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Legislative approaches to curb corporate influence in health care

State-level policy options to protect the integrity of medical practice amidst increased investment in health care by private equity firms and other corporate entities

Contents

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Introduction

This informational report offers a five-part framework for understanding state legislative approaches to address undue corporate influence in health care, drawn from an analysis of recent state legislative activity. Appendix I provides relevant AMA policy, while Appendix II compiles example relevant legislative provisions for ease of reference. While this resource does not purport to offer policy recommendations, it provides considerations and options for states seeking to address the growing role of private equity and other corporate entities in the health care sector.

Corporate partnerships in health care

Private equity (PE) and other corporate entities have become increasingly interested in health care, with corporate investment in physician practices skyrocketing over the past decade. To illustrate, PE acquisitions in the health care sector alone are estimated to have increased six-fold in a recent ten-year period, growing from 75 deals in 2012 to 484 deals in 2021.[1] At the same time, corporations, such as those affiliated with major health insurers, continue to acquire physician practices at high rates—to indicate, Optum, a subsidiary of UnitedHealthcare, is said to employ or otherwise be affiliated with more than 10% of all U.S. physicians.[2]

Independent physician practice owners acknowledge several reasons why they may choose to enter into partnerships with corporate entities. Some would prefer to remain independent but are nudged to engage with corporate buyers by environmental forces largely out of their control—namely, independent practice owners cite the inability to negotiate fair contracts with payers on their own as a major factor driving them toward a corporate buyout,[3] and engaging with a corporate partner may allow practice owners to maintain their practice without selling to a major health system.[4] At the same time, corporate acquisition is an attractive option entered into willingly by many physicians, in part because such arrangements promise to free physicians up from certain management, financial, and administrative duties associated with running a practice and corporate partnerships often include financially lucrative deals for physicians looking to retire, exit practice ownership, or access capital for practice expenses.

Still, corporate investment in health care also brings rise to a host of concerns around care delivery, physician autonomy, and health care market conditions. There is a growing body of evidence tending to suggest that PE ownership can degrade quality of care,[5] and PE acquisitions have been associated with worse health outcomes in certain health care settings.[6,7] Physicians working in corporate-owned practices have echoed these concerns, noting in addition that corporate involvement in a practice can interfere with physicians' ability to make decisions around governance

or practice operations. Physicians may be pressured to see more patients each day or meet lofty financial targets in order to maximize profitability. Additionally, high levels of debt from leveraged buyouts or sale lease-back arrangements can burden health care practices and increase the risk of failure, which ultimately threatens access to care for patients. Corporate investment in health care is also thought to accelerate consolidation in medical specialties, which changes the practice landscape for physicians and can drive down physician wages while increasing health care costs for patients.[8] Finally, for employed physicians, risks of corporate partnership include loss of liability tail coverage or loss of pension or retirement funds if their employer comes under private equity ownership or ultimately goes bankrupt.[9] Also, these employed physicians often must negotiate the terms of their employment from a position of limited bargaining power relative to their employers, which can lead to less-than-favorable contract terms, including non-competes that limit their professional mobility.

Despite all this, corporate influence in the practice of medicine often flies under the radar of state governments. Most states lack a legal framework for identifying potentially problematic health care transactions, and even where states ostensibly have long-standing laws intended to prevent corporate influence in health care, enforcement of these laws is severely lacking. Policy solutions are therefore needed to preserve the provision of high-quality patient care and protect physician autonomy and independent clinical judgment in a health care industry pressurized by corporate interests.

State legislative approaches to address undue corporate influence in health care

States are exploring ways to mitigate the impact of corporate interests that compromise the integrity of medical practice. A wide range of bills have been introduced across the country in recent years, each taking a different path. This report seeks to distill these legislative strategies into digestible elements for states considering action in this area. To that end, based on an analysis of proposed and enacted legislation addressing corporate influence in health care, this resource breaks down common policy mechanisms in this area into the following five approaches:

1. **Support transparency and oversight of health care transactions through notification and review requirements**
2. **Preserve the independent clinical judgment of physicians by strengthening the corporate practice of medicine doctrine**
3. **Limit the influence management services organizations (MSOs) may exert influence on physician practices**
4. **Support fair contracting in physician employment agreements**
5. **Protect patient access to care in consolidated markets**

Each section of this report outlines the rationale behind an approach and provides examples to highlight areas where legislative requirements tend to diverge. While this report attempts to capture key policy levers at play in this space, it does not purport to be exhaustive.

Appendices and resources

Appendix I provides AMA policy relevant to the policy options discussed in this report. The legislative provisions referenced in this report and other relevant bill text can be found in the resource enclosed as Appendix II, *Select legislation addressing corporate influence in health care - proposed and*

enacted bills. This compendium of proposed and enacted state laws intends to provide example legislative text. It is not exhaustive.

For more information on state laws surrounding restrictive covenants, access the AMA's National Managed Care Legal Database.[10]

Finally, many of the approaches discussed herein were inspired by a model bill developed by the National Academy of State Health Policy (NASHP), which can serve as an excellent additional resource for states interested in enacting related legislation.[11]

Approach 1. Support transparency and oversight of health care transactions through notification and review requirements

Background

States have begun to implement health care transaction review laws, which improve transparency around corporate investment in health care by requiring health care entities to provide notice of certain health care transactions to the state attorney general's (AG) office or another entity defined by statute. Provisions that establish a review or approval process for health care transactions can further add teeth to these transparency laws.

Health care transaction review laws are among the most common approaches to address corporate influence in health care. These may be attractive to states because strategies employed by entities such as PE investors often have anticompetitive effects and may impact cost, quality, and access to care. For example, PE firms often take a "roll-up" approach whereby they acquire multiple health care entities in a series of transactions, typically spaced out over time. This leads to greater consolidation in health care markets, especially for medical specialties: by consolidating a particular specialty in a local market, PE firms increase their market power, which they may leverage to raise prices. For example, one study found that PE acquisitions correlated with price increases for medical services across multiple specialties, including 14% for gastroenterology, 8.8% for OB/GYN, and 7.1% for orthopedics.[12] Further, the absence of local competition when medical specialty practices are consolidated can lead to lower wages for employed physicians.

Connections have been drawn between corporate acquisitions and circumstances that threaten access to care for patients due to practice instability. The delivery of care may be jeopardized where acquired health care entities face unsustainable financial pressures to pay rent or repay loans post-acquisition. Sale lease-back agreements—arrangements under which an investor purchases property owned by a medical practice and then leases the property back to the practice, often at rates that increase over time to a level that is unsustainable for the practice—are one way a corporate acquisition may ultimately jeopardize a practice's viability.

Under current law in most states, corporate acquisitions of physician practices typically fly under the radar of antitrust enforcement bodies, in part because they typically do not meet existing monetary thresholds for reporting and review, such as those implemented by the federal government (e.g., the Hart-Scott-Rodino threshold, which as of 2025 is $126.4 million, well over the value of most physician practice acquisitions).[13] Beyond that, laws in most states establish no infrastructure for oversight of health care transactions that may have negative impacts beyond the anticompetitive effects that might interest state antitrust enforcement bodies.

Legislation to increase transparency of health care transactions can expose deals that may have harmful antitrust implications and can reveal broader trends around corporate influence in health care. Going a step further, laws that grant a governing body authority to review or block certain health care transactions may allow states to mitigate arrangements that may have harmful impacts on health care markets, the practice of medicine, or patient care.

Legislative approaches supporting transparency and review of health care transactions

Health care transaction review laws fundamentally require that entities involved in certain transactions (e.g., a private equity firm purchasing a physician practice) must provide notice of the transaction to a designated entity, such as the state attorney general's office or a special designated Commission within the Department of Health and Human Services. These laws vary along several lines, including the transactions to which requirements apply, the type of notice required, requirements to make reported notices public, and review and approval criteria.

Applicability to certain transactions

Laws will establish the health care entities and transactions to which notice requirements apply.

Health care entities

Laws differ when it comes to the health care entities to which these requirements are applicable—for example, in Indiana, transactions involving organizations that provide health care services are subject to notice requirements, while legislation proposed in Texas would apply more broadly to transactions involving health plans, health insurers, hospitals or hospital systems, physician organizations, health care providers, health care facilities, pharmacy benefit managers, and "other health care entities."[14] Some bills also expressly state that notice requirements apply to health care transactions involving a "significant equity investor," including private equity funds.[15] Importantly, bills differ when it comes to whether transactions involving health insurers are subject to transparency requirements. New York, for example, excludes health insurers from the definition of "health care entity,"[16] while Nevada subjects transactions involving health insurance carriers to notice requirements.[17]

Monetary thresholds and other criteria

Many statutes establish that "material change transactions," apply to notice requirements and are therefore reportable, but what constitutes a qualifying material change transaction will differ from state to state. State law may impose requirements on transactions valued above a certain threshold (including such threshold in the definition of "material change transaction"), or it may focus on transactions that meet certain qualitative factors laid out in statute.

Where legislation establishes a monetary threshold, notice requirements apply to deals involving the transfer of assets valued at an amount that varies widely from state to state but is always well below reporting thresholds established by federal antitrust laws. The threshold may also be established based on the predicted value of the organization post-transaction. Minnesota requires notice of transactions involving a health care entity with an average revenue or a projected annual revenue of $80 million or more per year.[18] In Oregon, a transaction is a reportable material change transaction if

at least one party to the transaction had a revenue of $25 million or more in the 3 fiscal years preceding the deal and another party had at least $10 million in revenue in the preceding 3 fiscal years.[19] Indiana simply requires notice of health care transactions involving at least $10 million in assets,[20] and legislation proposed in California in 2024 and Vermont in 2025 would have set a baseline notice threshold at $4 million and $1 million, respectively.[21]

Other states find material change based not on the value but on the nature of a transaction. For example, in Washington, reportable material change transactions include a merger, acquisition, or contracting affiliation between two or more hospitals, health systems, or provider organizations.[22] Some provisions consider the transfer of a health care entity's voting securities or assets, capital, stock, or other interests—in California, for example, notice must be provided where a health care entity sells, transfers, leases, exchanges, options, encumbers, conveys, or otherwise disposes of a material amount of its assets, or transfers control, responsibility, or governance of a material amount of the assets or operations.[23]

Notably, there is an opportunity to use the definition of "material change transaction" to require notice of certain problematic transactions commonly initiated by PE investors, such as serial transactions or "roll-up acquisitions" (whereby the same corporate entity acquires multiple practices within a defined period of time, e.g., 5 years) or sale lease-back agreements. Massachusetts, for example, requires notice of real estate sale lease-back arrangements and transactions that will result in a provider organization having a dominant market share in a given service or region,[24] and New York law applies to events "occurring during a single transaction [or a] series of related transactions that take place within a rolling twelve month time period."[25]

Notice required

Initial criteria

Requirements around what must be reported in a notice to the reviewing entity vary broadly, and there is often room to revise proposed legislation to include reporting requirements that may be less burdensome on physician practices. Legislation proposed in Washington, for example, only requires the names and addresses of the parties to the transaction, identification of locations where each party provides health care services, a description of the material change, and the change's effective date.[26] By contrast, other legislation, such as a bill proposed in Pennsylvania in 2025, require multiple pages of detailed financial disclosures and other items.[27]

Ongoing reporting requirements

Generally, notice must be given in advance of material change transactions, but some states require ongoing reporting. For example, a 2025 law in Indiana requires that some health care entities, including many physician practices, report to the Secretary of State every two years. These reporting requirements include details surrounding the identity and ownership stake of any person with 1) 5% or more ownership interest, or, if the person is a practitioner, any ownership interest in the entity; 2) a controlling interest in the entity or 3) interest as a "private equity partner" in the entity. In Massachusetts, organizations may be required for up to five years to submit data and information that may be necessary for the assessment of post-transaction impacts of a material change.[28]

Publication requirements

Some state transparency laws require a designated body to develop a public report detailing some or all of the information provided by health care entities in their required notices of qualifying health care transactions. For example, Nevada requires that information provided in notices be maintained on a Department of Health and Human Services website, and that the Department of Health and Human Services prepare and make public an annual report regarding market transactions and concentration based on the information in the notices.[29] Indiana enacted a publication requirement in 2025,[30] and legislation proposed in Texas in 2025 would have done similar.[31] Further, a bill enrolled in California calls upon a special office to research and report on the impacts of reportable transactions.[32]

Review authority and criteria

Authority to review, impose conditions upon, or block transactions

More aggressive legislation goes beyond requiring notice of qualifying transactions and actually grants a designated authority to review, impose conditions upon, and sometimes block, transactions deemed inappropriate under the conditions prescribed in statute. California, for example, grants the Office of Health Care Affordability authority to conduct a detailed market impact review of, and report on, material transactions that may have harmful effects, and expressly directs the Office to refer any transactions with potential anticompetitive effects to the state AG.[33] A similar law is on the books in Massachusetts.[34] In Oregon, the Oregon Health Authority has authority to approve, deny, or impose conditions upon proposed material change transactions based on a review of whether the transaction will benefit the public good, have anticompetitive effects, or have the potential to negatively impact access to affordable health care in the state. Legislation proposed in a few states, including Pennsylvania, Wisconsin, and Vermont, would do similarly—a multifaceted bill introduced in Vermont in 2025 would have required a market impact analysis and would have granted a state Board the authority to disapprove of a transaction, going so far as to prescribe circumstances under which the Board may not approve a transaction.[35]

Whether a designated reviewing body may conduct a review only at the time a reportable transaction occurs or whether they may do so at a subsequent time also varies. Indiana, for example, expressly authorizes the attorney general to investigate a health care entity “at any time.”[36] This approach may promote oversight of issues that arise after the time at which the transaction is culminated.

Factors reviewing bodies may consider – antitrust implications and other concerns

Legislation may enumerate specific characteristics of a transaction that reviewing bodies may consider in an evaluation. Typically, this will include those anticompetitive effects that make up a standard antitrust analysis (e.g., an increase in health care prices or concerns about monopolistic market structures).[37] Importantly, though, some enacted laws and many proposed bills also name factors that the reviewing entity may consider beyond or in addition to antitrust concerns. Most often, these are factors tending to indicate whether the health care transaction would be in the public interest, and may include disruptions in access to care, effects on public health, and impacts to the physician labor market. Minnesota law allows the AG to bring an action in district court to enjoin or unwind a transaction that is against the public interest,[38] and specifies that a public interest analysis includes whether a transaction will:

(1) harm public health;
(2) reduce the affected community's continued access to affordable and quality care and to the range of services historically provided by the entities or will prevent members in the affected community from receiving a comparable or better patient experience;
(3) have a detrimental impact on competing health care options within primary and dispersed service areas;
(4) reduce delivery of health care to disadvantaged, uninsured, underinsured, and underserved populations and to populations enrolled in public health care programs;
(5) have a substantial negative impact on medical education and teaching programs, health care workforce training, or medical research;
(6) have a negative impact on the market for health care services, health insurance services, or skilled health care workers;
(7) increase health care costs for patients;
(8) adversely impact provider cost trends and containment of total health care spending
(9) have a negative impact on wages paid by, or the number of employees employed by, a health care entity involved in a transaction;
(10) have a negative impact on wages, collective bargaining units, and collective bargaining agreements of existing or future workers employed by a health care entity involved in a transaction.[39]

These types of provisions are noteworthy because they create a novel mechanism to address some of the harmful impacts of corporate involvement in health care that may not be captured in a traditional antitrust analysis.

