthcare Investment Structures

How Private Equity Acquires and Holds Healthcare Businesses

Wilson Sonsini Goodrich & Rosati | Bankruptcy, Insolvency & Restructuring

Private Equity Tools to Create Value

- Acquire businesses and assets, often utilizing debt to acquire assets
- Consolidate market share
- Increase efficiency
- Increase profitability, including stripping assets out of the purchased entities such as real estate
- Exit investment at highest multiple and in shortest time period

The Classic Roll-Up / Consolidation Play

Acquire a fragmented market, consolidate under centralized infrastructure, and capture margin through scale

How the Model Works

- Acquire a fragmented specialty market through a series of add-on acquisitions of physician practices, clinics, or service providers
- Consolidate acquired businesses under a centralized management platform (MSO) with shared back-office infrastructure
- Buy small practices at 4–6x EBITDA; exit the consolidated platform at 10–14x — pure multiple arbitrage
- Renegotiate payer contracts from a position of scale, a 200-location platform has leverage a single practice never will
- Common in physician specialties (dermatology, orthopedics, ophthalmology), dental, behavioral health, home health, and ASCs

Strategic Goals

Increase Operational Efficiency
Centralize billing, HR, compliance, and IT to reduce per-unit cost and improve margins across all acquired entities

Build Size and Scale
Grow the platform through successive tuck-in acquisitions to create a large, defensible enterprise with premium exit valuation

Capture Large Market Share
Dominate a geographic market or specialty to establish pricing power with payers and barriers to entry for competitors

The Core Problem: Corporate Practice of Medicine

CPOM prohibits non-physician entities from employing physicians or directing medical decision-making. This constraint shapes every structure. Hospital acquisitions are not subject to CPOM restraints and direct acquisition of an operating entity is more common. Hospitals are subject to additional regulatory overlays.

What CPOM Prohibits

- Non-physician ownership of medical practices
- Directing or controlling clinical decisions
- Fee-splitting with non-physician entities or kickbacks
- Employing physicians through lay corporations

State Level Restraints

- Various states have enacted a variety of laws and regulations to restrict the corporate practice of medicine
- Recently certain states, including California, appear to have active agendas to strictly enforce CPOM

Structural Consequence

- PE cannot directly acquire medical groups
- Requires bifurcated MSO / PC structure
- Nominee or "friendly" physician must own PC equity
- All economic control runs through MSO contract and related contracts

Bottom line: PE acquires the management layer — not the medical practice itself.

The MSO Model

The Managed Service Organization is the dominant PE structure for acquiring physician practices. An MSO includes different entities to bifurcate a healthcare business into clinical and non-clinical entities. MSO typically 30–40 year exclusive contract. PC pays management fee to MSO and PC cannot be terminated without cause

Management Services Org (MSO)

PE-OWNED | NON-CLINICAL

- Owns real estate and equipment practice uses
- Owns intellectual property (i.e., brand)
- Provides back-office services: billing and revenue cycle management, non-clinical staff and HR, IT and records management, and cash management
- Provides working capital

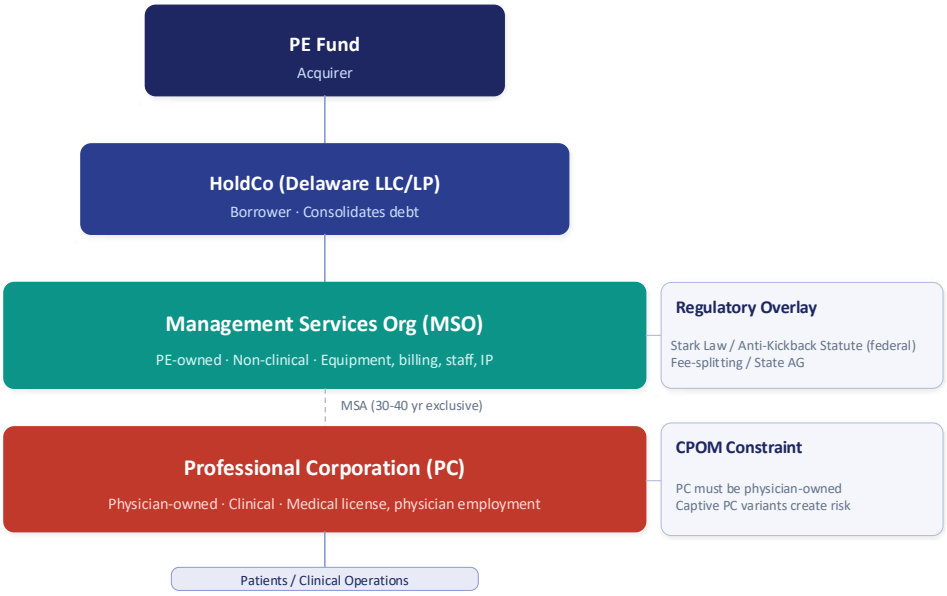
MSA

Professional Corporation (PC)

PHYSICIAN-OWNED | CLINICAL

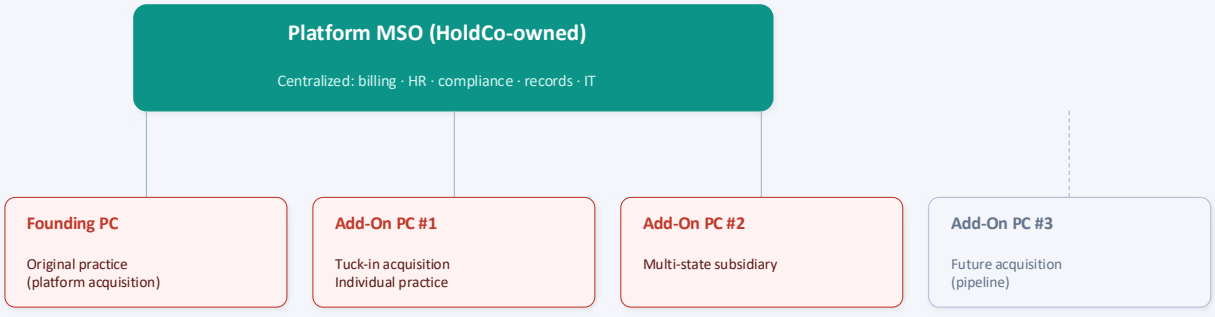
- Holds medical license
- Employs (or contracts with) physicians
- Makes all clinical decisions
- Patient care and treatment authority
- Owned by nominee or "friendly" physician
- Equity may be subject to call/put options

MSO Structure at a Glance



HoldCo & Roll-Up Architecture

Platform acquisition establishes MSO infrastructure. Tuck-ins converted into satellite PCs.