Summary and considerations

Key areas of variation across transparency laws are as follows:

- **Covered health care entities:** Health care entities subject to notice and review requirements typically include physician practices and corporate investors ("significant equity investors") but they may or may not include health insurers, health systems, or hospitals.
- **Qualifying transactions:** Health care transactions subject to notice requirements are commonly valued at a low enough threshold to capture deals that do not meet federal reporting thresholds, but specific requirements vary among states and currently range from $10 million to $80 million.[40, 41] However, many bills impose reporting requirements on other transactions of interest irrespective of value and based only on the nature of the transaction. For example, transactions involving private equity investors, serial ("roll-up") acquisitions or sale lease-back agreements may be subject to reporting requirements.
- **Publication and review versus approval authority:** Many laws only require that qualifying transactions be reported for the sake of transparency. In some cases, information gained in these notices is to be made public on a website or in a formal report. Provisions may specify that the authority to review may be time-limited or that the reviewing entity may initiate a review at any time. Other laws grant the AG or another designated body authority to seek additional information, prepare a market impact analysis, and approve, deny, or impose conditions upon qualifying transactions.
- **Review criteria:** Some bills authorize a designated entity to evaluate transactions based only on their anticompetitive effects, and others empower the reviewing entity to evaluate

qualifying transactions based on factors related to the public interest that are typically not associated with an antitrust analysis, such as impact on access to care, the preservation of care quality, and to the physician workforce.

Transaction review laws can improve oversight of problematic health care transactions involving corporate entities, however states considering these laws should be aware of a few concerns that may be relevant to physician practices. For one, in states where acquisition of physician practices by insurance carriers is an issue of concern, inclusion of health insurers as health care entities subject to notice and review requirements becomes important.

Further, some physicians find that these laws may impose burdensome reporting requirements upon physicians who are already underwater with administrative responsibilities. Laws that impose minimal reporting responsibility on physicians—or, if possible, that place the reporting burden on the involved corporate entity—may be preferred.

Some physicians express concerns that problematic elements of certain transactions may not be evident at the time the transaction occurs, but nevertheless may emerge down the line. Laws that authorize review of reportable transactions "at any time," or at intervals beyond when the transaction occurs may improve oversight of transactions that have concerning effects over time.

Finally, laws that allow an enforcement body to block or impose conditions on offending transactions may be attractive to prevent corporate influence in medical care or anticompetitive effects. However, they may also prevent transactions that physicians genuinely desire and intentionally pursued. Where this is the case, approaches that promote transparency but do not grant the state authority to block a transaction may help to safeguard against truly anticompetitive conduct without directly compromising the interests of physicians seeking to engage in qualifying transactions.

Approach 2. Preserve the independent clinical judgment of physicians by strengthening the corporate practice of medicine doctrine

Background

States have recently taken action to strengthen existing corporate practice of medicine bans. There is also an opportunity for state without corporate practice laws to implement new prohibitions on the corporate practice of medicine.

When a corporate investor acquires a physician practice, the investor and the physicians within the practice often have divided loyalties. While physicians generally value providing the highest quality care and feel a deep sense of responsibility to their patients, private equity firms and other corporate investors are known to pursue profit maximization first and foremost. PE investors, for example, typically enter a practice and implement cost-cutting operational changes aimed at improving profitability, with the goal of selling the practice for profit in three to seven years. Corporate owners in general are primarily accountable to their shareholders and not patients. For these reasons, a corporate investor is likely to impose upon the practice policies, procedures, or other requirements designed to prioritize dividends, often at the expense of patient care and smooth practice operations.

Indeed, physicians report feeling pressure to meet financial benchmarks set by investors, often in direct conflict with their independent clinical judgment. In one study of 1,000 physicians, a full 79

percent of those employed by PE- or venture capital-owned practices felt that ownership changes reduced their autonomy in the delivery of care.[42] This loss of clinical autonomy may manifest in several ways: physicians may be directed to see more patients or adjust treatment plans to reduce costs; they may be limited in their decision-making authority when it comes to drug therapies; or they may face restrictions when it comes to referring patients outside of their ownership structure.[43] In addition, once a PE firm enters a practice, physicians may be encouraged to order and bill for additional tests, procedures, and services, even where such interventions may be medically unnecessary.[44] These practices, while not exhaustive, reflect the growing influence of corporate ownership on medicine and the corresponding erosion of physicians' clinical independence.[45] Therefore, wherever PE or other corporate investment is pursued, it is necessary to ensure that corporate influence does not dictate decisions around the provision of care. Acquisition and investment models that preserve a high degree of physician leadership in decision-making around the provision of patient care should be supported by law.

The corporate practice of medicine (CPOM) doctrine refers to a long-standing legal precept intended to preserve the independent clinical judgment of physicians and safeguard patient care from undue corporate influence. CPOM laws date back centuries in some states, and they vary widely. Fundamentally, however, CPOM prohibitions forbid lay (i.e., non-physician) corporations from interfering with the practice of medicine or owning physician practices. Underscored by an objective to protect the sanctity of the patient-physician relationship, CPOM restrictions aim to 1) avoid the commercialization of medical practice that might result when corporations own practices or perform activities that constitute the practice of medicine, 2) address any lack of alignment between a corporation's obligation to its shareholders and a physician's obligation to their patients, and 3) ensure that a physician's exercise of independent medical judgment is not threatened just because they are employed by a corporate entity. However, many of these laws include broad exemptions and carveouts. Notably, authority to enforce CPOM bans is typically granted to state AG offices or to state medical boards, but at this point, enforcement activity at the state level is, by and large, severely lacking.

There is room to modernize, strengthen, and reinvigorate corporate practice restrictions at the state level through renewed legislative efforts. The CPOM doctrine, as it exists across the states now, is generally regarded as both highly complex and ineffectual. Even though most states have some kind of CPOM restriction in place, the specific tenets of the law can be difficult to discern as the doctrine in each state has evolved over time, not only through legislation but often also through judicial decisions and medical board policy. Exceptions to the doctrine are often broad, and loopholes exist that allow for corporate influence in the practice of medicine.

Legislative approaches to strengthen the CPOM doctrine

Existing state CPOM bans can be fortified to curb corporate influence in medical decision-making, and the implementation of modernized CPOM statutes may be helpful to bring clarity to state doctrines that are historically complex. Laws that aim to strengthen state CPOM laws may bolster several different elements commonly found in the CPOM doctrine, including around practice ownership structure, non-interference with clinical decision-making, and creating a legitimate threat of enforcement.

Ownership share and structure

Bills that aim to strengthen state CPOM doctrines may impose specific requirements on the ownership structure of medical practices, both in terms of who may participate and in what proportion. To name one example of many, a law proposed in Washington would have required that licensees (in this context, physicians), hold the majority of each class of voting shares in a practice, constitute a majority of the board of directors, and occupy nearly all officer positions within the corporation.[46] Laws that regulate ownership structure of physician practices aim to limit corporate influence amidst the most powerful positions within a health care entity, with the goal of preventing situations where the major decision-makers in a practice are loyal to shareholders over patients.

Non-interference with clinical decision-making

By contrast, other states rely less on formal shareholding rules. There is an opportunity for state law to make clear that clinical decision-making must be reserved for physicians and that the independent professional judgment of physicians must be protected, regardless of the practice's ownership structure. This approach emphasizes structural and contractual safeguards rather than detailed allocation of governance positions. While some existing laws may merely state that non-physician corporations are not to interfere with clinical decision-making, or that physicians are to maintain ultimate control over the same, virtually all recent legislation that aims to strengthen the CPOM doctrine expressly shores up what constitutes clinical decision-making or the independent professional judgment of physicians compared to what constitutes the type of *non*-clinical decision-making that may be appropriate for a contracted management services organization (MSO) or a non-physician owner or investor.

Bills proposed in New Mexico,[47] Massachusetts,[48] Washington,[49] and elsewhere in 2025 would have prohibited lay corporations from interfering with a physician's independent professional judgment and clinical decision-making. By way of example, New Mexico's proposed law included the following as examples of the type of professional judgment that must be executed by physicians:

(a) determining what diagnostic tests are appropriate for a particular condition;
(b) determining the need for referrals to, or consultation with, another licensed health care provider;
(c) being responsible for the ultimate overall care of the patient, including treatment options available to the patient; and
(d) determining how many patients a health care provider shall see in a given time period

Under the New Mexico bill, non-physician health care entities would have been forbidden from exercising control or being delegated the power to do any of the following:

(a) own or otherwise determine the content of patient medical records;
(b) select, hire or fire health care providers, allied health staff or medical assistants based, in whole or in part, on clinical competency or proficiency;
(c) set the parameters pursuant to which a health care provider shall enter into contractual relationships with third-party payers;
(d) set the parameters pursuant to which a health care provider shall enter into contractual relationships with other health care providers for the delivery of care;
(e) make decisions regarding coding and billing procedures for patient care services; and
(f) approve the selection of medical equipment and medical supplies for a health care provider.

Applicability to a range of corporate entities

Strong CPOM provisions include language to ensure that restrictions apply to a range of corporate entities that may exert influence over a practice. A bill enrolled in California in 2025, for example, specifies that hedge funds and private equity groups shall not interfere with the professional judgment of physicians[50]—elements that are crucial in a landscape rife with corporate investment. More broadly, legislation proposed in Connecticut would have restricted "health care facilities" from interfering with the clinical decisions of health care clinicians with full practice ability.[51] Notably, in the absence of an express exception, Connecticut's approach may include hospitals in the entities that cannot control clinical practice decisions. This approach may be attractive to states where hospital consolidation is an issue. There is also an opportunity to include health insurers under the umbrella of corporate entities to which corporate practice bans apply.

Bans on "controlling or directing" a practice

State law may also ban certain non-physician entities from controlling or directing a physician practice. For example, while existing California law bars corporations or lay entities from practicing medicine, legislation proposed (and ultimately vetoed) in 2024 would have bolstered California's already-strong corporate practice ban by preventing private equity companies or hedge funds from exercising managerial authority over physician practices by forbidding them from controlling or directing a physician practice. "Controlling or directing" specifically included influencing or entering into contracts on behalf of the practice with third parties, setting rates, or influencing policies relating to patient admission, referrals, or provider availability.[52] Similar language was proposed in Massachusetts in 2025.[53]

Enforcement

By and large, at present, CPOM laws are minimally enforced at the state level. It is crucial, then, that state laws attempting to strengthen CPOM restrictions come with a legitimate threat of enforcement. States looking to implement a modernized CPOM ban need therefore prioritize and invest in a mechanism of oversight for CPOM laws.

State attorney general's (AG's) office

State legislation may equip the state AG's office or the state medical board with authority to take action toward enforcing a CPOM ban. New Mexico's proposed bill, for example, authorizes the AG to bring an action in the name of the state alleging violations of the CPOM act whenever the AG has reasonable belief that a person is, or is about to, engage in an act that violates the CPOM laws and enforcement proceedings would be in the public interest. There, the AG may also petition the district court for injunctive relief. A law proposed in Vermont would have authorized the AG to subpoena any records necessary to enforce CPOM provisions and generally empower the AG to enforce CPOM provisions to the fullest extent of the law.[54]

State medical board involvement

Proposed legislation in North Carolina would draw upon the authority of both the medical board and the AG. It would authorize the medical board to request certain information from an employer of clinicians upon receipt of a complaint of a CPOM violation by that employer. Information requested may include the practice's structure and ownership interests, the roles and relationships between

key players in the organization, and an affirmation that a clinician's professional medical judgment takes priority. Ultimately, the medical board may investigate CPOM violations and inform the AG of its findings, and the AG may then take legal action. Where violations are found, the medical board may only reinstate approval of employers upon recommendation of the North Carolina Medical Care Commission, the AG, or pursuant to a court finding that the CPOM violations have been rectified.[55]

Private right of action

State laws may also create a private right of action against CPOM violations, which would establish a means for individuals harmed by violations of the CPOM doctrine to sue for damages. New Mexico's proposed bill, for example, establishes that a person who has suffered injury due to a CPOM violation may sue in district court.[56] This approach avoids a formal enforcement regime and instead positions individuals as "unofficial enforcers" of the law. It is rare among proposed CPOM laws and generally unavailable under existing laws. While some believe that a private right of action may put necessary muscle behind CPOM laws, others doubt its utility—either because they believe those harmed by CPOM violations will not take advantage of the right, or, to the contrary, because they believe the private right of action could lead to excess lawsuits.

Categorization as "unprofessional conduct"

Finally, one notable approach, proposed in Washington, would expressly designate violations of the CPOM doctrine as "unprofessional conduct" for licensed physicians. Unprofessional conduct is subject to disciplinary action by the state medical board. Altogether, this means that *physicians* practicing in organizations where corporate practice bans are violated could be regarded solely culpable and disciplined by the licensing authority. This framework raises significant concerns, as it places sole responsibility on physicians for unlawful activities that may in fact be driven by non-physicians or corporate entities involved in the practice.

Summary and considerations

Provisions to strengthen state CPOM laws may cover the following:

- **Corporate ownership or control prohibited:** Statutes may impose requirements that a certain number of voting shareholders or members or officers of the board of directors must be physicians. Legislation may also ban non-physicians from buying, operating, or holding a controlling interest in a hospital or a physician practice.
- **Provisions explicitly prohibiting interference with the professional judgment of physicians:** Virtually every bill that aims to strengthen the CPOM doctrine includes language to expressly prohibit non-physician entities from interfering with the professional judgment and clinical decisions of a physician.
- **Activities that constitute interference with physicians' professional judgment or clinical decision-making:** Elements that constitute "professional judgment" or "clinical decision-making" vary by statute. Some statutes enumerate specific examples in a non-inclusive list. These may include: determining what diagnostic tests are appropriate; determining the need for referrals to another licensed health care provider; being responsible for the ultimate overall care of the patient; determining how many patients a health care provider shall see in a given time period; selection, hiring and firing of health care providers; setting the parameters by which a health care provider enters into contractual relationships

with third-party payers; and making decisions regarding coding and billing procedures for patient care services. [57]

- **Applicability of CPOM language:** Laws may specify that CPOM prohibitions apply to "hedge funds" or "private equity groups." Others may more broadly implicate "health care facilities," which may or may not include hospitals. Other entities precluded from practicing medicine by a CPOM ban include "equity investors," "health care entities," or "an individual, corporation, partnership or any other entity without a license" to practice medicine. There is an opportunity to include health insurers here.
- **Enforcement and oversight:** Some statutes grant the AG or state medical licensing boards authority to investigate or enforce CPOM prohibitions, other statutes create a private right of action allowing a person who has suffered injury due to a CPOM violation to sue in district court. There is room for a statute to specify that enforcement action for CPOM violations shall be made against the corporate entity violating the doctrine and not a physician in the medical practice.

At base, laws that aim to strengthen CPOM provisions tend not to be ultra-controversial among physicians. However, for these laws to have the desired impact, they must be accompanied by a meaningful threat of enforcement—and one that does not solely, or even primarily, implicate physicians. To that end, provisions that categorize CPOM violations as "unprofessional conduct" or conduct otherwise punishable by the licensing board tend not to be preferred.

There is great latitude for states to identify the entities to which corporate practice restrictions apply. Provisions typically might apply to hedge funds or private equity firms, but they also could be crafted to apply to certain hospitals or to health insurers. The best approach likely depends on the health care market of the state.

Ultimately, while renewed CPOM requirements may support the clinical decision-making of a physician, they may not address the most common loopholes to existing CPOM laws, namely the influence by management services organizations, especially via the "friendly PC" model.

Approach 3. Limit the influence management services organizations (MSOs) may exert influence on physician practices

Background

States have taken action to prevent corporate influence on the practice of medicine by attempting to restrict the level of control management services organizations (MSOs) may exert upon the physician practices with which they contract.

In states that prohibit lay ownership of physician practices, physicians and corporate investors often enter into arrangements that allow both entities some equity in the practice, physicians through a physician-owned professional corporation (i.e., the physician practice, or PC) and lay investors through a management services organization (MSO) which contracts with the PC. Ostensibly, when a physician practice contracts with an MSO, the physician owners control the clinical aspects of the practice while an MSO agrees to operate certain nonclinical aspects of a practice—for example, the MSO may conduct administrative functions, handle practice financials, and provide clinical support services to the practice. However, the line between what constitutes a clinical function and what

constitutes a non-clinical function is blurry, and states have expressed concerns around the difficulty in separating business or administrative decision-making that may be done by the MSO and medical decision-making to be done by a physician. Moreover, specific terms of management services agreements vary broadly, and where there is an absence of clear corporate practice of medicine restrictions or enforcement, many such terms afford the MSO broad authority to influence the delivery of patient care.