Why HoldCo?

Consolidates debt, separates liability, serves as borrower under credit facility, facilitates add-ons without touching the fund.

State Compartmentalization

Often there is one MSO entity per state for regulatory isolation. Multi-state roll-ups require jurisdiction-by-jurisdiction CPOM analysis.

Tuck-In Mechanics

Acquired practice converted to PC opco under MSA agreement. Centralized back-office absorbed. Founder often retains rollover equity.

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Debt Finance Utilized for PE in Healthcare

Jonathan Young, Troutman Peppler Locke LLP

Market Context – Private Credit is Extremely Active

- **U.S. buyout deal value in pharma, medical, and biotech reached $78.9 billion 2025**
  - Second highest in 15 years, second only to 2021 at $79.6B
- **Private Credit considered "port of first call" for healthcare sponsors**
  - U.S. private credit AUM is ~ $1.5 trillion
- **Private credit financed ~85% of 2024 LBOs**

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Exemplar Transactions

Deal	PE Sponsor/Lender	Structure and Key Terms
Walgreens Boots Alliance, take-private, 2025	Sycamore Partners; Citi, Goldman, JPMorgan, UBS, Wells Fargo	~$23.7B enterprise value; ~$18.2B debt (ABL revolver, term loans, bridge, receivables financing, preferred equity);
Surgery Partners (ambulatory surgery centers), refinancing, Aug. 2025	Syndicated; bank-arranged term loan and revolver Bain Capital held 37% of equity at time of transaction	$1.38B senior term loan, SOFR+ 2.5% bps (or alternate rate with 1% floor), matures Dec. 2030, repayment in quarerly installments of 0.25% of original principal
Greenway Health (ERH / practice-management software), refinancing, 2024	Oak Hill Advisors (OHA) as lead left arranger	~$375M unitranche term loan, used to refinance maturing syndicated first-lien debt; OHA committed ~50% of the facility
NextGen Healthcare (healthcare IT), take-private, 2023	Thoma Bravo	$1B unitranche finance
PetVet Care Centers (vet chain), recapitalization, 2023	KKR; unitranche led by Blue Owl, with Ares, Oaktree, Oak Hill	$2.3B unitranche, SOFR+600 bps, 7 yr. maturity, plus $400M third-party preferred equity and $600M new KKR common equity

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Example Chapter 11 Debtors (Pre-Petition)

Debtors	PE Sponsor/Ownership	Transaction	Real Estate Structure	Outstanding Debt at Filing
Steward Healthcare	Cerberus Capital Management, partnering with Dr. Ralph de la Torre, acquired six MA hospitals from Caritas Christi in 2010 (rebranded as Steward). In May 2020, physician-mgmt group bought out Cerberus via $350M convertible note; Jan. 2021, Steward investors borrowed $335M from MPT to retire the Cerberus note.	2010 acquisition/rebrand from Caritas Christi. Expansion: Community Health Systems (7 hospitals, early 2017); merger with IASIS Healthcare (18 hospitals, 2017); 5 South Florida hospitals from Tenet (2021).	2016 MPT recapitalization: sold/leased back 5 hospitals under Oct. 3, 2016 Master Lease; ~$1.2B mortgage on 4 MA hospitals; $50M MPT equity investment. 2017 IASIS: MPT acquired hospital RE, made $700M mortgage on 2 UT hospitals, $100M equity investment. At filing: 36 facilities under 2 non-severable master leases (ML I: 28 facilities; ML II: 8 facilities); ~$341M annual rent.	$1.2B funded debt + $8B unsecured ($6.6B LT MPT lease obligations) = $9.2B total. Funded debt: ABL First Out $49.3M; ABL $247.3M; FILO $305.5M; Bridge $274.5M; MPT Facility $216.7M; MPT Stewardship Note $82.5M.
Center City Healthcare	Owned directly/indirectly by Philadelphia Academic Health System, LLC (PAHS); ultimate parent Philadelphia Academic Health Holdings, LLC (PAHH). Control via MBNF Investments, LLC (Freedman family, controlled by Joel Freedman) and American Academic Health System, LLC.	Jan. 11, 2018: PAHH and affiliated Buyers purchased Hahnemann, St. Christopher's, and physician groups from Tenet Business Services Corp. under Asset Sale Agreement dated Aug. 31, 2017. Tenet had owned the businesses since 1998.	Acquisition financed via: (i) MidCap credit facility; (ii) ~$51M Harrison Street Real Estate loan; (iii) $17.5M Tenet loan to non-debtor Front Street entities (secured by Phila. RE, guaranteed by PAHH). Operating entities separated from non-debtor propcos at acquisition. HUH RE held by non-debtor Broad Street Healthcare Properties (nominal-consideration lease); STC leases from Front Street entities and HSRE-PAHH master-lease entities.	MidCap facility: $100M revolver + $20M term loan; outstanding ~$38.6M (revolver) + $20M (term). ~$87M trade debt; Tenet/Conifer claims >$41M; DUCOM claim >$13M; potential pension withdrawal liability.
Prospect Medical Holdings	Founded as Alta Hospital Systems (mid-to-late 1990s). Leonard Green & Partners held 11-year majority ownership. LGP acquired ~60% stake in 2011 for $363M; ~$645M in dividends/preferred (~$424M to LGP), incl. $457M debt-funded dividend.	2011 LGP leveraged buyout / dividend recapitalization, followed by growth through acquisitions 2012-2016: Nix Health (TX, 2012), CharterCARE (RI JV, 2014), East Orange General (NJ, 2016), Crozer-Keystone (PA, 2016), ECHN & Waterbury Hospital (CT, 2016).	Aug. 23, 2019: entered two MPT master leases with $760M lease obligations. May 2023: (Centerbridge, Blue Torch, MPT): $375M new capital; MPT obligations reduced ~$646M for 49% PHP Holdings interest + convertible note; related $167M MPT mortgage loan.	~$2.3B total funded obligations (~$1.1B at Debtors). Components: MPT Master Leases $760M; MPT Mortgage $167M; HospitalCo Term Loan $75M (MPT); HospitalCo Revolver $84M (eCapital); PhysicianCo Term Loan $453M (Centerbridge/Blue Torch); MPT Convertible Notes $732M.
Genesis Healthcare	July 2007: taken private via $1.52B merger by Formation Capital and JER Partners (through FC-GEN Acquisition Holding). 2010: FC-GEN Operations Investment became ultimate parent; JER exited ~2011. March 2021: ReGen Healthcare provided ~$100M capital infusion via convertible sub notes (~93% voting shares if converted). ReGen affiliated with Pinta Capital / Joel Landau.	2007 $1.52B take-private. Expansion: Sun Healthcare Group (2012); merger with Skilled Healthcare Group (2015), forming Genesis Healthcare, Inc. (NYSE: GEN). ReGen rescue financing + Welltower lease restructuring averted 2021 bankruptcy; NYSE delisting March 2021.	April 1, 2011: transferred substantially all RE (147 facilities in 11 states) to Health Care REIT (now Welltower) for $2.4B; entered long-term triple-net master lease.	Secured liabilities $708.5M: White Oak Non-HUD ABL $223.6M; White Oak HUD ABL $55.7M; Prepetition Term Loan ~$317.8M (Welltower $112.5M, Omega $120.8M, MAO $14.7M, WAX $69.8M); Rochester Manor HUD $8.3M; IRS $103.1M. Unsecured liabilities $1,568.0M (incl. AP $339.4M, litigation ~$259M, provider assessments $74.5M, ReGen/MAO/WAX notes).