Even where a physician practice that contracts with an MSO technically remains in the ownership position of the practice, corporate entities often seek to circumvent CPOM laws and take advantage of workarounds that allow them to influence the practice of medicine. One such workaround is the "friendly PC" model. Under the friendly PC model, also known as the friendly physician or friendly practice model, a corporate investor in a medical practice with an ownership stake in an MSO typically secures a physician (or physicians) to control the practice who is sympathetic, i.e., "friendly," to the MSO. Often, the friendly physician(s) will serve on the board of directors of, or otherwise have an ownership stake in, both the MSO and the PC, effectively becoming a catalyst for the MSO to influence practice operations. Where the friendly physician has a financial stake in both entities, that influence is amplified. In effect, friendly PC arrangements allow corporations to assume control of physician practices. Indeed, major corporate investors in healthcare, including Oak Street Health and One Medical, leverage the friendly PC model.

In addition to influencing the ownership structure and control of a physician practice, MSOs often impose contract terms upon practices with which they do business that allow them a degree of control in a practice's ownership structure. Namely, MSOs may require practices to enter equity transfer restriction agreements (ETRAs), or stock transfer restriction agreements (STRAs). These ban a PC from selling or transferring ownership of the practice without the express consent of the MSO, thereby enabling the MSO to maintain control over the practice's ownership. Other such agreements may restrict the PC from revising its bylaws without the consent of the MSO and may allow the MSO to substitute a physician practice owner when the MSO deems it necessary for ongoing functioning of practice. Ostensibly, limitations like these enable the MSO to minimize the impact of ownership changes on practice operations, however they also may reduce physician autonomy and bolster the MSO's influence on clinical practice.

Legislative approaches to limit MSOs' control over physician practices

States have begun to introduce legislative approaches to curb the influence of corporate-backed MSOs on clinical practice, including by: expressly defining what constitutes clinical decision-making that must be done wholly by the physician-owned PC, addressing the friendly PC model through laws that impose requirements on MSO and PC ownership structures, and restricting certain contract terms that afford an MSO undue control over physicians. Notably, provisions like these are found in two trailblazing pieces of legislation passed in Oregon in 2025—a primary bill (SB 951) and a bill making technical amendments to the primary bill (HB 3410)—which together employ a range of strategies to insulate MSOs from clinical operations.

Prohibitions on clinical decision-making by MSOs

Through provisions very similar to CPOM prohibitions that apply broadly to corporate owners, investors, or employers, legislation aiming to limit the function of the MSO may prohibit MSOs from exercising control over clinical decision-making within the PC. For example, Oregon's law specifies that the following activities are among those that constitute clinical decision-making, which must be

done by the PC:

(i) Hiring or terminating, setting work schedules or compensation for, or otherwise specifying terms of employment of medical licensees;
(ii) Setting clinical staffing levels, or specifying the period of time a medical licensee may see a patient, for any location that serves patients;
(iii) Making diagnostic coding decisions;
(iv) Setting clinical standards or policies;
(v) Setting policies for patient, client or customer billing and collection
(vi) Advertising a professional medical entity's services under the name of an entity that is not a professional medical entity;
(vii) Setting the prices, rates or amounts the professional medical entity charges for a medical licensee's services; or
(viii) Negotiating, executing, performing, enforcing or terminating contracts with third-party payors or persons that are not employees of the professional medical entity.

Near-identical language defining "clinical operations that may affect clinical decision making or the nature or quality of medical care that a medical practice delivers" was considered in 2025 in Vermont.[58] Similar language may prevent an MSO from "controlling or directing" a physician practice. Fundamentally, these types of provisions aim to delineate what constitutes clinical functions that must be performed by the medical practice and what constitutes practice management activities the MSO may perform. Contract terms between MSOs and PCs are likely to cover many of these practices and should be reviewed where relevant laws are enacted.

Restrictions on the role of the friendly PC and the structure of the MSO

Novel legislation also aims to directly address the friendly PC loophole through structural requirements that place restrictions on the makeup of the MSO.

Prohibitions against straw ownership

Some bills, such as one proposed in Vermont, aim to prevent straw ownership of physician practices by requiring that each physician owner of a practice exhibit meaningful ownership—i.e., substantial engagement in care delivery or practice management—in the practice.[59] While provisions against straw ownership may help ensure that any physician owner has a legitimate interest in the practice, they do not address the fact that conflicts of interest may arise where a practice owner is dually affiliated between an MSO and a practice.

Limitations on dual affiliation

As such, states are beginning to seek limitations on dual affiliation between an MSO and PC. This type of language varies in its complexity. A bill introduced in North Carolina simply would have prohibited a stakeholder of a PC from also being a stakeholder of an MSO with which the PC contracts.[60] More nuanced language proposed in Vermont would impose specific requirements on the ownership structure of practices and MSOs, and would prohibit a shareholder, director, or officer of a practice from owning, controlling shares in, serving as a director, officer, employee, or contractor of, an MSO with which the practice contracts and prevent physicians from receiving substantial compensation from an MSO in return for ownership or management of the practice.[61] There, exceptions apply to shareholders, directors, or officers of a physician practice when the physician

practice owns a majority of the interest in the MSO.[62]

The bills passed in Oregon—together creating the only law of its kind—place some restrictions on dual affiliations with complex caveat. The final language bans a shareholder, director, member, manager, officer, employee, or contractor of an MSO from owning or controlling a majority of shares in a practice, controlling or restricting the sale/transfer of a practice, or acquiring or financing the acquisition of a majority of shares in a practice, among other things. Many exceptions apply, however, including for physicians who provide health care services in a practice if the physician does not own more than 10% of the total interest in the practice, is compensated at fair market rate, and the physician's services to the MSO are aligned with the physician's professional obligations, ethics and duties to the practice and their patients. There are also exceptions for physician practice directors who own less than 25% of the ownership interest in a practice, so long as the practice owns less than 49% of the ownership interest with voting rights in the MSO, the physician does not receive compensation for serving as director/officer of the MSO, any action of the MSO that impacts the governance, professional, or ownership interests of the MSO is done by a majority vote, and the arrangement existed before January 2024. [63]

The nature and structure of existing agreements between PCs and MSOs are often long-standing and complex. As such, some advocates may soundly reject provisions with very broad applicability, calling instead for nuance based on the health care market in the state.

Bans on ETRAs or STRAs

Legislation surrounding MSOs may also ban certain agreements that afford an MSO too much control over a clinical practice. Primarily, states have sought to ban equity transfer restriction agreements or stock transfer restriction agreements (ETRAs/STRAs) between MSOs and PCs. For example, proposed legislation in Vermont would have prohibited medical practices from transferring or relinquishing control over the issuing of stock in the medical practice, and banning the sale, restriction or encumbrance of the sale, of the medical practice's shares or assets. Similarly, Oregon's law bans use of ETRAs by MSOs in contracts with PCs in most circumstances, however there are some exceptions, including that an MSO may require a transfer of equity in the event a shareholder or member of the PC breaches the management services agreement, or where a shareholder's medical license is revoked, where a shareholder has been disqualified from holding stock in the medical practice, and should a shareholder have a felony indictment.

Summary and considerations

In short, laws regulating contracts between medical practices and management services organizations may address the following:

- **Prohibition on clinical decision-making by the MSO.** Similar to laws that strengthen CPOM provisions, state laws aiming to regulate agreements between physician practices and MSOs often expressly ban the MSO from controlling or directing patient care, engaging in activities that interfere with the independent professional judgment of physicians, or from engaging in clinical decision-making. While some state laws enumerate what, specifically, constitutes activity that would impact clinical decision-making and others do not, often, setting staffing levels, hiring and terminating employees, and negotiating rates with payers are among activities considered inappropriate for the MSO to control.
- **MSO-PC structural requirements.** New proposed bills and enacted laws would impose

requirements on how the ownership and direction of MSOs and PCs may be structured. Softer provisions may ban straw ownership of physician practices by requiring all physician practice owners to exhibit meaningful ownership through substantial engagement in care delivery or management of the practice. Stricter bills expressly prohibit dual ownership or dual affiliation between the MSO and the physician practice. The only legislation that has been enacted along these lines was passed in Oregon in 2025. Oregon's law places some restrictions on dual affiliation but with caveats largely based on ownership share or voting interest. Further, Oregon generally prohibits an affiliate of an MSO from owning or controlling a majority of shares in the practice, with some exceptions.

- **Bans on contract terms that limit autonomy of practice owners.** Laws surrounding MSOs may prohibit medial practices from transferring or relinquishing to the MSO control over the sale, restriction or encumbrance of the sale, of the practice's assets, or from transferring or relinquishing control over the issuing of stock in the practice. Alternatively, as is the approach taken by Oregon, these provisions may ban the MSO from taking control of the same. Exceptions may apply.

Altogether, these provisions limit the amount of control an MSO may exert over a physician practice with whom it contracts and aim to insulate corporate interests of the MSO from the practice of medicine. Proponents of these bills view them as a novel way to protect the integrity of medical practice. However, these types of provisions receive mixed support from physicians.

While the friendly PC model may allow for unfavorable corporate influence in health care, it also may allow physicians to enjoy a greater stake in their practice. Laws that limit dual affiliation may limit physicians' equity in an MSO or prevent them from benefitting financially in the event of a sale (i.e., from receiving "roll-over equity").

When it comes to what activities the MSO may or may not do, in the absence of specific guidance, stakeholders express confusion around how to draw the line between clinical decision-making that should be preserved for the physician-owned PC and appropriate management and administrative functions of the MSO. In any case, some physicians feel that some activities included in MSO agreements, which may be prohibited under proposed law, are necessary for practice operations. Overly restrictive provisions could interrupt the services MSOs provide. These bills are also controversial because they may disrupt or require the unwinding of arrangements that have been in place—and to many physicians, successful—for many years.

Finally, enforcement of these types of provisions must be considered as well. The Oregon legislation creates a private right of action, however whether that private right of action will be leveraged appropriately remains to be seen. Other options include provisions that allow for state action against anticompetitive conduct, for example by granting the state AG authority to enforce provisions that govern MSOs.

Approach 4. Support fair contracting in agreements physicians enter with employers or MSOs

Background

States have taken a renewed interest in banning the use of non-compete agreements, non-disclosure agreements, and non-disparagement agreements between physicians and their employers and, in some cases, MSOs.

Corporate entities that take ownership of medical practices commonly impose upon employed physicians' contractual terms that restrict a physician from choosing their place of employment or from speaking out about harmful business practices that may be occurring within a PE-backed practice.[64] Unfair contracting practices such as these may harm physicians working within PE arrangements, and they may have harmful anticompetitive effects, especially where a single entity has acquired multiple practices across a large geographic area (e.g., as a result of serial acquisitions).

A restrictive covenant, or a non-compete, is a contractual term between an employer and a physician employee that prohibits the employee from working within a certain geographic area and period of time after the physician's employment ends. The use of non-compete agreements by corporations has the potential to prevent physicians from leaving a practice in search of another position. This is especially true of corporations that have a large geographical footprint or those that are in concentrated markets. Without the option to leave for another opportunity, the physician's ability to advocate for better working conditions is undermined. In these scenarios, a physician's only choice may be to move to another geographic area entirely, often uprooting themselves and their families. As a practical matter, working outside of the non-compete's geographic restriction may then be out of the question. Thus, the physician will simply have no option but to stay in an undesirable employment situation.

Non-competes also compromise physician autonomy, which in turn may harm patients. For example, a physician working under "at will employment" terms who knows that an employer can end their employment at any time, and that this will in turn trigger a non-compete, may be very reluctant to engage in patient advocacy or to speak up about matters negatively affecting patient care or clinical decision-making.

Relatedly, contractual terms that inhibit physicians from raising ethical concerns or concerns about quality of care within a corporate-backed practice are also problematic. These types of restrictions—namely, non-disclosure and non-disparagement agreements, or "gag clauses"—may make physicians afraid or unable to speak out against their current or former employer, for example about issues such as utilization practices, upcoding, staffing levels, or other quality of care concerns.[65] As a matter of public policy, the chilling effect of non-disclosure and non-disparagement agreements can perpetuate harmful practices by corporate investors. However, non-disclosure agreements that protect against the disclosure of trade secrets may be appropriate.

Legislative approaches that regulate the use of non-competes, non-disclosures, and non-disparagement agreements for physicians

State legislation increasingly seeks to ban restrictive covenants and gag clauses, often proposing broad prohibitions with minimal exceptions.

Prohibitions on restrictive covenants

At the state level, at least 39 jurisdictions have enacted laws to regulate the use of restrictive covenants (non-competes) in physician contracts in some way, however the details of and context surrounding such legislation varies widely. To name a few variations, some state laws limiting use of non-competes apply specifically to physicians or other health care providers, while other non-compete bans apply broadly to employers and employees in many sectors; some laws provide exceptions for certain business transactions (e.g., partnership dissolutions) while others do not; and some laws include provisions allowing for employers to recover damages at the termination of employment in certain circumstances while others do not. Further, physician non-compete bans in some states may allow employers to recover damages from physicians where appropriate upon termination of the employment agreement.

Outright bans, permissions with conditions, and exceptions

Some laws ban non-competes outright, while others permit the use non-competes with restrictions. Other states ban non-competes with exceptions.

Montana, for example, broadly banned physician non-competes in 2025, using relatively straightforward language prohibiting "the right of [a] health care provider, after the termination of the employment, partnership, or other form of professional relationship, to: (a) practice or provide services for which the provider is licensed, in any geographic area and for any period; (b) treat, advise, consult with, or establish a provider-patient relationship with any current patient of the employer or with a patient affiliated with a partnership or other form of professional relationship; or (c) solicit or seek to establish a provider-patient relationship with any current patient of the employer or with a patient affiliated with a partnership or other form of professional relationship." [66]

At the same time, other states allow non-competes but with restrictions that may be complex and myriad: under Texas law, for example, a physician may be subject to a restrictive covenant, but the covenant must meet specific conditions, including to 1) not deny the physician access to a list of patients the physician has seen within one year of contract termination, 2) provide access to the medical records of the physician's patients in the format in which those records are maintained, 3) allow for a buyout of the covenant by the physician in an amount equal to or less than the physician's total annual salary and wages at the time the contract is terminated, and 4) allow the physician to provide continuing care to specified patients during the course of an illness after the contract has been terminated; in addition, the non-compete must 5) expire no later than the one-year anniversary of the date the contract/employment is terminated, 6) limit the geographic area subject to the non-compete to a five-mile radius or less from where the physician practiced, and 7) state terms and conditions clearly and conspicuously in writing.[67]

Oregon's 2025 law broadly bans non-competition agreements in health care, however non-competes may still be enforceable if the physician is a shareholder, member or owner of, the other entity, with an ownership interest equivalent to 1.5% or more; where the entity can demonstrate a "recruitment investment" in the physician totaling at least 20% of that physician's salary; and where the non-compete has a 3-to-5-year duration, depending on whether and under what circumstances the physician provides direct clinical services. Similarly, legislation proposed in Vermont would have

generally banned non-competes between physicians and other persons, except "where the physician is a shareholder or member of the other person or otherwise owns or controls an ownership or membership interest that is equivalent to 25 percent or more of the entire ownership or membership interest that exists in the other person."

Bans on non-disclosures or non-disparagement agreements

Legislation may also ban non-disclosure or non-disparagement agreements, together sometimes known as "gag clauses." In this context, a non-disclosure agreement restricts physicians from sharing certain information about a health care entity with whom they contract (i.e., an MSO or an employer)—this may include information surrounding policies or practices that associated with the physician's employment, the sharing of health information, or other information about or associated with the physician's employment, conditions of employment, or compensation.[68] Generally, under a non-disparagement agreement, a physician must refrain from making any statement that causes harm or threatens to cause harm to a health care entity's reputation or business relations, or other economic interests.

Non-disclosures

Dating back to the 1990s managed care era, many states have enacted legislation prohibiting the use of non-disclosure clauses that restrict what treatment-related information doctors may discuss with patients—namely in agreements between physicians and managed care organizations. These existing legal protections could be expanded to expressly prohibit agreements that ban disclosure by physicians of issues that arise in the context of corporate investment, for example statements by current or former employed physicians about quality of care, profit strategies, or other ethical or professional challenges from business practices physicians encounter in the workplace. [69]

Bans on gag clauses generally

As an alternative, novel provisions that impose blanket bans on gag clauses in agreements between physicians and employers or MSOs are increasingly common in proposed legislation. For example, legislation proposed in Vermont in 2025 would have broadly rendered void and unenforceable all non-disclosure and non-disparagement agreements between a physician and an MSO. Relatedly, the 2025 law enacted in Oregon implicates non-disclosure and non-disparagement agreements between a physician and an MSO, hospital, or hospital-affiliated clinic, banning them with some caveat. Namely, that law renders void and unenforceable non-disclosures and non-disparagement agreements between a physician and an MSO, a hospital, or a hospital-affiliated clinic employing that physician, except that non-disclosures may be enforceable where trade secrets are at play, and a non-disclosure or a non-disparagement agreement may be enforceable if an MSO, hospital, or hospital-affiliated clinic terminated the physician's employment or the physician voluntarily left the MSO, hospital, or hospital-affiliated clinic (except where disclosures are based on the physician's good faith report of what the physician believes is evidence of a violation of state or federal law or regulation), or if the gag clause is part of a negotiated settlement between a physician and an MSO, hospital, or hospital-affiliated clinic. In both Oregon and Vermont, these provisions would not foreclose legal action against a physician who engaged in libel, slander or other tortious action.

Pertinence of whistleblower protections

Finally, where non-disclosures and non-disparagement agreements are unenforceable, there is also an opportunity to implement certain whistleblower protections. These could forbid termination of, or retaliation against, a physician employee for exposing employer conduct that may be viewed in a negative light.[70] Such whistleblower provisions could protect physicians who, for example, speak out about concerns related to care quality in the wake of corporate investment in a practice, or other matters that tend to reflect poorly on an employer.

Summary and considerations

Laws that support fair contracting may do the following:

- **Ban non-competes between physicians and employers.** Some proposed and enacted laws would ban non-competes outright, while under some legislative exceptions, non-competes may still be enforceable under certain conditions, for example if there is a partnership dissolution, or as was enacted in Oregon, in the case of agreements between health care entities and physicians who possess a certain ownership interest in the health care entity, or where the health care entity has made a significant and demonstrable recruitment investment in the physician. Non-compete bans may also include provisions allowing employers to seek damages from physicians upon termination of the employment agreement in some circumstances.
- **Ban non-disclosure agreements between physicians and employers or MSOs.** These provisions may expand on existing laws that restrict contracts limiting what treatment-related information doctors may discuss with patients, or they may create new law. Legislation may allow for contractual terms that protect the disclosure of trade secrets where appropriate.
- **Ban non-disparagement agreements between physicians and employers or MSOs.** These provisions generally ban restrictions against statements that harm or threaten to cause harm to a health care entity's reputation or business relations, or other economic interests. Some states would ban all non-disparagement agreements between a physician and an employer or MSO, while others might implement some exceptions, such as for physicians whose employment was terminated or voluntarily left employment. There is an opportunity to implement whistleblower protections where non-disparagement clauses are unenforceable.
- **Specify application to MSOs.** Laws that ban non-disclosures or non-disparagement agreements may specify that bans on non-disclosure agreements apply to agreements between physicians and MSOs, or they may be constructed not to apply to agreements between physicians and MSOs.

Bans against non-competes, non-disclosures, and non-disparagement agreements are largely favored by employed physicians. At the same time, physicians who employ other physicians sometimes feel that reasonable non-competes are essential to protect their own legitimate business interests. For example, an independent physician group may train the physician, make referral sources and contacts available to the physician, give the physician access to patients and patient lists, market the physician in the community, and provide the physician with proprietary practice information to help the physician build up his or her practice. Physician employers may hope to use non-competes to prohibit a physician from leaving and then opening up their own practice "down the hall." Per policy enacted by the AMA House of Delegates, the AMA is opposed to the use of restrictive covenants in physician employment contracts.

Approach 5. Protect access to care where corporate entities invest in hospitals or medical practices

Background

There is an opportunity for states to enact laws to help ensure financial stability of acquired health care facilities and to protect continuity of care in the event of a facility closure following a corporate acquisition.

Disruptions to patient care caused by service reductions or health care facility closures have emerged as a growing concern where corporate entities gain control of health care institutions. The business model most frequently employed by PE groups and other corporate investors allows a firm to control the health care facility it acquires while contributing only a small fraction of the purchase price upfront and requiring the health care organization to take on significant debt. Given the relatively small amount of capital at stake for the firm, and to maximize short-term profit, corporate investors may then employ aggressive and high-risk cost-cutting strategies. Ultimately, health care facility operations can become unsustainable when these risky strategies are combined with a heavy debt burden.[71]

In recent years, this phenomenon has been particularly evident in the case of acquired hospitals, where PE acquisition has been directly correlated with bankruptcies, service reductions, and closures that inhibit patient access to care. Across the country, both non-profit and for-profit hospitals have been sold to PE firms that often promise to invest in rural or underserved areas, but instead remove value from the acquired facility, often by selling the hospital's real estate (for example, to a Real Estate Investment Trust, or REIT), and requiring the facility to lease the property back. Over time, the institution may be unable to keep up with rent obligations, and may ultimately be forced to implement staff and service reductions and face closure.[72] When facilities close or significantly reduce services, patients lose access to critical health care resources.

Examples of casualties related to PE investment in hospitals include the 2019 bankruptcy of Hahnemann University Hospital in Pennsylvania, the bankruptcy and closure of several Steward hospitals and related physician practices over the past several years in Massachusetts, and the recent devastation of Prospect Medical hospitals in California, Connecticut, Pennsylvania, and Rhode Island.[73]

Legislative approaches to protecting access to care where corporate involvement is at play

Legislative options to protect access to care following the acquisition of a hospital or another health care organization are multifaceted. One approach has already been addressed in Section 1: where a reviewing entity may investigate an acquisition based on its potential to serve or harm the public interest, it opens the door to block transactions that are likely to disrupt access to care for patients.

However, additional, more specific provisions can create safeguards to protect patient access to care where corporate involvement in a health care facility threatens, or actually leads to, service disruptions or facility closures. These include requirements around advanced planning for potential closures, mandates that investors make a minimum capital investment or set aside funds to support

care delivery in the event of service reductions or closures, and limitations surrounding activities or conditions that may lead to financial distress.

While there has not yet been significant activity on this front in the states, proposed federal legislation may serve as a guide for policy solutions implementable at the state level. Specifically, the 2024 federal Health Over Wealth Act, introduced by Sen. Markey, is instructive, and this section draws upon it.[74]

Mitigation or continuity plans

There is an opportunity for states to implement laws requiring health care entities acquired by corporate investors to create a plan to mitigate the harmful effects of service disruptions and ensure continuity of care should the health care facility cease providing services.

For example, the federal Health Over Wealth Act requires hospitals to provide notice in advance of a discontinuation of services and, in some cases, submit a mitigation plan detailing how they may preserve access to essential services for impacted communities through partnerships, commitments from surrounding facilities, transportation plan access, and preparation for surge response, and how they may support employees in transitioning to new positions within health care. It also must include information on workforce and public engagement to ensure awareness of the discontinuation of services or closure, a description of potential alternatives to the discontinuation of services or closure that the hospital considered and an explanation of why those alternatives are not a viable option; and a local market study to ascertain regional bed supply, payor mix distribution among all providers, demographic trends, and remaining health systems in the area. A less exhaustive bill introduced in Massachusetts would authorize the board of medicine to promulgate regulations establishing requirements for the development of a continuity plan to ensure access to medical records, provide notice to patients, and assist patients with transferring to a new provider in the event of a closure of a health care practice.[75]

Requirements to set aside funds for use in the event of service disruptions

Legislation may require health care facilities acquired by private equity or other corporate investors to set aside funds in advance to support continuity of care in the event of service disruptions.

The proposed Health Over Wealth Act establishes that private equity firms may be required to establish an escrow account with sufficient funding to cover expenditures for at least 5 years in the case of the closure of or service reductions, including sufficient funding to pay out contract obligations to health care providers and other staff, and to provide supplemental funding to community health care or non-profit health care providers in the geographical area impacted by the closure or service reductions. Relatedly, this bill would also authorize an enforcement entity to require that an acquiring firm make a minimum capital investment in the acquired hospital or health system.

Likewise, state legislation proposed in Massachusetts would require PE firms that invest in health care facilities to submit a bond to the department of public health equaling at least 1 year of the facility's average or estimated operating expenses, plus certain administrative costs. This bill would require a private equity firm to maintain the bond for as long as it has a financial interest in a provider organization and for 7 years thereafter. In the event that the organization declares bankruptcy, the

department of public health would be authorized to collect the bond proceeds and use it to, with input from the public, support the continued provision of services to patients served by the provider organization.[76]

Prohibition on activities, conditions, and transactions that may lead to financial distress

Some activities, conditions, and transactions are correlated with an increased risk of financial distress. There is an opportunity for states to implement provisions limiting the ability of corporate investors in health care entities to engage to refrain from engaging in certain transactions or maintain a certain debt-to-income ratio.

Sale lease-back agreements and the use of REITs are ripe for regulation. Legislation introduced in Connecticut in 2025 would impose restrictions on the ability of a private equity firm to lease the property back to the hospital for a fee after purchasing the land rights.[77] Relatedly, the Health Over Wealth Act would limit the use of REITs in health care by prohibiting health care entities or private equity firms investing in health care from entering into an agreement to sell to or lease from an REIT if the terms of such sale or lease would lead to long-term weakened financial status of the health care entity or place the public health at risk, as determined by an enforcement body.

Relatedly, to help ensure that acquired practices remain financially solvent, legislation introduced in Massachusetts would prohibit a provider organization in which a private equity firm has a financial interest from exceeding the maximum adjusted debt to adjusted EBITDA ratio as determined by a designated commission—in other words, this would require a PE-acquired provider organization to maintain a ratio of *total adjusted debt* to *adjusted earnings before interest, taxes, depreciation and amortization* that is lower than what an enforcement body determines a provider organization may have without becoming financially unstable.[78] That bill would also require an investor to make a minimum capital investment in a practice and prohibit a provider organization in which a private equity firm has a financial interest from: becoming “highly leveraged,”; transacting with an unsafe financial actor; providing capital distributions, including cash dividends and certain stock dividends; performing stock buybacks or stock redemptions; or paying management fees to a private equity firm.

Summary and considerations

A state legislative approach to protect access to care amidst corporate acquisitions may:

- **Require acquired entities to develop a plan to mitigate any eventual service disruptions.** This may include plans for transferring care of patients, for preserving access to care via other local service providers, for supporting health care workers in transitioning to new positions in the health care industry, and other contingencies.
- **Mandate that a corporate-acquired organization set aside funds for use in a closure or severe service disruption.** Proposed laws require the establishment of escrow accounts or bonds to cover operating and capital expenditures for a specified period of time should the organization cease delivering services. These funds may mitigate the impact of potential closure, reduction of essential health services, workforce understaffing, or reduction in quality or safety of care or health care access.

- **Prohibit conditions and activities likely to lead to financial distress.** For example, banning use of REITs and sale lease-back agreements, requiring that acquired organizations maintain a stable EPITDA ratio, and prohibiting activities determined to be correlated with financial instability, like transacting with an unsafe financial actor, performing stock buybacks, or paying management fees to a PE firm.

Opponents of these requirements argue that they are financially burdensome or otherwise too restrictive, and that requirements to set aside funds merely delay the impact of service reductions. Proponents, however, note that while these types of provisions may not always prevent facility closures, they do provide safeguards to protect patient access to care in the event that an acquisition results in closures or reductions in essential services.

Conclusion

States are increasingly moving to address the expanding role of corporate entities in health care. Based on recent legislative activity across the country, this resource outlines provisions that states may consider to limit undue corporate influence. Examples of relevant provisions are included in Appendix II.

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[8] Fuse Brown, et al., Private Equity Investment As A Divining Rod For Market Failure: Policy Responses To Harmful Physician Practice Acquisitions. 2021. Available at: https://www.brookings.edu/wp-content/uploads/2021/10/Private-Equity-Investment-As-A-Divining-Rod-For-Market-Failure-14.pdf
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[10] AMA Managed Care Legal Database, Available at: https://managedcarelegaldatabase.org/
[11] National Academy of State Health Policy, Comprehensive Consolidation Model Addressing Transaction Oversight, Corporate Practice of Medicine and Transparency. Available at: https://nashp.org/a-model-act-for-state-oversight-of-proposed-health-care-mergers/
[12] *See* Comments of Eleven Attorneys General in Response to the February 29, 2024 Request for Information on Consolidation in Healthcare Market, June 2024, Available at: https://oag.ca.gov/system/files/attachments/press-docs/Comments%20by%2011%20Attorneys%20General%20in%20Response%20to%20Feb.%2029%20RFI%20on%20Consolidation%20in%20Healthcare%20%281%29%5B2%5D.pdf, citing Richard M. Scheffler et al., Monetizing Medicine: Private Equity and Competition in Physician Practice Markets, AM. ANTITRUST INST. 30 (Jul. 10, 2023), Available at: https://www.antitrustinstitute.org/wpcontent/uploads/2023/07/AAI-UCB-EG_Private-Equity-I-Physician-Practice-Report_FINAL.pdf.
[13] "Hart-Scott-Rodino Act" refers to section 201 of the Hart-Scott Rodino antitrust improvements act of 1976, 15 U.S.C. Sec. 18a.
[14] TX HB 4408 (proposed 2025)
[15] ALM GL ch. 6d § 1 *et seq.*
[16] *See* NY CLS Pub Health § 4550
[17] Nev. Rev. Stat. Ann. § 598A.370
[18] Minn. Stat. § 145D.01
[19] ORS § 415.501
[20] IC 4-6-3-6 (PL 95 2024)
[21] CA AB 2319 (proposed 2024, Gov. vetoed).
[22] WASH. REV. CODE § 19.390.030 et. seq.
[23] Cal Health and Saf Code § 127507
[24] ALM GL ch. 6d § 1
[25] N.Y. Pub. Health Law § 4551
[26] WASH. REV. CODE § 19.390.030 et. seq.
[27] CO SB 198 L.002 (proposed 2025)
[28] ALM GL ch. 6d § 1 *et seq.*
[29] NRS § 439A.126
[30] IN HB 1666 (enacted 2025)
[31] TX HB 4408 (proposed 2025)
[32] CA AB 1415 (enrolled 2025)
[33] Cal Health & Saf Code § 127507
[34] ALM GL ch. 6d § 1 *et seq.*
[35] VT HB 71 (proposed 2025)
[36] IN HB 1666 (enacted 2025)