Example Chapter 11 Debtors – City Center Healthcare & Genesis Healthcare DIP Terms

Debtors	Lender(s)	Facility Type and Size	Interest Rate	Fees	Roll-Up	Lien Priority/Superpriority Claims
City Center Healthcare	MidCap Funding IV Trust (successor-by-assignment to MidCap Financial Trust), as DIP Agent and lender	Senior secured, priming, superpriority. Total $67,000,000: $50M revolving facility (asset-based, subject to Borrowing Base) + $17M term loan ($15M rolled up prepetition term + $2M admin reserve)	LIBOR Rate (0.50% LIBOR floor) + Applicable Margin	Unused line fee: 0.50% p.a. Collateral mgmt fee: 0.10% per month Origination fee: 1.0% of Revolving Loan Commitment	$15M of the term loan refinanced/rolled up the prepetition MidCap term loan. Prepetition obligations at filing: $37,456,342.37 (revolving) + $20,000,000 (term)	Liens under Sec. 364(c)(1), (c)(2), (c)(3) and 364(d) (priming). Subject to Carve-Out and Permitted Prior Liens. Sec. 364(c)(1) superpriority claims.
Genesis Healthcare	Welltower Lender (Markglen, LLC), Omega Lender (OHI Mezz Lender, LLC), WAX Lender (CPE 88988 LLC / ReGen-affiliated). Welltower OP LLC as admin & collateral agent	Junior secured DIP term loan up to $30,000,000 ($12M Initial Borrowing + up to $18M Final Borrowing)	15.0% p.a., PIK Default rate: +2.0% p.a.	Upfront Fee: 2.0% of Commitments (PIK, capitalized on Closing Date). Exit Fee: 4.0% of initial Commitments (earned on Closing, payable in cash on Maturity Date)	None	Junior in priority to prepetition ABL (White Oak Healthcare Finance), prepetition term loan, and WELL/OHI master-lease liens. DIP liens subject to Carve-Out and Permitted Lien Sec. 364(c)(1) superpriority claims.

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Example Chapter 11 Debtors – Steward Healthcare DIP Terms

DIP Facility	Lender(s)	Facility Type and Size	Interest Rate	Fees	Roll-Up	Lien Priority/Superpriority Claims
Junior DIP	MPT TRS Lender-Steward, LLC	Junior-lien, superpriority term loan. Authorized up to $300,000,000. Initial commitment $75,000,000	Term SOFR + Applicable Rate, PIK/capitalized. Default rate: +2.00% p.a.	Funding Payment: 3.00% of Initial Term Loans funded (PIK) Exit Premium:3.00% of Initial Term Loans repaid or prepaid	$72,588,448.15 of Prepetition Stewardship Obligations rolled up and converted into DIP Roll-Up Loans upon entry of Final Order	Junior-lien DIP. Sec. 364(c)(1) superpriority claims, pari passu with prepetition MPT Obligations under intercreditor agreement
FILO DIP – Provided by new lenders when original DIP Lender did not want to extend further credit	Brigade Agency Services LLC (admin & collateral agent). Lenders: Owl Creek Investments I, WhiteHawk Finance, OneIM Fund I LP	Priming, superpriority term loan up to $225,000,000. $75M Initial Draw (interim order, June 14, 2024) Initial Term Loans capped at $150M until binding APA for Stewardship assets	Adjusted Term SOFR + Applicable Rate, paid in cash. Floor: 2.50% p.a. Default rate: +2.00% p.a	Upfront Premium: 4.0% of initial term loans funded plus amount od delayed draw commitments provided (PIK) Administrative agent fee: $50,000/month to Brigade	$150,000,000 of prepetition FILO Term Loans rolled up into DIP Roll-Up Loans; treated as "Last Out Loans"	Priming liens under Sec. 364(d)(1) per Priorities Annex. Sec. 364(c)(1) superpriority claims. Roll-up liens pari passu with prepetition ABL/FILO liens but last-out in payment