[37] See Cal Health & Saf Code § 127507, ORS § 415.501, VT HB 71, WI SB 45
[38] Minn. Stat. § 145D.01
[39] Minn. Stat. § 145D.01
[40] Minn. Stat. § 145D.01
[41] 740 ILCS 10/7.2a
[42] Physicians Advocacy Institute and NORC at the University of Chicago, The Impact of Practice Acquisitions and Employment on Physician Experience and Care Delivery, Available at: https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/NORC-Employed-Physician-Survey-Report-Final.pdf?ver=yInykkKFPb3EZ6JMfQCelA%3d%3d
[43] Id.
[44] Comments of Eleven Attorneys General in Response to the February 29, 2024 Request for Information on Consolidation in Healthcare Market, June 2024, Available at: https://oag.ca.gov/system/files/attachments/press-docs/Comments%20by%2011%20Attorneys%20General%20in%20Response%20to%20Feb.%2029%20RFI%20on%20Consolidation%20in%20Healthcare%20%281%29%5B2%5D.pdf, citing Ashish K. Jha, Private equity firms are gnawing away at U.S. health care, WASHINGTON POST, (Jan. 10, 2024), https://www.washingtonpost.com/opinions/2024/01/10/private-equity-health-care-costs-acquisitions/.
[45] Physicians Advocacy Institute and NORC at the University of Chicago, The Impact of Practice Acquisitions and Employment on Physician Experience and Care Delivery, Available at: https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/NORC-Employed-Physician-Survey-Report-Final.pdf?ver=yInykkKFPb3EZ6JMfQCelA%3d%3d.
[46] WA HB 1675 (proposed 2025)
[47] NM SB 450 (proposed 2025)
[48] MA S 1628 / SD 2325 (proposed 2025)
[49] WA HB 1675 (proposed 2025)
[50] CA SB 351 (enrolled 2025)
[51] CT SB 261 (proposed 2025)
[52] *See* CA AB 3129. 2024 Legislature. Available at: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB3129
[53] S 1628 / SD 2325
[54] VT HB 71 (proposed 2025)
[55] NC SB 570 (proposed 2025)
[56] NM SB 450 (proposed 2025)
[57] NM SB 450 (proposed 2025)
[58] VT HB 71 (proposed 2025)
[59] VT HB 71 (proposed 2025)
[60] NC SB 570 (proposed 2025)
[61] VT HB 71 (proposed 2025)
[62] VT HB 71 (proposed 2025)
[63] OR HB 3410 / SB 951 (enacted 2025)
[64] Fuse Brown, et al., Private Equity Investment As A Divining Rod For Market Failure: Policy Responses To Harmful Physician Practice Acquisitions. Available at: https://www.brookings.edu/wp-content/uploads/2021/10/Private-Equity-Investment-As-A-Divining-Rod-For-Market-Failure-14.pdf
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[66] MT HB 198 (enacted 2025)
[67] Texas Statutes-Business and Commerce Code-Title 2-Chapter 15-Subchapter E. Covenants not to Compete. Tex. Bus. & Com. Code § 15.50 et. seq.
[68] OR HB 3410 / SB 951 (enacted 2025)
[69] Fuse Brown and Hall, Private Equity and the Corporatization of Health Care. Stanford Law Review. March 2024. Available at: https://review.law.stanford.edu/wp-content/uploads/sites/3/2024/03/Fuse-Brown-Hall-76-Stan.-L.-Rev.-527.pdf
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[72] Comments of Eleven Attorneys General in Response to the February 29, 2024 Request for Information on Consolidation in Healthcare Market, June 2024, Available at: https://oag.ca.gov/system/files/attachments/press-docs/Comments%20by%2011%20Attorneys%20General%20in%20Response%20to%20Feb.%2029%20RFI%20on

%20Consolidation%20in%20Healthcare%20%281%29%5B2%5D.pdf
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[74] Health Over Wealth Act, 118th Congress, 2024. Full text available at: https://www.markey.senate.gov/imo/media/doc/health_over_wealth_act1.pdf.
[75] MA S 1628 / SD 2325 (proposed 2025)
[76] MA S. 2871 (proposed 2025)
[77] CT SB 261 (proposed 2025)
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Appendix I: AMA Policy

The American Medical Association's House of Delegates has enacted the following policy relevant to corporate investment in health care and the provisions discussed in this report.

Corporate Investors and Other Corporate Entities H-160.891

1. Our AMA encourages physicians who are contemplating corporate investor partnerships or corporate entity relationships, including those under "friendly" physician professional corporation (PC) arrangements with Management Service Organizations (MSOs), to consider the following guidelines:
    a. Physicians should consider how the practice's current mission, vision, and long-term goals align with those of the corporate investor/entity.
    b. Due diligence should be conducted that includes, at minimum, review of the corporate investor/entity's business model, strategic plan, leadership and governance, and culture.
    c. External legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor/entity transactions.
    d. Retaining negotiators to advocate for best interests of the practice and its employees should be considered.
    e. Physicians should consider whether and how corporate relationships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management.
    f. Physicians should consider the potential impact of corporate relationships on physician and practice employee satisfaction and future physician recruitment.
    g. Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate relationships, and application of restrictive covenants, including any changes in the scope or implementation of any current or proposed restrictive covenants based on the corporate relationship.
    h. Physicians should consider corporate procedures for medical staff representation on the board of directors and medical staff leadership selection as well as processes for resolution of conflict between medical staff leadership and the corporate entity.
    i. Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate relationships.
    j. Prior to entering into a relationship with a corporate entity, physicians and the corporate entity should explicitly identify the types of clinical and business decisions that should remain in the ultimate control of the physician, including but not limited to:
        i. Determining which diagnostic tests are appropriate;
        ii. Determining the need for referrals to, or consultation with another physician or licensed health professional;
        iii. Being responsible for the ultimate overall care of the patient, including treatment options available to the patient;
        iv. Determining how many patients a physician shall see in a given period of time or how many hours a physician should work;
        v. Determining the content of patient medical records;
        vi. Selecting, hiring, or firing physicians, other licensed health care professionals, and/or other medical staff based on clinical competency or proficiency;

vii. Setting the parameters under which a physician or physician practice shall enter into contractual relationships with third-party entities;
viii. Making decisions regarding coding and billing procedures for patient care services; and
ix. Approving the selection of medical equipment and medical supplies.

k. Each individual physician should have the ultimate decision for medical judgment in patient care and medical care processes, including supervision of non- physician practitioners.
l. Clear protection and dispute resolution processes for physicians advocating on patient care and quality issues should be incorporated into an agreement between physicians and corporate entities.
m. Physicians should retain primary and final responsibility for structured medical education inclusive of undergraduate medical education including the structure of the program, program curriculum, selection of faculty and trainees, as well as education and disciplinary issues related to these programs.

2. Our AMA supports improved transparency regarding corporate investments in and/or relationships to physician practices, subsidiaries and/or related organizations that interact with the physician group and/or patients of the physicians, and subsequent changes in health care prices, quality, access, utilization, and physician payment.
3. Our AMA encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor relationships on patients and the physicians in practicing in that specialty.
4. Our AMA supports consideration of options for gathering information on the impact of private equity and corporate investors/entities on the practice of medicine.
5. Our AMA supports meaningful physician representation in any corporate governance structure (e.g., seats on the board of directors, and/or other relevant leadership bodies) of any entity with which a physician practice, hospital, or other health care organization establishes a corporate relationship.

Corporate Practice of Medicine H-215.981

1. Our AMA vigorously opposes any effort to pass federal legislation or regulation preempting state laws prohibiting the corporate practice of medicine.
2. Our AMA vigorously opposes any effort to pass legislation or regulation that removes or weakens state laws prohibiting the corporate practice of medicine.
3. Our AMA opposes the corporate practice of medicine and supports the restriction of ownership and operational authority of physician medical practices to physicians or physician-owned groups.
4. Our AMA, at the request of state medical associations, will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately owned management service organizations.
5. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient centered care and other relevant issues.
6. Our AMA will work with interested state medical associations, the federal government, and other interested parties to develop and advocate for regulations and appropriate legislation pertaining to corporate control of practices in the healthcare sector such that physician clinical autonomy and operational authority are preserved and protected.
7. Our AMA will create a state corporate practice of medicine template to assist state medical associations and national medical specialty societies as they navigate the intricacies of corporate investment in physician practices and health care generally at the state level and develop the most effective means of prohibiting the corporate practice of medicine in ways that are not detrimental to the sustainability of physician practices.
8. Our AMA supports enforcement of existing regulations and legislation pertaining to corporate control of practices in the health care sector to ensure that physician clinical autonomy and operational authority is preserved and protected.

9. Our AMA supports capital reserve requirements and leverage standards that preserve access to care for patients and fulfillment of contractual obligations to physicians and trainees by providing stable financing for hospitals, clinics, and other health care facilities.

Prohibiting Covenants Not-To-Compete in Physician Contracts H-265.988

1. Our American Medical Association support policies, regulations, and legislation that prohibits covenants not-to-compete for all physicians in clinical practice who hold employment contracts with for-profit or non-profit hospital, hospital system, or staffing company employers.
2. Our AMA wil oppose the use of restrictive covenants not-to-compete as a contingency of employment for any physician-in-training, regardless of the ACGME accreditation status of the residency/fellowship training program.
3. Our AMA will study and report back on current physician employment contract terms and trends with recommendations to address balancing legitimate business interests of physician employers while also protecting physician employment mobility and advancement, competition, and patient access to care -such recommendations to include the appropriate regulation or restriction of a) Covenants not to compete in physician contracts with independent physician groups that include time, scope, and geographic restrictions; and b) De facto non-compete restrictions that allow employers to recoup recruiting incentives upon contract termination.

Appendix II: Select legislation addressing corporate influence in health care

Proposed and enacted bills

This chart is designed to be a companion to the AMA resource entitled *State legislative approaches to curb corporate influence in health care*. The bills included here are meant to demonstrate how the different types of requirements discussed in the report might be implemented in statute. While this resource aims to include many notable provisions, it is not intended to represent a fully comprehensive compendium of all relevant proposed or enacted state law.

This document is made up of 5 charts of proposed and enacted laws:

1. **Support transparency and oversight of health care transactions through notification and review requirements**
2. **Preserve the independent clinical judgment of physicians by strengthening the corporate practice of medicine doctrine**
3. **Limit the influence management services organizations (MSOs) may exert influence on physician practices**
4. **Support fair contracting in physician employment agreements**
5. **Protect patient access to care in consolidated markets**

Approach 1. Support transparency and oversight of health care transactions through notification and review requirements

State	Status	Bill/Statute	Relevant Definitions	Notice	Review, Approval, and Enforcement
California	**ENACTED**	Cal Health & Saf Code § 127507	(k) "Health care entity" means a payer, provider, or a fully integrated delivery system. Cal Health & Saf Code § 127500.2 (n) "Material change" means any change in ownership, operations, or governance for a health care entity, involving a material amount of assets of a health care entity. Cal Health & Saf Code § 127500.2 (q) "Provider" means any of the following that delivers or furnishes health care services: (1) A physician organization. (2) A health facility, as defined in Section 1250, including a general acute care hospital. (3) A clinic conducted, operated, or maintained as an outpatient department of a hospital, as described in subdivision (d) of Section 1206. (4) A clinic described in subdivision (*l*) of Section 1206. (5) A clinic described in subdivision (a) of Section 1204. (6) A specialty clinic, as described in paragraphs (1) to (3), inclusive, of subdivision (b) of Section 1204. (7) An ambulatory surgical center or accredited outpatient setting. (8) A clinical laboratory licensed or registered with the State Department of Public Health under Chapter 3	(c) (1) A health care entity shall provide the office with written notice of agreements or transactions that will occur on or after April 1, 2024, that do either of the following: (A) Sell, transfer, lease, exchange, option, encumber, convey, or otherwise dispose of a material amount of its assets to one or more entities. (B) Transfer control, responsibility, or governance of a material amount of the assets or operations of the health care entity to one or more entities. (2) Written notice pursuant to paragraph (1) shall be provided to the office at least 90 days prior to entering into the agreement or transaction. If the conditions in paragraph (1) of subdivision (a) of Section 127507.2 apply, the office shall make the notice of material change publicly available, including all information and materials submitted to the office for review with regard to the material change. (d) The requirement to provide notice of a material change pursuant to subdivision (c) does not apply to any of the following: (1) Agreements or transactions involving health care service plans that are subject to review by the Director of the Department of Managed Health Care for cost impact or market consolidation under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2).	(3) The office shall adopt regulations for proposed material changes that warrant a notification, establish appropriate fees, and consider appropriate thresholds, including, but not limited to, annual gross and net revenues and market share in a given service or region. Cal Health & Saf Code § 127507 (a) (1) If the office finds that a material change noticed pursuant to Section 127507 is likely to have a risk of a significant impact on market competitions, the state's ability to meet cost targets, or costs for purchasers and consumers, the office shall conduct a cost and market impact review that examines factors relating to a health care entity's business and its relative market position, including, but not limited to, changes in size and market share in a given service or geographic region, prices for services compared to other providers for the same services, quality, equity, cost, access, or any other factors the office determines to be in the public interest. The office also may conduct cost and market impact reviews on any health care entity based on a determination by the director under subdivision (g) of Section 127502.5, or in association with agreements or transactions referred to the office by a reviewing authority listed in paragraphs (1) to (4), inclusive, of subdivision (d) of Section 127507. (2) In conducting the review, the office shall consider the benefits of the material change to consumers of health care services, where those benefits could not be achieved without that transaction, including, but not limited to, increased access to health care services, higher quality, and more efficient health care services where consumers of health care services benefit directly from those efficiencies. The party subject to the review may provide information demonstrating the benefits of the material change or information demonstrating the benefits of an integrated

Approach 1. Support transparency and oversight of health care transactions through notification and review requirements

State	Status	Bill/Statute	Relevant Definitions	Notice	Review, Approval, and Enforcement
California (cont.)	**ENACTED**		(commencing with Section 1200) of the Business and Professions Code. (9) An imaging facility that employs or contracts with persons that are subject to the Radiation Control Law (Chapter 8 (commencing with Section 114960) of Part 9 of Division 104), or the Radiologic Technologists Act (Article 5 (commencing with Section 106955) of Chapter 4 of Part 1, or Article 6 (commencing with Section 107150) of Chapter 4 of Part 1 of Division 104). Cal Health & Saf Code § 127500.2	(2) Agreements or transactions involving health insurers that are subject to review by the Insurance Commissioner under Article 14 (commencing with Section 1091) of Chapter 1 of Part 2, of Division 1 of the Insurance Code. (3) Agreements or transactions where a county is purchasing, acquiring, or taking control, responsibility, or governance of an entity to ensure continued access in that county. (4) Agreements or transactions involving nonprofit corporations that are subject to review by the Attorney General under Article 2 (commencing with Section 5914) of Chapter 9 of Part 2, Division 2 of Title 1 of the Corporations Code. Cal Health & Saf Code § 127507	organization where the material change would increase those benefits, and where the benefits involve cost, quality, or access to care for consumers of health care services. (3) (A) Within 60 days of receipt of a notice of material change, the office shall either advise the noticing health care entity of the office's determination to conduct a cost and market impact review or provide a written waiver from the review. An agreement or transaction for which a cost and market impact review proceeds shall not be implemented until 60 days after the office issues a final report. (B) The office may adopt regulations that expedite these timelines, as warranted, depending on the nature of the agreement or transaction. (4) In furtherance of this article, the office shall conduct investigations, including, but not limited to, compelling, by subpoena, health care entities and other relevant market participants to submit data and documents. (5) Upon completion of the cost and market impact review, the office shall make factual findings and issue a preliminary report of its findings. After allowing for the affected parties and the public to respond in writing to the findings in the preliminary report, the office shall issue its final report. (b) The office shall adopt regulations for notification to affected parties for the basis of the review, factors considered in the review, requests for data and information from affected parties, the public, and other relevant market participants, and relevant timelines. (c) (1) The office, the department, employees, contractors, and advisors of the office and the department, the board, and the board members shall keep confidential all nonpublic information and documents obtained under this article that were not required with the notice of material change or from the parties to the transaction, and shall not disclose the

Approach 1. Support transparency and oversight of health care transactions through notification and review requirements

State	Status	Bill/Statute	Relevant Definitions	Notice	Review, Approval, and Enforcement
California (cont.)	**ENACTED**				confidential information or documents to any person, other than the Attorney General, without the consent of the source of the information or documents, except in a preliminary report or final report under this section if the office believes that disclosure should be made in the public interest after taking into account any privacy, trade secret, or anticompetitive considerations. Prior to disclosure in a report, the office shall notify the relevant party and provide the source of nonpublic information an opportunity to specify facts documenting why release of the information is damaging or prejudicial to the source of the information and why the public interest is served in withholding the information. Information that is otherwise publicly available, or that has not been confidentially maintained by the source, shall not be considered nonpublic information. (2) Notwithstanding any other law, all nonpublic information and documents obtained under this article shall not be required to be disclosed pursuant to the California Public Records Act (Division 10 (commencing with Section 7920.000)) of Title 1 of the Government Code), or any similar local law requiring the disclosure of public records. (d) (1) The office may refer its findings, including the totality of documents gathered and data analysis performed, to the Attorney General for further review of any unfair methods of competition, anticompetitive behavior, or anticompetitive effects. (2) This section does not limit the authority of the Attorney General to protect consumers in the health care market or to protect the economy of the state, or any significant part thereof, insofar as health care is concerned, under any state or federal law. The authority of the Attorney General to maintain competitive markets and prosecute state and federal antitrust and unfair competition violations shall not be narrowed, abrogated, or otherwise altered by this section. Cal Health & Saf Code § 127507.2

Approach 1. Support transparency and oversight of health care transactions through notification and review requirements

State	Status	Bill/Statute	Relevant Definitions	Notice	Review, Approval, and Enforcement
California	**ENROLLED 2025**	AB 1415	(h) For purposes of this article, "noticing entity" includes all of the following: (1) A private equity group or hedge fund. (2) A newly created business entity created for the purpose of entering into agreements or transactions with a health care entity. (3) A management services organization. (4) An entity that owns, operates, or controls a provider, regardless of whether the provider is currently operating, providing health care services, or has a pending or suspended license. (k) "Health care entity" means a payer, provider, or a fully integrated delivery system. (s) "Private equity group" means an investor or group of investors who primarily engage in the raising or returning of capital and who invest, develop, dispose of, or purchase any equity interest in assets, either as a parent company or through another entity the investor or investors completely or partially own or control. A private equity group does not include natural persons or other entities that contribute or promise to contribute funds to the private equity group, but otherwise do not	(c) (1) A health care entity shall provide the office with written notice of agreements or transactions that do either of the following: (A) Sell, transfer, lease, exchange, option, encumber, convey, or otherwise dispose of a material amount of its assets to one or more entities. (B) Transfer control, responsibility, or governance of a material amount of the assets or operations of the health care entity to one or more entities. (2) (A) A noticing entity shall provide the office with written notice of agreements or transactions between the noticing entity and a health care entity or management services organization, or an entity that owns or controls the health care entity or management services organization that do either of the following: (i) Sell, transfer, lease, exchange, option, encumber, convey, or otherwise dispose of a material amount of the health care entity's or management services organization's assets to one or more entities. (ii) Transfer control, responsibility, or governance of a material amount of the assets or operations of the health care entity or management services organization to one or more entities. (B) In addition to reporting obligations under subparagraph (A), a management services organization shall provide the office with written notice of any agreement or transaction that is described in clauses (i) and (ii) of subparagraph (A) between the	**127507.** (a) The office shall monitor cost trends, including conducting research and studies on the health care market, including, but not limited to, the impact of consolidation, market power, venture capital activity, profit margins, and other market failures on competition, prices, access, quality, and equity. In a manner supportive of the efforts of the Attorney General, the Department of Managed Health Care, and the Department of Insurance, as appropriate, the office shall promote competitive health care markets by examining mergers, acquisitions, corporate affiliations, or other transactions that entail a material change to ownership, operations, or governance structure involving health care service plans, health insurers, hospitals or hospital systems, physician organizations, providers, pharmacy benefit managers, and other health care entities. The office shall prospectively analyze those transactions likely to have significant effects, seek input from the parties and the public, and report on the anticipated impacts to the health care market. The role of the office is to collect and report information that is informative to the public. [...] (4) Agreements or transactions involving nonprofit corporations that are subject to review by the Attorney General under Article 2 (commencing with Section 5914) of Chapter 9 of Part 2, Division 2 of Title 1 of the Corporations Code. (e) Agreements or transactions exempted under subdivision (d) from the requirement to provide a notice of material change may be referred to the office for a cost and market impact review by the reviewing authority. (f) This article does not limit the Attorney General's review of the conversion or restructuring of charitable trusts held by a nonprofit health facility or by an affiliated nonprofit health system or the Attorney General's review of any health care agreement or transaction under any state or federal law.

Approach 1. Support transparency and oversight of health care transactions through notification and review requirements

State	Status	Bill/Statute	Relevant Definitions	Notice	Review, Approval, and Enforcement
California (cont.)	**ENROLLED 2025**		participate in the management of the private equity group or the group's assets, or in any change in control of the private equity group or the group's assets.	management services organization and any other entity. (C) The office shall adopt regulations to eliminate duplicative reporting if a noticing entity or health care entity is required to submit notice to the office under more than one provision in subdivision (c). (3) Written notice pursuant to paragraph (1) shall be provided to the office at least 90 days prior to entering into the agreement or transaction. If the conditions in paragraph (1) of subdivision (a) of Section 127507.2 apply, the office shall make the notice of material change publicly available, including all information and materials submitted to the office for review with regard to the material change. (4) The office shall adopt regulations for proposed material changes that warrant a notification, establish appropriate fees, and consider appropriate thresholds, including, but not limited to, annual gross and net revenues and market share in a given service or region. (d) The requirement to provide notice of a material change pursuant to subdivision (c) does not apply to any of the following: (1) Agreements or transactions involving health care service plans that are subject to review by the Director of the Department of Managed Health Care for cost impact or market consolidation under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2).	(g) This article does not narrow, abrogate, or otherwise alter the corporate practice of medicine doctrine, which expressly prohibits the practice of medicine or control of medicine, medical corporations, medical partnerships, or physician practices by entities or individuals other than licensed physicians and surgeons.

Approach 1. Support transparency and oversight of health care transactions through notification and review requirements

State	Status	Bill/Statute	Relevant Definitions	Notice	Review, Approval, and Enforcement
California (cont.)	**ENROLLED 2025**			(2) Agreements or transactions involving health insurers that are subject to review by the Insurance Commissioner under Article 14 (commencing with Section 1091) of Chapter 1 of Part 2, of Division 1 of the Insurance Code. (3) Agreements or transactions where a county is purchasing, acquiring, or taking control, responsibility, or governance of an entity to ensure continued access in that county.	
California	**PROPOSED 2024** (Governor vetoed)	AB 3129	(11) (A) "Transaction" means the direct or indirect acquisition in any manner, including, but not limited to, lease, transfer, exchange, option, receipt of a conveyance, creation of a joint venture, or any other manner of purchase, by a private equity group or hedge fund of a material amount of the assets or operations, or a change of control, of a health care facility, provider group, or provider doing business in this state. (B) A transaction involves a "material amount of the assets or operations" if either the transaction affects more than 15 percent of the market value or ownership shares of the health care facility, provider group, or provider or the transaction involves a hospital. *provider*. A transaction that vests rights significant enough to constitute a change in control, including, but not limited to, supermajority rights, veto	(a) Except as provided in subdivision (h), a private equity group or hedge fund shall provide written notice to, and obtain the written consent of, the Attorney General before a transaction between the private equity group or hedge fund and any of the following: (1) A health care facility, except for hospitals. (2) A provider group. (3) A provider, if the private equity group or hedge fund has been involved, directly or indirectly, in a transaction involving a health care facility, provider group, provider, or related health care services within the past seven years. (4) Any health care facility, provider group, or provider as described in paragraph (3) under common control or (3), that directly or indirectly controls, is controlled by, is under common control of, or is otherwise affiliated with a payor, if the private equity group or hedge fund has been involved, directly or indirectly, in a	(a) The Attorney General may consent to, give conditional consent to, or not consent to a transaction between a private equity group or hedge fund and a health care facility, provider group, or provider, pursuant to subdivision (a) of Section 1190.10, depending on the Attorney General's determination of whether the transaction may have a substantial likelihood of anticompetitive effects, including a substantial risk of lessening competition or of tending to create a monopoly, or may create a significant effect on the access or availability of health care services to the affected community. (b) The Attorney General, in making a determination whether to consent to, give conditional consent to, or not consent to a transaction pursuant to this section, shall apply the public interest standard. The term "public interest" is defined as being in the interests of the public in protecting competitive and accessible health care markets for prices, quality, choice, accessibility, and availability of all health care services for local communities, regions, or the state as a whole. Protecting competitive and accessible health care markets includes considering the substantial risk of lessening competition in horizontal, vertical, or related markets, the substantial risk of anticompetitive effects from increased leverage or the ability to tie, the substantial risk of foreclosing competitors in the same or

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State	Status	Bill/Statute	Relevant Definitions	Notice	Review, Approval, and Enforcement
California (cont.)	**ENROLLED 2024** (Governor vetoed)		rights, exclusivity provisions, and similar provisions, involves a "material amount of the assets or operations" even if less than 15 percent of the market value or ownership shares of the health care facility, provider group, or provider is affected.	transaction involving a health care facility, provider group, or provider. (5) A health district may refer a transfer by the district, as defined in Section 32121, of a health care facility, provider group, or provider to a private equity group or hedge fund to the Attorney General. (b) The notice shall be submitted at the same time that any other state or federal agency is notified pursuant to state or federal law, and otherwise shall be provided at least 90 days before the transaction, and shall contain information sufficient to evaluate the nature of the transaction and information sufficient for the Attorney General to determine that the criteria set forth in subdivisions (a) and (b) of Section 1190.20 have been met or that a waiver may be granted pursuant to subdivision (h). [...] THRESHOLDS: (f) A private equity group or hedge fund shall provide advance written notice to the Attorney General before a transaction between a private equity group or hedge fund and a nonphysician provider or between a private equity group or hedge fund and a provider, if the nonphysician provider has gross annual revenue of more than four million dollars ($4,000,000) or the provider has gross annual revenue between four million dollars ($4,000,000) and twenty-five million dollars ($25,000,000) and is not required to provide written notice under subdivision (a). Transactions between a private equity group or hedge fund and a nonphysician provider, or transactions	related markets, the substantial risk of decreased access or services in local markets, any other negative effects from the transaction, any benefits from the transaction that are specific to the transaction, any views from local communities on the transaction, and any other factors the Attorney General determines to be a public benefit. Negative effects may involve the substantial risk of increases in prices or costs, decreases in quality, or the lessening of access to or availability of services. Benefits from the transaction may include price or cost decreases directly passed to patients, improvements in access or availability of services in the community, or capital improvements that will benefit local community care if that financing cannot be reasonably obtained elsewhere. The Attorney General may, in the public interest, take account of any other negative or positive effects of the transaction. Transactions shall not be presumed to be efficient for the purpose of assessing compliance with the public interest standard. **1190.30.** (a) The Attorney General shall make a written determination, including the factual and legal basis for that determination, whether to consent to, give conditional consent to, or not consent to a transaction pursuant to Section 1190.20.

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California (cont.)	**ENROLLED 2024** (Governor vetoed)			between a private equity group or hedge fund and a provider, that are required to be notified under this subdivision shall not be subject to consent by the Attorney General.	
Illinois	**ENACTED**	740 ILCS 10/7.2a	"Covered transaction" means any merger, acquisition, or contracting affiliation between 2 or more health care facilities or provider organizations not previously under common ownership or contracting affiliation. 740 ILCS 10/7.2a "Health care facility" means the following facilities, organizations, and related persons: (1) An ambulatory surgical treatment center required to be licensed under the Ambulatory Surgical Treatment Center Act [210 ILCS 5/1 et seq.]. (2) An institution, place, building, or agency required to be licensed under the Hospital Licensing Act [210 ILCS 85/1 et seq.]. (3) A hospital, ambulatory surgical treatment center, or kidney disease treatment center maintained by the State or any department or agency thereof. (4) A kidney disease treatment center, including a free-standing hemodialysis unit required to meet the requirements of 42 CFR 494 in order to be certified for participation in Medicare and Medicaid under Titles XVIII and XIX of the federal Social Security Act of 1935.	(b) Health care facilities or provider organizations that are party to a covered transaction shall provide notice of such transaction to the Attorney General no later than 30 days prior to the transaction closing or effective date of the transaction. Covered transactions between an Illinois health care entity and an out-of-state health care entity must provide notice under this subsection where the out-of-state entity generates $10,000,000 or more in annual revenue from patients residing in this State. (c) The written notice provided by the parties under subsection (b) shall be provided as follows: (1) For any health care facility or provider organization that is a party to a covered transaction and files a premerger notification with the Federal Trade Commission or the United States Department of Justice, in compliance with the Hart-Scott-Rodino Antitrust Improvements Act of 1976, 15 U.S.C. 18a, the notice requirement is satisfied by providing a copy of such filing to the Attorney General at the same time as it is provided to the federal government. (2) For any health care facility that is a party to a covered transaction that is not described in paragraph (1), the notice requirement is satisfied when the healthcare facility files an application for a	(d) The Attorney General may make any requests for additional information from the parties that is relevant to its investigation of the covered transaction within 30 days of the date notice is received under subsections (b) and (c). If the Attorney General requests additional information, the covered transaction may not proceed until 30 days after the parties have substantially complied with the request. Any subsequent request for additional information by the Attorney General shall not further delay the covered transaction from proceeding. Nothing in this Section precludes the Attorney General from conducting an investigation or enforcing State or federal antitrust laws at a later date. (e) Any health care facility or provider organization that fails to comply with any provision of this Section is subject to a civil penalty of not more than $500 per day for each day during which the health care facility or provider organization is in violation of this Section. Whenever the Attorney General has reason to believe that a health care facility or provider organization has engaged in or is engaging in a covered transaction without complying with the provisions of this Section, the Attorney General may apply for and obtain, in an action in the Circuit Court of Sangamon or Cook County, a temporary restraining order or injunction, or both, prohibiting the health care facility or provider organization from continuing its noncompliance or doing any act in furtherance thereof. The court may make such further orders or judgments, at law or in equity, as may be necessary to remedy such noncompliance. Before bringing such an action or seeking to recover a civil penalty, the Attorney General shall permit the health care facility or provider organization to come into compliance

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Illinois (cont.)	**ENACTED**		(5) An institution, place, building, or room used for the performance of outpatient surgical procedures that is leased, owned, or operated by or on behalf of an out-of-state facility. (6) An institution, place, building, or room used for provision of a health care category of service, as defined under the Illinois Health Facilities Planning Act [20 ILCS 3960/1 et seq.], including, but not limited to, cardiac catheterization and open heart surgery. 740 ILCS 10/7.2a "Provider organization" means a corporation, partnership, business trust, association, or organized group of persons, whether incorporated or not, which is in the business of health care delivery or management and that represents 20 or more health care providers in contracting with health carriers or third-party administrators for the payment of health care services. "Provider organization" includes physician organizations, physician-hospital organizations, independent practice associations, provider networks, and accountable care organizations. 740 ILCS 10/7.2a	change of ownership with the Health Facilities and Services Review Board, in compliance with the Illinois Health Facilities Planning Act. The Health Facilities and Services Review Board shall provide a copy of such filing to the Attorney General at the same time as it is provided to the applicable State legislators under subsection (a) of Section 8.5 of the Illinois Health Facilities Planning Act. (3) For any health care facility or provider organization that is a party to a covered transaction that is not described in paragraph (1) or (2), written notice provided by the parties must include: (A) the names of the parties and their current business address; (B) identification of all locations where health care services are currently provided by each party; (C) a brief description of the nature and purpose of the proposed transaction; and (D) the anticipated effective date of the proposed transaction. Nothing in this subsection prohibits the parties to a covered transaction from voluntarily providing additional information to the Attorney General. 740 ILCS 10/7.2a	with this Section within 10 days of being notified of its alleged noncompliance. The right to cure noncompliance does not exist on or after the covered transaction's proposed or actual closing date of the covered transaction, whichever is sooner. 740 ILCS 10/7.2a
Indiana	**ENACTED 2024**	Ind. Code Ann. § 25-1-8.5(4)(a). *See HB 1666 below for*	Sec. 1. As used in this chapter, "acquisition" means any agreement, arrangement, or activity the consummation of which results in a person acquiring directly or indirectly the control of another person. Sec. 2.	Sec. 4. (a) An Indiana health care entity that is involved in a merger or acquisition with another health care entity with total assets, including combined entities and holdings, of at least ten million dollars ($10,000,000)	(d) Not later than forty-five (45) days from the submission of a notice under subsection (a), the office of the attorney general: (1) shall review the information submitted with the notice; and