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Example Chapter 11 Debtors – Prospect DIP Terms

DIP Facility	Lender	Facility Type and Size	Interest Rate	Fees	Roll-Up	Lien Priority/Superpriority Claims
Term Loan	JMB Capital Partners Lending, LLC	Non-amortizing, priming, superpriority senior secured term loan up to $100M. $29M interim amount drawn in single draw at interim stage. Remainder available after Final Order; no more than $46M incremental to the Interim Amount could be drawn before entry of MPT Settlement Approval Order.	14.0% p.a. Default rate: +2.0%	Commitment Fee: 4.00% of Commitments (fully earned on Interim Order, paid in cash from Interim Amount). Exit Fee: 6.00% (of outstanding Loans pre-Final Order / of total Commitments post-Final Order; fully earned on Interim Order).	None	First-priority priming liens under Sec. 364(d)(1); plus Sec. 364(c)(2) and (c)(3) liens; second liens on eCapital Priority Collateral. Subject to Carve-Out and Permitted Prior Liens. Sec. 364(c)(1) superpriority claims.
ABL	eCapital Healthcare Corp	Super-priority senior secured revolving credit (ABL) facility; Facility Cap of $90,000,000; DIP ABL Loan Limit = lesser of the Facility Cap and 85% of the Borrowing Base.	Prime Rate + 1.50% Applicable Margin (computed on a 360-day year). Default rate: +2.0%.	Facility Fee: 1.0% of Facility Cap. Unused Line Fee: 0.083%/month of unused amount. Collateral Management Fee: 0.15%/month of average daily outstanding balance.	"Creeping" cashless roll-up: upon each Advance at interim stage, equal amount of Prepetition ABL Obligations becomes DIP ABL Roll-Up Obligations dollar-for-dollar; upon Final Order, total outstanding Prepetition ABL Obligations (not less than $82,370,974) roll up in full.	First-priority priming liens under Sec. 364(d)(1) and junior liens under Sec. 364(c)(3) on DIP ABL Collateral. Subject to Carve-Out (15% allocation) and Permitted Prior ABL Liens. Sec. 364(c)(1) superpriority claims.

Trends in Deal Terms

Pricing

- PetVet priced at SOFR + 600 bps — illustrative of healthcare unitranche spreads in the higher-rate environment.
- Healthcare-specialist private credit funds posted median net IRRs of ~15% vs. ~11% for generalist US direct lending — and did so at lower fund-level leverage (0.3x vs. 1.0x).
- Lenders increasingly use payment-in-kind (PIK) flexibility to win deals and ease cash-interest pressure.

Covenants

- Cov-lite dominated: ~89% of outstanding US leveraged loans at par (year-end 2023) and ~93% of institutional leveraged-loan issuance volume
- Maintenance covenants persist in the mid-market: more common for borrowers with EBITDA < $100M; cov-lite more common above that threshold.
- Legal advisors are drafting tiered covenant testing triggers to avoid technical defaults while preserving lender protection.

Recourse to Sponsor

Typical LBO – Structurally Non-Recourse

- Acquisition debt is contained in an SVP to silo it and prevent default contagion across the sponsor's broader portfolio; counsel manages veil-piercing risk by keeping the vehicle independently governed and capitalized.
- Any guarantees are typically limited-recourse guarantees secured by a pledge of the borrower's equity rather than full personal/affiliate recourse.

A Contractual Sponsor "Backstop" Not True Recourse

- Cure rights let the sponsor inject equity to cure a covenant breach, with the cure amount added back to EBITDA.
- Over 60% of broadly syndicated LBOs in 2023 included equity-cure language (up from 45% in 2021); healthcare/pharma use cures frequently because regulation and launches cause temporary breaches. (Private Equity Bro, Aug 2025)
- Lenders guard against "round-tripping" by requiring funds come from outside the loan-party group.

- **Regulatory Recourse — Where Principals/Affiliates Can Be Reached Directly**
  - False Claims Act (FCA) exposure is the principal avenue to reach sponsors. Diabetic Care Rx / Riordan Lewis & Hayden was the first DOJ settlement extracting payment from a PE firm over a portfolio company. (Bradley; Temple 10-Q)
  - Ancor Holdings paid $1.8M alongside its portfolio company's $15.3M Alliance settlement, based on alleged inaction after diligence. (Paul Weiss, 2021)
  - A KHN investigation found PE portfolio companies settled at least 34 FCA suits since 2014, paying $500M+
  - Liability is not automatic: in Oct 2025 a court dismissed Pharos Capital from a healthcare qui tam suit — control and management involvement drive exposure.

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Dividends & Distributions

- **Mechanics**
  - A dividend recap raises new debt on the portfolio company solely to fund a special cash dividend to equity (*i.e.* the PE sponsor) — a partial exit that de-risks the sponsor while increasing the company's leverage and default risk.

- **Scale of Activity**
  - Private equity-owned companies raised $94 billion across leveraged loans and high-yield bonds in 2025 to finance dividend recapitalizations.
  - Of 2025 recap volume, ~$50B (53%) went to sponsors, up from $33B (34%) in 2024.
  - Moody's view: this signals sponsors prioritizing distributions over credit health.

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Default Scenarios

Covenant Default

- A breach of a financial maintenance covenant triggers an event of default even without a missed payment
  - Cov-lite deals and equity cures exist to defer this

Distressed Exchanges

- Sponsors can avoid bankruptcy court via distressed debt exchanges (*e.g.* in 2024 at least six PE-owned healthcare companies defaulted but restructured out of court.

Defaults Leading to Bankruptcies

- Genesis Healthcare (nursing homes, 17 states) filed bankruptcy in July 2025 after years of "high-risk borrowing" and recurring regulatory violations.
- Steward Health Care
  - $9B+ liabilities, including $290M unpaid wages/benefits ~$1B to vendors, and $6.6B in long-term lease obligations to Medical Properties Trust.
  - Steward's collapse traces to a 2016 sale-leaseback to MPT that funded dividends to Cerberus while loading unaffordable rent; Cerberus exited with $800M+ profit
- Reimbursement cuts to Medicare/Medicaid can independently precipitate restructuring or bankruptcy for borrowers serving those programs.

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Over-Leverage by PE in the Healthcare Space?

- PE-acquired healthcare companies averaged 5.9x debt/EBITDA in 2023, versus ~3x for publicly traded healthcare companies.
- PE was linked to 21% of all healthcare bankruptcies in both 2023 and 2024; healthcare bankruptcies were 21% of all US corporate bankruptcies in 2024.
- PE-backed companies accounted for 88% of the largest healthcare bankruptcies (>$500M liabilities) in 2024

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Discussion: Do these financing arrangements have a positive, negative, or neutral impact on the PE Sponsor's stewardship of the investment?

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Exit Scenarios for PE Investments in Healthcare

Sale transactions, refinancing and recapitalization, Chapter 11 restructuring, and the sponsor's role across each path to exit

PANEL DISCUSSION

Consensual Exit Strategies: The Landscape

Three primary, non-distressed paths for a PE sponsor to exit a healthcare investment

Sale Transaction

Strategic or sponsor-to-sponsor sale of the portfolio company, in whole or in part, to a third-party buyer.

Refinancing

Replacing existing debt with new financing to extend runway, adjust covenants, or return capital to equity.

Recapitalization

Restructuring the balance sheet's debt-equity mix — often via a dividend recap or new sponsor investment.

Logistical Hurdles — and the Sponsor's Role

Sale transactions and refinancing/recapitalization surface distinct challenges in healthcare deals

Sale Transaction

KEY CHALLENGES

- Regulatory and licensure transfer requirements (CON, change-of-ownership)
- Payor and provider consents; network and referral continuity
- Valuation gaps amid reimbursement and rate uncertainty

SPONSOR'S ROLE

Sponsor drives process design, manages diligence flow, and negotiates reps/warranties and escrow to bridge risk.

Refinancing & Recapitalization

KEY CHALLENGES

- Lender appetite and covenant headroom in a higher-rate, healthcare-scrutinized credit market
- Balance-sheet capacity for a dividend recap without impairing operations
- Timing relative to portfolio-company performance and market windows

SPONSOR'S ROLE

Sponsor structures the capital stack, leads lender relationships, and balances near-term liquidity against long-term credit health.

Chapter 11: A Sponsor-Led Restructuring Path

When consensual options are exhausted, Chapter 11 offers a court-supervised route to a healthcare exit

01

Pre-Filing Positioning

Sponsor negotiates a stalking-horse bid or restructuring support agreement ahead of filing.

→

02

DIP Financing

Sponsor or affiliate may provide debtor-in-possession financing to fund operations through the case.

→

03

363 Sale / Plan Process

Sponsor navigates a Section 363 asset sale or plan of reorganization, managing regulatory and patient-care continuity requirements.

→

04

Emergence / Exit

Sponsor's residual equity, claims, or new investment position is resolved as the estate exits the case.

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THE PANEL DEBATE

NET POSITIVE

- Capital, operational expertise, and process discipline speed the exit
- Sponsor networks widen the buyer/lender pool

NET NEUTRAL

- Outcome depends more on asset quality and market timing than sponsor involvement
- Sponsor effect is situational, not systematic

NET NEGATIVE

- Leverage and dividend recaps can constrain optionality at exit
- Sponsor-driven timelines may conflict with clinical or regulatory realities

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LEGISLATIVE LANDSCAPE: PRIVATE EQUITY UNDER REGULATORY SCRUTINY

A survey of federal and state legislation targeting PE in Healthcare and other sectors

Christopher Ward

Office Managing Partner, Wilmington

Executive Summary

Private equity faces an unprecedented wave of legislative scrutiny at both federal and state levels.

Healthcare remains the primary target, with bills addressing transparency, transaction review, clinical independence, and asset-stripping. Federal proposals include criminal penalties, clawback authority, and outright Medicare payment prohibitions. Meanwhile, at least 15 states have enacted "mini-HSR" laws to capture PE transactions below federal thresholds.

Beyond healthcare, PE faces scrutiny in housing (institutional landlord restrictions), youth sports, and broad anti-looting measures applicable across all industries.

$1T+	PE invested in healthcare over the past decade
6,000	Physician practices acquired by PE in the last decade
90%+	PE healthcare transactions go unreported under HSR
25	States with PE-targeted healthcare legislation

Federal Healthcare Legislation

Proposed federal bills targeting PE's role in healthcare delivery, with criminal penalties, clawbacks, and payment prohibitions.