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Indiana (cont.)	**ENACTED 2024**	*additional requirements*	(a) As used in this chapter, "health care entity" means any of the following: (1) Any organization or business that provides diagnostic, medical, surgical, dental treatment, or rehabilitative care. (2) An insurer that issues a policy of accident and sickness insurance (as defined in IC 27-8-5-1), except for the following types of coverage: (A) Accident only, credit, dental, vision, long term care, or disability income insurance. (B) Coverage issued as a supplement to liability insurance. (C) Automobile medical payment insurance. (D) A specified disease policy. (E) A policy that provides indemnity benefits not based on any expense incurred requirements, including a plan that provides coverage for: (i) hospital confinement, critical illness, or intensive care; or (ii) gaps for deductibles or copayments. (F) Worker's compensation or similar insurance. (G) A student health plan. (H) A supplemental plan that always pays in addition to other coverage. (3) A health maintenance organization (as defined in IC 27-13-1-19).	shall, at least ninety (90) days prior to the date of the merger or acquisition, provide written notice of the merger or acquisition to the office of the attorney general in a manner prescribed by the office of the attorney general. (b) The notice required by subsection (a) must include the following information from each health care entity: (1) Business address and federal tax number. (2) Name and contact information of a representative of the health care entity concerning the merger or acquisition. (3) Description of the health care entity. (4) Description of the merger or acquisition, including the anticipated timeline. (5) A copy of any materials that have been submitted to a federal or state agency concerning the merger or acquisition. The notice submitted under this section must be certified before a notary public. (c) The office of the attorney general shall keep confidential all nonpublic information, and the confidential information may not be released to the public	(2) may analyze in writing any antitrust concerns with the merger or acquisition. The office of the attorney general shall provide any written analysis described in subdivision (2) to the person that submitted the notice under subsection (a). (e) The office of the attorney general may issue a civil investigative demand under IC 4-6-3 to a health care entity that has submitted a notice under this section for additional information. (f) Any information received or produced by the office of the attorney general under this section is confidential

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Indiana (cont.)	**ENACTED 2024**		(4) A pharmacy benefit manager (as defined in IC 27-1-24.5-12). (5) An administrator (as defined in IC 27-1-25-1). (6) A private equity partnership, regardless of where the private equity partnership is located, seeking to enter into a merger or acquisition with an entity described in subdivisions (1) through (5).		
Indiana	**ENACTED 2025**	HB 1666	(a) As used in sections 13 and 14 of this chapter, "health care entity" means any organization or business that provides health care services. The term does not include the following: (1) A hospital. (2) An insurer (as defined in IC 27-1-4.5-2). (3) A pharmacy benefit manager (as definedinIC27-1-4.5-3). (4) A third party administrator (as defined in IC 27-1-4.5-4). (5) A person or entity that does not accept commercial health insurance reimbursement.	Sec. 14. (a) Each health care entity that does business in Indiana shall report the following information as part of the report under this chapter: (1) The name of each person or entity that has: (A) either: (i) an ownership interest of at least five percent (5%); or (ii) if the person is a practitioner of the health care entity, any ownership interest; (B) a controlling interest; or (C) an interest as a private equity partner; in the health care entity. (2) The business address of each person or entity identified under subdivision (1). The business address must include A: (A) building number; (B) street name; (C) city name; (D) ZIP code; and (E) country name. The business address may not include a post office box number.	Sec. 35. (a) The state department shall do the following: (1) Cooperate with the secretary of state and the department of insurance to develop and implement a plan to collect the information described in IC 16-21-6-3(a)(14) through IC 16-21-6-3(a)(18), IC 23-0.5-2-13(a)(6), and IC 27-1-4.5-5. (2) Annually publish on the state department's website a report concerning the information collected under subdivision (1). (3) Upon request, provide the information collected under subdivision (1) to any the following: (A) The legislative council created by IC 2-5-1.1-1. (B) The office of the attorney general. (C)The healthcare cost oversight task force established by IC 2-5-47. (4) In carrying out the state department's duties under this section, operate within existing appropriations for the state department. (b) In publishing the report required under subsection (a)(2), the state department: (1) may omit information the state department determines is not widely available to the general public; and (2) may not include the name of a person or entity that has an ownership stake in a hospital, healthcare entity, insurer, third party administrator, or pharmacy benefit manager

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Indiana (cont.)	**ENACTED 2025**			(3) The business website, if applicable, of each person or entity identified under subdivision (1). (4) Any of the following identification numbers, if applicable, for a person or entity identified under subdivision (1): (A) National provider identifier (NPI). (B) Taxpayer identification number (TIN). (C) Employer identification number (EIN). (D) CMS certification number (CCN). (E) National Association of Insurance Commissioners (NAIC) identification number. (F) A personal identification number associated with a license issued by the department of insurance. (5) The ownership stake of each person or entity identified under subdivision (1). (6) Whether the healthcare entity is a Medicaid provider and, if so, whether the health care entity accepted Medicaid recipients during a majority of the preceding two (2) calendar years.	[…] (a) The office of the attorney general may at any time investigate the market concentration of a health care entity. The office of the attorney general may issue a civil investigative demand under IC 4-6-3 to a health care entity subject to an investigation conducted under this section. (b) The office of the attorney general shall keep confidential all nonpublic information obtained in the course of an investigation conducted under this section. Confidential information may not be released to the public.
Massachusetts	**ENACTED**	ALM GL ch. 6d § 1 *et seq*.	"Significant equity investor", (i) any private equity company with a financial interest in a provider, provider organization or management services organization; or (ii) an investor, group of investors or other entity with a direct or indirect possession of equity in the capital, stock or profits totaling more than 10 per cent of a provider, provider organization or management services organization; provided, however, that "significant equity investor" shall not	(a) Every provider or provider organization shall, before making any material change to its operations or governance structure, submit notice to the commission, the center and the attorney general of such change, not fewer than 60 days before the date of the proposed change. Material changes shall include, but not be limited to: (i) significant expansions in a provider or provider organization's capacity; (ii) a corporate merger, acquisition or affiliation of a provider or provider organization and a carrier;	Within 30 days of receipt of a completed notice filed under the commission's regulations, the commission shall conduct a preliminary review to determine whether the material change is likely to result in a significant impact on the commonwealth's ability to meet the health care cost growth benchmark established in section 9, or on the competitive market. If the commission finds that the material change is likely to have a significant impact on the commonwealth's ability to meet the health care cost growth benchmark, or on the competitive market, the commission may conduct a cost and market impact review under this section.

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Massachusetts (cont.)	**ENACTED**		include venture capital firms exclusively funding startups or other early-stage businesses.	(iii) mergers or acquisitions of hospitals or hospital systems; (iv) acquisition of insolvent provider organizations; (v) transactions involving a significant equity investor which result in a change of ownership or control of a provider or provider organization; (vi) significant acquisitions, sales or transfers of assets including, but not limited to, real estate sale lease-back arrangements; (vii) conversion of a provider or provider organization from a non-profit entity to a for-profit entity; and (viii) mergers or acquisitions of provider organizations which will result in a provider organization having a dominant market share in a given service or region. ALM GL ch. 6D, § 13	(b) In addition to the grounds for a cost and market impact review set forth in subsection (a), if the commission finds, based on the center's annual report under section 16 of chapter 12C, that the percentage change in total health care expenditures exceeded the health care cost growth benchmark in the previous calendar year, the commission may conduct a cost and market impact review of any provider organization identified by the center under section 18 of said chapter 12C. (c) (1) The commission shall initiate a cost and market impact review by sending the provider or provider organization notice of a cost and market impact review, which shall explain the basis for the review and the particular factors that the commission seeks to examine through the review. The provider or provider organization shall submit to the commission, within 21 days of the commission's notice, a written response to the notice, including, but not limited to, any information or documents sought by the commission that are described in the commission's notice. The commission may require that any provider, provider organization, significant equity investor, or other party involved in a given transaction submit documents and information in connection with a notice of material change or a cost and market impact review under this section. The commission shall keep confidential all nonpublic information and documents obtained under this section and shall not disclose the information or documents to any person without the consent of the provider or payer that produced the information or documents, except in a preliminary report or final report under this section if the commission believes that such disclosure should be made in the public interest after taking into account any privacy, trade secret or anti-competitive considerations. The confidential information and documents shall not be public records and shall be exempt from disclosure under clause

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Massachusetts (cont.)	**ENACTED**				Twenty-sixth of section 7 of chapter 4 or section 10 of chapter 66. (2) For any material change involving a significant equity investor, the commission may specify certain information required to be submitted as part of the notice, including, but not limited to, information regarding the significant equity investor's capital structure, general financial condition, ownership and management structure and audited financial statements. (3) The commission may also require, for a period of 5 years following the completion of a material change, that any provider or provider organization submit data and information necessary for the commission to assess the post-transaction impacts of a material change. (d) A cost and market impact review may examine factors relating to the provider or provider organization's business and its relative market position, including, but not limited to: (i) the provider or provider organization's size and market share within its primary service areas by major service category, and within its dispersed service areas; (ii) the provider or provider organization's prices for services, including its relative price compared to other providers for the same services in the same market; (iii) the provider or provider organization's health status adjusted total medical expense, including its health status adjusted total medical expense compared to similar providers; (iv) the quality of the services provided by the provider or provider organization, including patient experience; (v) provider cost and cost trends in comparison to total health care expenditures statewide; (vi) the availability and accessibility of services similar to those provided, or proposed to be provided, through the provider or provider organization within its primary service areas and dispersed service areas;

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Massachusetts (cont.)	**ENACTED**				(vii) the provider or provider organization's impact on competing options for the delivery of health care services within its primary service areas and dispersed service areas including, if applicable, the impact on existing service providers of a provider or provider organization's expansion, affiliation, merger or acquisition, to enter a primary or dispersed service area in which it did not previously operate; (viii) the methods used by the provider or provider organization to attract patient volume and to recruit or acquire health care professionals or facilities; (ix) the role of the provider or provider organization in serving at-risk, underserved and government payer patient populations, including those with behavioral, substance use disorder and mental health conditions, within its primary service areas and dispersed service areas; (x) the role of the provider or provider organization in providing low margin or negative margin services within its primary service areas and dispersed service areas; (xi) consumer concerns, including but not limited to, complaints or other allegations that the provider or provider organization has engaged in any unfair method of competition or any unfair or deceptive act or practice; (xii) the size and market share of any corporate affiliates or significant equity investors of the provider or provider organization; (xiii) the inventory of health care resources maintained by the department of public health, pursuant to section 25A of chapter 111; (xiv) any related data or reports from the office of health resource planning, established in section 22; and (xv) any other factors that the commission determines to be in the public interest. (e) The commission shall make factual findings and issue a preliminary report on the cost and market impact review. In

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Massachusetts (cont.)	**ENACTED**				the report, the commission shall identify any provider or provider organization that meets all of the following criteria: (i) the provider or provider organization has, or likely will have as a result of the proposed material change, a dominant market share for the services it provides; (ii) the provider or provider organization charges, or likely will charge as a result of the proposed material change, prices for services that are materially higher than the median prices charged by comparable providers for the same services in the same market; and (iii) the provider or provider organization has, or likely will have as a result of the proposed material change, a health status adjusted total medical expense that is materially higher than the median total medical expense of comparable providers in the same market. (f) Within 30 days after issuance of a preliminary report, the provider or provider organization may respond in writing to the findings in the report. The commission shall then issue its final report. The commission shall refer to the attorney general its report on any provider or provider organization that meets all 3 criteria under subsection (e). The commission shall issue its final report on the cost and market impact review within 185 days from the date that the provider or provider organization has submitted a completed notice to the commission; provided, that the provider or provider organization has certified substantial compliance with the commission's requests for data and information pursuant to subsection (c) within 21 days of the commission's notice, or by a later date set by mutual agreement of the provider or provider organization and the commission. (g) Nothing in this section shall prohibit a proposed material change under subsection (a); provided, however, that any proposed material change shall not be completed: (i) until at least 30 days after the commission has issued its final report; or

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Massachusetts (cont.)	**ENACTED**				(ii) if the attorney general brings an action under chapter 93A or any other law related to the material change, while such action is pending and prior to a final judgment being issued by a court of competent jurisdiction, whichever is later. (h) When the commission, under subsection (f), refers a report on a provider or provider organization to the attorney general, the attorney general may: (i) conduct an investigation to determine whether the provider or provider organization engaged in unfair methods of competition or anti-competitive behavior in violation of chapter 93A or any other law; (ii) report to the commission in writing the findings of the investigation and a conclusion as to whether the provider or provider organization engaged in unfair methods of competition or anti-competitive behavior in violation of chapter 93A or any other law; and (iii) if appropriate, take action under chapter 93A or any other law to protect consumers in the health care market. The commission's final report may be evidence in any such action. (i) Nothing in this section shall limit the authority of the attorney general to protect consumers in the health care market under any other law. (j) The commission shall adopt regulations for conducting cost and market impact reviews and for administering this section. These regulations shall include definitions of material change and non-material change, primary service areas, dispersed service areas, dominant market share, materially higher prices and materially higher health status adjusted total medical expenses, and any other terms as necessary to provide market participants with appropriate notice. These regulations may identify filing thresholds in connection with this section; provided, however, that any financial threshold identified by the commission shall be adjusted annually based on any inflation index established

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					by the United States Department of Health and Human Services or similarly reliable national index, as set forth by the commission. All regulations promulgated by the commission shall comply with chapter 30A. ALM GL ch. 6D, § 13
Minnesota	**ENACTED**	Minn. Stat. § 145D.01 et seq.	(j) "Transaction" means a single action, or a series of actions within a five-year period, which occurs in part within the state of Minnesota or involves a health care entity formed or licensed in Minnesota, that constitutes: (1) a merger or exchange of a health care entity with another entity; (2) the sale, lease, or transfer of 40 percent or more of the assets of a health care entity to another entity; (3) the granting of a security interest of 40 percent or more of the property and assets of a health care entity to another entity; (4) the transfer of 40 percent or more of the shares or other ownership of a health care entity to another entity; (5) an addition, removal, withdrawal, substitution, or other modification of one or more members of the health care entity's governing body that transfers control, responsibility for, or governance of the health care entity to another entity; (6) the creation of a new health care entity; (7) an agreement or series of agreements that results in the sharing of 40 percent or more of the	Subd. 2.Notice required. (a) This subdivision applies to all transactions where: (1) the health care entity involved in the transaction has average revenue of at least $80,000,000 per year; or (2) the transaction will result in an entity projected to have average revenue of at least $80,000,000 per year once the entity is operating at full capacity. (b) A health care entity must provide notice to the attorney general and the commissioner and comply with this subdivision before entering into a transaction. Notice must be provided at least 60 days before the proposed completion date of the transaction, subject to waiver of all or any part of this waiting period under paragraph (f). (c) Subject to waiver of all or any part of these disclosure requirements under paragraph (f), as part of the notice required under this subdivision, at least 60 days before the proposed completion date of the transaction, a health care entity must affirmatively disclose the following to the attorney general and the commissioner: (1) the entities involved in the transaction; (2) the leadership of the entities involved in the transaction, including all board members, managing partners, member managers, and officers;	Subd. 5. *Attorney general enforcement and supplemental authority.* (a) The attorney general may bring an action in district court to enjoin or unwind a transaction or seek other equitable relief necessary to protect the public interest if a health care entity or transaction violates this section, if the transaction is contrary to the public interest, or if both a health care entity or transaction violates this section and the transaction is contrary to the public interest. Factors informing whether a transaction is contrary to the public interest include but are not limited to whether the transaction: (1) will harm public health; (2) will reduce the affected community's continued access to affordable and quality care and to the range of services historically provided by the entities or will prevent members in the affected community from receiving a comparable or better patient experience; (3) will have a detrimental impact on competing health care options within primary and dispersed service areas; (4) will reduce delivery of health care to disadvantaged, uninsured, underinsured, and underserved populations and to populations enrolled in public health care programs; (5) will have a substantial negative impact on medical education and teaching programs, health care workforce training, or medical research; (6) will have a negative impact on the market for health care services, health insurance services, or skilled health care workers; (7) will increase health care costs for patients;