6 **Major bills**
introduced or reintroduced

0 **Advanced**
none expected to pass

2 **Regulatory actions**
FTC task force; HSR rules vacated

CORPORATE CRIMES AGAINST HEALTH CARE ACT OF 2026

S. 3829 | Introduced Feb. 11, 2026 | Referred to Senate Finance Committee

Sponsors: Sens. Warren (D-MA), Blumenthal (D-CT), Markey (D-MA), Merkley (D-OR), Welch (D-VT); House co-lead Rep. Goodlander (D-NH)

- Criminal penalties up to 6 years imprisonment for covered parties whose actions contribute to patient injury/death after ownership change
- Clawback authority: AG and state AGs can recover up to 10 years of executive compensation from PE executives at healthcare firms experiencing "triggering events"
- Civil penalties up to 5x the clawback amount
- Restricts sale-leaseback arrangements with REITs
- Prohibits payments from federal programs to entities selling assets to REITs
- Increases ownership/financial transparency; $5M penalties for non-reporting
- Mandates HHS OIG study evaluating profit-driven practices

Status

Referred to committee. Not expected to advance. Reintroduction of failed 2024 version.

Significance

Most aggressive federal proposal. Combines criminal liability with financial clawbacks and REIT restrictions. Signals legislative intent even if passage unlikely.

ADDITIONAL FEDERAL HEALTHCARE BILLS

02	**Take Back Our Hospitals Act of 2026**	Rep. Scanlon (D-PA). Prohibits Medicare payments to hospitals/SNFs "owned or controlled" by PE funds, PE-controlled corporations, or REITs.
03	**Health Over Wealth Act (2024)**	Sen. Markey / Rep. Jayapal. Additional reporting on for-profit entities; HHS task force on PE role; PE licensure requirement; HHS authority to prohibit PE acquisitions pending review. Did not advance.
04	**Stop Wall Street Looting Act (2024)**	Sen. Warren + 9 House members. 100% tax on PE fund manager fees; dividend caps; clawback provisions; expanded disclosures; removes limited-liability protections. Applies beyond healthcare. Response to Steward Health Care.
05	**PATIENT Act (2023)**	Increase transparency and oversight of PE healthcare transactions. Limited advancement.

FEDERAL REGULATORY DEVELOPMENTS

FTC Healthcare Task Force

March 20, 2026

- FTC Chair Andrew Ferguson directed formation of dedicated Healthcare Task Force
- Coordinated enforcement and advocacy approach across entire healthcare spectrum
- Not legislation, but signals significant regulatory focus on PE-backed healthcare consolidation

New HSR Rules Vacated

February 12, 2026

- FTC's new Hart-Scott-Rodino premerger notification rules successfully challenged in court
- Return to old rules while appeals pending
- Reduces federal oversight capacity, reinforcing importance of state-level mini-HSR regimes

State Healthcare Legislation

States are leading the charge with mini-HSR laws, CPOM reforms, and transaction review frameworks.

15+

states have enacted mini-HSR laws to track PE investments

CALIFORNIA AND OREGON

California

AB 1415 (enacted 2025): MSOs and PE transactions subject to OHCA review; MSOs designated as "noticing entities." Eff. Jan. 1, 2026.

SB 351 (signed Oct. 2025): Codifies CPOM restrictions; prohibits PE/hedge fund interference with clinical judgment; bars non-competes in MSAs; AG enforcement. Eff. Jan. 1, 2026.

AB 3129 (vetoed 2024): Would have given AG power to review PE acquisitions. Vetoed by Gov. Newsom.

Oregon

SB 951 (signed June 9, 2025)

Comprehensive CPOM reform. Described as the "highest state legislative barrier" for PE in healthcare.

Key provisions:

- Restricts dual ownership across PMEs and MSOs
- Targets MSO de facto control over clinical staffing, visit duration, coding, pricing, billing, payer contracting
- Violations = unlawful trade practices

Compliance: Jan. 1, 2026 (new entities); Jan. 1, 2029 (legacy)

MASSACHUSETTS AND CONNECTICUT

Massachusetts

H.5159 (signed Jan. 8, 2025):
- Strengthens PE oversight with mandatory notice for equity investor transactions
- Annual financial reporting requirements
- Strict penalties for noncompliance
- Expanded HPC authority over PE-backed entities, REITs, MSOs

2026 proposed amendments:
Would require PE companies acquiring providers to deposit bond with Department of Health.

Connecticut

HB 5316:
Prohibits REITs from acquiring or increasing operational control over hospitals starting Oct. 1, 2026.

SB 196:
Focuses on PE control of hospitals; received Joint Favorable Substitute report March 2, 2026.

- Would push start to Feb. 2027
- Prohibits sale-leaseback transactions

NEW YORK AND MAINE

New York

Article 45-A (enacted Feb. 2024):
Expanded state-level HSR-type oversight of healthcare transactions.

SB 9192 (introduced Feb. 12, 2026):
Prohibits overlapping ownership/control between health insurance companies and healthcare providers.

3-year divestiture window for existing conflicts.

Maine

LD 2198: Impose debt-to-equity ratio limits on PE healthcare transactions.

LD 2201: Comprehensive review framework; 180-day advance notice; AG approval authority for PE/hedge fund/MSO transactions.

LD 2202: Concurrent HSR filing with Maine AG.

One-year moratorium on hospital purchases by PE/REITs.

New law (eff. July 15, 2026): HSR filers with Maine nexus must provide materials to Maine AG.

RHODE ISLAND, MARYLAND, NEW HAMPSHIRE, AND PENNSYLVANIA

RI — Rhode Island

AG final rule (Jan. 2026): Premerger notification for PE/medical practice transactions. HB 7172: 60-day notice to Dept. of Health & AG. SB 2950: Amends Hospital Conversions Act; bond deposit; prohibits PE interference with clinical decisions; private right of action.

MD — Maryland

HB 632 (introduced Jan. 30, 2026): Exempts psychiatric facilities from CON; requires 90-day notice of material change transactions to Maryland Health Care Commission.

NH — New Hampshire

"Keep Wall Street Out of Health Care Act": Targets PE and for-profit ownership of healthcare providers. Enforcement via civil actions, injunctive relief, civil penalties, divestiture/rescission.

PA — Pennsylvania

Proposed legislation: AG notice for transactions involving healthcare entities and "covered entities" (PE companies, hedge fund groups, out-of-state investors).

ADDITIONAL STATE ACTIVITY

Minnesota

- SB 2939 (reintroduced Feb. 2026): Annual disclosure of ownership, control, financial data to Commissioner of Health.
- HF 2771 (March 2, 2026): Regulates PE acquisitions of nursing homes/ALFs; 120-day notice; AG approval; prohibits asset-stripping; 75% of public funds to direct care.

Indiana

- SB 219: Incorporate Uniform Antitrust Pre-Merger Notification Act; concurrent HSR filing with Indiana AG.
- Existing law (eff. July 1, 2024): 90-day notice to AG before mergers involving healthcare entities including PE partnerships.

Illinois, New Mexico, Virginia, West Virginia, Arizona

- IL HB 5000: Broaden covered transactions to capture PE companies.
- NM: Made temporary consolidation authority permanent; widened scope; added penalties.
- VA HB 1458: Directs study of PE impact on healthcare (failed).
- WV HB 4917: Would terminate Health Care Authority and eliminate CON program.
- AZ HB 2211: Deems IDR offers exceeding 300% of Medicare unprofessional conduct (stalled).

PE Legislation: Other Sectors

Housing, youth sports, and broad anti-looting measures expanding legislative scrutiny beyond healthcare.

Housing

Institutional landlord limits

Cross All Industry

Broad PE reforms

Youth Sports

Congressional scrutiny

HOUSING AND REAL ESTATE

Federal Bills

Stop Wall Street Landlords Act (H.R. 7138)	Targets institutional investors acquiring single-family homes.
Stopping Wall Street From Competing With Main Street Homebuyers Act	Amends Investment Company Act of 1940 to prevent large entities from buying single-family homes. Referred to committee.
Stop Predatory Investing Act of 2026	Denies tax deductions for interest and depreciation on properties owned by institutional investors holding 50+ single-family homes.

State Bills

Connecticut: Prohibits PE from purchasing single/two-family homes unless listed publicly for 90 days. Penalties up to $250,000. Died on House Calendar.
Iowa: Allow cities to prohibit PE-funded entities from buying single-family properties (2025-2030 sunset). Died in committee.
Mississippi: Included in Stop Predatory Investing Act provisions for state tax compliance.

CROSS ALL INDUSTRY & YOUTH SPORTS

Stop Wall Street Looting Act

Applies across ALL industries (not just healthcare)

- 100% tax on fees paid by portfolio companies to PE fund managers
- Cap on dividends extracted from portfolio companies
- Clawback provisions for money transferred out
- More extensive public disclosures by PE funds and portfolio companies
- Remove limited-liability protections from controlling PE funds for portfolio company liabilities

Youth Sports

Congressional and state AG scrutiny of PE investments in:

- Youth sports leagues
- Facilities
- Related assets

Concerns:
Rising costs and limited participation access for families.

Status: Congressional attention noted but no specific bill identified as of July 2026.

KEY TAKEAWAYS & OUTLOOK

State action outpaces federal

With federal bills unlikely to advance, states are the primary regulatory vector. At least 15 states have enacted mini-HSR laws; more are pending.

CPOM and clinical independence

Oregon and California lead with CPOM reforms restricting MSO/PE interference in clinical decision-making. Expect other states to follow.

Expanding beyond healthcare

Housing, youth sports, and cross-sector anti-looting proposals signal PE scrutiny as a bipartisan theme beyond healthcare.

Compliance complexity increasing

Multi-state notice requirements, bond deposits, debt-to-equity limits, and moratoriums create a patchwork compliance challenge for PE-backed entities.

Q1 2026 Scorecard: 2 bills passed | 10 stalled | 10 battleground states remaining


Questions?

Faculty

Steven D. Adler is counsel in Bayard P.A.'s Business Bankruptcy and Restructuring group in Wilmington, Del., and concentrates his practice in the areas of corporate bankruptcy and restructuring. He has represented corporate debtors, official committees, creditors, lenders, asset-purchasers and other significant parties in interest in various bankruptcy court proceedings and out-of-court restructurings and dissolutions. He also has experience handling commercial and corporate litigation matters. Prior to joining Bayard, Mr. Adler pursued his practice for several years in the Delaware office of an international law firm. He received his B.S. in finance *cum laude* from the University of Delaware in 2010, and his J.D. *cum laude* from Temple University Beasley School of Law, during which he served as a judicial intern to Hon. Mary Walrath of the U.S. Bankruptcy Court for the District of Delaware and as the lead research editor for the *Temple International & Comparative Law Journal*. Prior to law school, Mr. Adler worked in the banking and finance industry.

Erin R. Fay is a partner in the Wilmington, Del., office of Wilson Sonsini Goodrich & Rosati, where she is a member of its restructuring practice. She counsels management, boards and creditors on issues related to distressed companies, fiduciary duties, creditors' rights and insolvency strategies. In chapter 11 cases, Ms. Fay represents a variety of clients, including debtors, lenders, individual creditors, equityholders, asset-purchasers, official committees and ad hoc committees. She has represented clients in a broad range of industries, including biotechnology, medical devices, retail, manufacturing, transportation, energy, health care and financial services. Previously, Ms. Fay was a partner at Bayard P.A., a Wilmington-based boutique law firm, where she was a member of its business restructuring and liquidations group and served on the firm's executive committee. Early in her legal career, she clerked for Hon. Brendan L. Shannon, Hon. Kevin Gross and Hon. Peter J. Walsh, all of the U.S. Bankruptcy Court for the District of Delaware. While in law school, she interned for Hon. Shirley S. Abrahamson of the Wisconsin Supreme Court. Following graduation, Ms. Fay practiced restructuring law as an associate at Morris, Nichols, Arsht & Tunnell LLP. She was honored as a member of the 2020 class of ABI's "40 Under 40." Ms. Fay received her B.A. *summa cum laude* in English and political science from the University of Wisconsin – Stevens Point and her J.D. from the University of Wisconsin Law School, where she was inducted into the Order of the Coif and participated in moot court and on the *Wisconsin International Law Journal*. Following college, she spent a year in service with AmeriCorps VISTA administering a teen court in Southern Maryland.

Christopher A. Ward is a managing partner for Lowenstein Sandler LLP's Wilmington, Del., office and a partner in its Bankruptcy & Restructuring Department. He is ABI's Immediate Past President, having served as ABI's President from 2024-25. Mr. Ward's focuses his practice on corporate bankruptcy, financial restructuring, bankruptcy and distressed litigation, and distressed asset sales, as well as nonbankruptcy alternatives. In his career, he has been lead chapter 11 debtor's counsel in *Avante Health Solutions/Jordan Health Products*, *Esco Ltd.*, *Lucky's Markets*, *Elements Behavioral Health*, *Orchids Paper Products*, *PhaseRx*, *ActiveCare* and *Bayou Steel Group*, among many others. Mr. Ward has been recognized for excellence in Delaware Bankruptcy/Restructuring by *Chambers USA* (2010 - Present (Band 2)), recognized by *Super Lawyers* in Delaware for Bankruptcy & Creditor Rights (2012 (RS) and 2014-present), recognized in *Lawdragon*'s 500 Leading U.S. Bankruptcy & Restructuring Lawyers (2022-present) and recognized by *The Best Lawyers in America* for Bank-

ruptcy/Restructuring in Delaware (2015-present). In addition, he is editor and author of ABI's *Professional's Guide to Non-Bankruptcy Alternatives*, author of *The Zone of (In)solvency: Fiduciary Duties and Standards of Review for Corporations and Limited Liability Companies* and *A Business Creditors' Guide to Distressed Vendors, Debt Collection and Bankruptcy*, and editor and co-author of *The Chief Restructuring Officer's Guide to Bankruptcy*. He also served as an editor and contributor to the interactive web version of Polsinelli's *The Devil's Dictionary of Bankruptcy Terms*. Mr. Ward received his B.A. from Moravian College in 1995 and his J.D. *cum laude* from Widener University School of Law in 1999.

Allen D. Wilen, CPA, CIRA, CFA, CTP, ABV is a partner with EisnerAmper LLP in Iselin, N.J., and serves as the national director of its Financial Advisory Services Group. In this role, he leads a team of over 100 professionals dedicated to assisting the firm's clients through the litigation and restructuring process. Mr. Wilen provides operational consulting, valuation and litigation-support services specializing in the areas of distress, debt restructuring and business disputes. In addition, he provides analysis of insolvent and troubled companies, provides advice in turnaround and crisis situations, counsels purchasers in the acquisition of assets within the bankruptcy arena, and provides expert advice to parties in civil matters. Mr. Wilen has more than 25 years of financial and accounting experience in both national and regional public accounting firms. He has been involved in numerous complex matters requiring expertise in forensic accounting and operational analysis, and he has been qualified as an expert in numerous state and federal courts throughout the U.S. Mr. Wilen has represented numerous distressed entities in navigating their path through the complexity and confusion of the turnaround, sale and liquidation processes. He has been appointed in numerous fiduciary capacities by both federal and state courts as a receiver, special fiscal agent, liquidating trustee, examiner, provisional director and CRO. In addition, he often represents court-appointed trustees, receivers and examiners, and has been involved in a large number of high-profile cases. Mr. Wilen has served as trustee for a hospital in chapter 11 and was successful in his litigation against directors and officers and other professionals. Mr. Wilen has written articles and industry journals, including a number of sections in the Turnaround Management Association's *Body of Knowledge* and a chapter on "Financial Reporting in Bankruptcy" for ABI's *The Chief Restructuring Officers Guide to Bankruptcy: Views from Leading Insolvency Professionals*. He has also been a speaker on several topics, including director and officer liability in nonprofit entities, prepackaged chapter 11s, valuation, professional ethics and distressed health care-related entities. Mr. Wilen received his B.S. in accounting from Binghamton University.

Jonathan W. Young is a partner in the Washington, D.C., office of Troutman Pepper Locke and chairs the firm's Bankruptcy and Restructuring Practice Group, which is comprised of a team of more than 50 professionals representing a wide range of stakeholders and industries in a variety of courtroom and boardroom situations. His practice encompasses out-of-court restructuring, distressed lending and M&A, governance of financially stressed and distressed entities, and complex bankruptcy and insolvency proceedings in the U.S. and internationally. Mr. Young advises investors, lenders, noteholders, directors, equity sponsors and portfolio companies across multiple industries and jurisdictions. He also represents trustees, receivers and other fiduciaries in reorganizing, restructuring or liquidating financially distressed entities. His practice also extends to complex litigation, focusing on governance disputes, avoidance and insolvency-related claims, and secured lending and related intercreditor issues. With substantial experience in restructuring and, when necessary, winding down private equity-sponsored portfolio companies, Mr. Young's practice bridges restructuring and bank-

ruptcy, debt finance, private equity and governance, and he represents the company, directors and management, 1L, 2L or mezzanine lenders, equityholders, or a potential purchaser or investor. He has been listed in *Chambers USA* for Restructuring and Insolvency since 2013, *The Best Lawyers in America* for Bankruptcy and Creditor Debtor Rights/Insolvency and Reorganization Law since 2021, *Global Restructuring Review 100* since 2019, and *Illinois Super Lawyers* for Bankruptcy since 2009. Mr. Young received his B.A. *cum laude* in 1986 from Yale University and his J.D. in 1990 from Northwestern University School of Law.