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Minnesota (cont.)	**ENACTED**		health care entity's revenues with another entity, including affiliates of such other entity; (8) an addition, removal, withdrawal, substitution, or other modification of the members of a health care entity formed under chapter 317A that results in a change of 40 percent or more of the membership of the health care entity; or (9) any other transfer of control of a health care entity to, or acquisition of control of a health care entity by, another entity. (k) A transaction as defined in paragraph (j) does not include: (1) an action or series of actions that meets one or more of the criteria set forth in paragraph (j), clauses (1) to (9), if, immediately prior to all such actions, the health care entity directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with, all other parties to the action or series of actions; (2) a mortgage or other secured loan for business improvement purposes entered into by a health care entity that does not directly affect delivery of health care or governance of the health care entity; (3) a clinical affiliation of health care entities formed solely for the purpose of collaborating on clinical trials or	(3) the services provided by each entity and the attributed revenue for each entity by location; (4) the primary service area for each location; (5) the proposed service area for each location; (6) the current relationships between the entities and the affected health care providers and practices, the locations of affected health care providers and practices, the services provided by affected health care providers and practices, and the proposed relationships between the entities and the affected health care providers and practices; (7) the terms of the transaction agreement or agreements; (8) all consideration related to the transaction; (9) markets in which the entities expect postmerger synergies to produce a competitive advantage; (10) potential areas of expansion, whether in existing markets or new markets; (11) plans to close facilities, reduce workforce, or reduce or eliminate services; (12) the brokers, experts, and consultants used to facilitate and evaluate the transaction; (13) the number of full-time equivalent positions at each location before and after the transaction by job category, including administrative and contract positions; and	(8) will adversely impact provider cost trends and containment of total health care spending; (9) will have a negative impact on wages paid by, or the number of employees employed by, a health care entity involved in a transaction; or (10) will have a negative impact on wages, collective bargaining units, and collective bargaining agreements of existing or future workers employed by a health care entity involved in a transaction. (b) The attorney general may enforce this section under section 8.31. (c) Failure of the entities involved in a transaction to provide timely information as required by the attorney general or the commissioner shall be an independent and sufficient ground for a court to enjoin or unwind the transaction or provide other equitable relief, provided the attorney general notified the entities of the inadequacy of the information provided and provided the entities with a reasonable opportunity to remedy the inadequacy. (d) The commissioner shall provide to the attorney general, upon request, data and research on broader market trends, impacts on prices and outcomes, public health and population health considerations, and health care access, for the attorney general to use when evaluating whether a transaction is contrary to public interest. The commissioner may share with the attorney general, according to section 13.05, subdivision 9, any not public data, as defined in section 13.02, subdivision 8a, held by the commissioner to aid in the investigation and review of the transaction, and the attorney general must maintain this data with the same classification according to section 13.03, subdivision 4, paragraph (c). Minn. Stat. § 145D.01

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Minnesota (cont.)	**ENACTED**		providing graduate medical education; (4) the mere offer of employment to, or hiring of, a health care provider by a health care entity; (5) contracts between a health care entity and a health care provider primarily for clinical services; or (6) a single action or series of actions within a five-year period involving only entities that operate solely as a nursing home licensed under chapter 144A; a boarding care home licensed under sections 144.50 to 144.56; a supervised living facility licensed under sections 144.50 to 144.56; an assisted living facility licensed under chapter 144G; a foster care setting licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, for a physical location that is not the primary residence of the license holder; a community residential setting as defined in section 245D.02, subdivision 4a; or a home care provider licensed under sections 144A.471 to 144A.483. Minn. Stat. § 145D.01	(14) any other information relevant to evaluating the transaction that is requested by the attorney general or commissioner. (d) Subject to waiver of all or any part of these submission requirements under paragraph (f), as part of the notice required under this subdivision, at least 60 days before the proposed completion date of the transaction, a health care entity must affirmatively submit the following to the attorney general and the commissioner: (1) the current governing documents for all entities involved in the transaction and any amendments to these documents; (2) the transaction agreement or agreements and all related agreements; (3) any collateral agreements related to the principal transaction, including leases, management contracts, and service contracts; (4) all expert or consultant reports or valuations conducted in evaluating the transaction, including any valuation of the assets that are subject to the transaction prepared within three years preceding the anticipated transaction completion date and any reports of financial or economic analysis conducted in anticipation of the transaction; (5) the results of any projections or modeling of health care utilization or financial impacts related to the transaction, including but not limited to copies of reports by appraisers, accountants, investment bankers, actuaries, and other experts;	

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Minnesota (cont.)	**ENACTED**			(11) audited and unaudited financial statements from all entities involved in the transaction and tax filings for all entities involved in the transaction covering the preceding five fiscal years; and (12) any other information or documents relevant to evaluating the transaction that are requested by the attorney general or commissioner. Minn. Stat. § 145D.01	
Nevada	**ENACTED**	NRS § 439A.126 NRS § 598A.390	1. "Group practice" means two or more practitioners who are legally organized in a partnership, professional corporation, limited-liability company formed to render professional services, medical foundation, nonprofit corporation, faculty practice plan or other similar entity: (a) In which each practitioner who is a member of the group provides substantially the full range of services that the practitioner routinely provides, including, without limitation, medical care, consultation, diagnosis or treatment, through the joint use of shared office space, facilities, equipment or personnel; (b) For which substantially all of the services of the practitioners who are members of the group practice are billed in the name of the group practice and amounts so received are treated as receipts of the group; or	2. A physician group practice or a person who owns all or substantially all of a physician group practice shall notify the Department of a transaction described in subsection 3 to which the physician group practice or person, as applicable, is a party or any contract for the management of the physician group practice not later than 60 days after the finalization of the transaction or execution of the contract for management, as applicable, if: (a) The physician group practices that are parties to the transaction or contract for management or that are owned by those parties represent at least 20 percent of the physicians who practice any specialty in a primary service area; and (b) The physician group practice represents the largest number of physicians of any physician group practice that is a party to or owned by a party to the transaction or contract for management. 3. Notice must be provided pursuant to subsection 2 for any: (a) Merger of, consolidation of or other affiliation between physician group	5. The Department shall: (a) Post the information contained in the notices provided pursuant to subsections 1 and 2 on an Internet website maintained by the Department; and (b) Annually prepare a report regarding market transactions and concentration in health care based on the information in the notices and post the report on an Internet website maintained by the Department. 7. If a physician group practice or a person who owns all or substantially all of a physician group practice fails to provide timely notice to the Department pursuant to subsection 2 and the failure was not caused by excusable neglect, technical problems or other extenuating circumstances, the Department shall notify the Board of Medical Examiners or the State Board of Osteopathic Medicine, or both, as applicable, of such failure. Nev. Rev. Stat. Ann. § 439A.126 Nothing in NRS 598A.290 to 598A.430, inclusive, limits the power of the Attorney General to issue an investigative demand in connection with an investigation of a suspected violation of the provisions of this chapter pursuant to NRS 598A.100. Nev. Rev. Stat. Ann. § 598A.410

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Nevada (cont.)	**ENACTED**		(c) In which the overhead expenses of, and the income from, the group are distributed in accordance with methods determined by members of the group. 2. The term includes any entity that otherwise meets the definition whose shareholders, partners or owners include single-practitioner professional corporations, limited-liability companies formed to render professional services or other entities to which beneficial owners are individual practitioners. Nev. Rev. Stat. Ann. § 598A.320 1. "Reportable health care or health carrier transaction" means any transaction that: (a) Results in a material change to the business or corporate structure of a group practice or health carrier; and (b) As a result of the transaction, would cause a group practice or health carrier to provide within a geographic market 50 percent or more of any health care service, including, without limitation, a health care service involving a specialty, or any health carrier service. 2. The term does not include a transaction involving business entities which: (a) Are under common ownership; or	practices, persons who own physician group practices or any combination thereof; (b) The acquisition of all or substantially all of the properties and assets of a physician group practice; (c) The acquisition of all or substantially all of the capital stock, membership interests or other equity interests of a physician group practice; (d) The employment of all or substantially all of the physicians in a physician group practice; or (e) The acquisition of an insolvent physician group practice Nev. Rev. Stat. Ann. § 439A.126 1. Except as otherwise provided in subsection 2, any person conducting business in this State who is a party to a reportable health care or health carrier transaction shall, at least 30 days before the consummation of the reportable health care or health carrier transaction, submit to the Attorney General a notification on a form prescribed by the Attorney General. The notification must contain the following information, to the extent such information is applicable: (a) A brief description of the nature of the proposed relationship among the parties to the proposed reportable health care or health carrier transaction; (b) The names and specialties of each practitioner working for the group practice that is the subject of the reportable health care or health carrier transaction and who is anticipated to work with the resulting group	

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Nevada (cont.)	**ENACTED**		(b) Have a contracting relationship that was established before October 1, 2021. 3. As used in this section, a "material change to the business or corporate structure of a group practice or health carrier" includes, without limitation: (a) The merger, consolidation or affiliation of a group practice or health carrier with another group practice or health carrier; (b) The acquisition of all or substantially all of: (1) The properties and assets of a group practice; or (2) The capital stock, membership interests or other equity interest of a group practice or health carrier; (c) The employment of all or substantially all of the practitioners in a group practice; and (d) The acquisition of one or more insolvent group practices. Nev. Rev. Stat. Ann. § 598A.370	practice following the effective date of the transaction; (c) The names of the business entities that are anticipated to provide health care services or health carrier services following the effective date of the reportable health care or health carrier transaction; (d) An identification of each anticipated location where health care services or health carrier services are to be provided following the effective date of the reportable health care or health carrier transaction; (e) A description of the services to be provided by practitioners at each location identified pursuant to paragraph (d); and (f) The primary service area to be served by each location identified pursuant to paragraph (d). 2. If a person who is a party to a reportable health care or health carrier transaction is required to: (a) Submit a copy of a filing to the Attorney General pursuant to NRS 598A.400 regarding the transaction, the copy of the filing submitted pursuant to NRS 598A.400 satisfies the requirement for notification pursuant to subsection 1. (b) Submit a notification to the Commissioner of Insurance pursuant to NRS 692C.363 regarding the transaction, the person may satisfy the requirement for notification pursuant to subsection 1 by simultaneously submitting to the Attorney General a copy of the notification submitted to the Commissioner of Insurance. Nev. Rev. Stat. Ann. § 598A.390	

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New York	**ENACTED**	N.Y. Pub. Health Law § 4551 *et. seq.*	2. "Health care entity" shall include but not be limited to a physician practice, group, or management services organization or similar entity providing all or substantially all of the administrative or management services under contract with one or more physician practices, provider-sponsored organization, health insurance plan, or any other kind of health care facility, organization or plan providing health care services in this state; provided, however, that a "health care entity" shall not include an insurer authorized to do business in this state, or a pharmacy benefit manager registered or licensed in this state. An "insurer" shall not include non-insurance subsidiaries and affiliated entities of insurance companies regulated under the insurance law or this chapter. 4. "Material transaction" shall mean: (a) any of the following, occurring during a single transaction or in a series of related transactions that take place within a rolling twelve month time period, and meet or exceed thresholds, for factors including but not limited to changes in revenue: (i) a merger with a health care entity; (ii) an acquisition of one or more health care entities, including but not limited to the assignment, sale, or other conveyance of assets, voting	1. A health care entity shall submit to the department written notice, with supporting documentation as described below and further defined in regulation developed by the department, which the department shall be in receipt of at least thirty days before the closing date of the transaction, in the form and manner prescribed by the department. Immediately upon the submission to the department, the department shall submit electronic copies of such notice with supporting documentation to the antitrust, health care and charities bureaus of the office of the New York attorney general. Such written notice shall include, but not be limited to: (a) The names of the parties to the material transaction and their current addresses; (b) Copies of any definitive agreements governing the terms of the material transaction, including pre- and post-closing conditions; (c) Identification of all locations where health care services are currently provided by each party and the revenue generated in the state from such locations; (d) Any plans to reduce or eliminate services and/or participation in specific plan networks; (e) The closing date of the proposed material transaction; (f) A brief description of the nature and purpose of the proposed material transaction including: (i) the anticipated impact of the material transaction on cost, quality, access, health equity, and competition in the impacted	2. (a) Except as provided in paragraph (b) of this subdivision, supporting documentation as described in subdivision one of this section shall not be subject to disclosure under article six of the public officers law. (b) During such thirty-day period prior to the closing date, the department shall post on its website: (i) a summary of the proposed transaction; (ii) an explanation of the groups or individuals likely to be impacted by the transaction; (iii) information about services currently provided by the health care entity, commitments by the health care entity to continue such services and any services that will be reduced or eliminated; and (iv) details about how to submit comments, in a format that is easy to find and easy to read. 3. A health care entity that is a party to a material transaction shall notify the department upon closing of the transaction in the form and manner prescribed by the department. 4. Failure to notify the department of a material transaction under this section shall be subject to civil penalties under section twelve of this chapter. Each day in which the violation continues shall constitute a separate violation. NY CLS Pub Health § 4552

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New York (cont.)	**ENACTED**		securities, membership, or partnership interest or the transfer of control; (iii) an affiliation agreement or contract formed between a health care entity and another person; or (iv) the formation of a partnership, joint venture, accountable care organization, parent organization, or management services organization for the purpose of administering contracts with health plans, third-party administrators, pharmacy benefit managers, or health care providers as prescribed by the commissioner by regulation. (b) "Material transaction" shall not include a clinical affiliation of health care entities formed for the purpose of collaborating on clinical trials or graduate medical education programs and shall not include any transaction that is already subject to review under article twenty-eight, thirty, thirty-six, forty, forty-four, forty-six, forty-six-A, or forty-six-B of this chapter. "Material transaction" shall not include a de minimis transaction, which shall mean for purposes of this article a transaction or a series of related transactions which result in a health care entity increasing its total gross in-state revenues by less than twenty-five million dollars. NY CLS Pub Health § 4550	markets, which may be supported by data and a formal market impact analysis; and (ii) any commitments by the health care entity to address anticipated impacts. NY CLS Pub Health § 4552	

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Oregon	**ENACTED**	ORS § 415.501	(a) "Health care entity" includes: (A) An individual health professional licensed or certified in this state; (B) A hospital, as defined in ORS 442.015, or hospital system, as defined by the authority by rule; (C) A carrier, as defined in ORS 743B.005, that offers a health benefit plan in this state; (D) A Medicare Advantage plan; (E) A coordinated care organization or a prepaid managed care health services organization, as both terms are defined in ORS 414.025; and (F) Any other entity that has as a primary function the provision of health care items or services or that is a parent organization of, or is an entity closely related to, an entity that has as a primary function the provision of health care items or services. (b) "Health care entity" does not include: (A) Long term care facilities, as defined in ORS 442.015. (B) Facilities licensed and operated under ORS 443.400 to 443.455.ORS § 415.500 (6)(a) "Material change transaction" means: (A) A transaction in which at least one party had average revenue of $25 million or more in the preceding three fiscal years and another party:	(2) In accordance with subsection (1) of this section, the Oregon Health Authority shall adopt by rule criteria approved by the Oregon Health Policy Board for the consideration of requests by health care entities to engage in a material change transaction and procedures for the review of material change transactions under this section. (3)(a) A notice of a material change transaction involving the sale, merger or acquisition of a domestic health insurer shall be submitted to the Department of Consumer and Business Services as an addendum to filings required by ORS 732.517 to 732.546 or 732.576. The department shall provide to the authority the notice submitted under this subsection to enable the authority to conduct a review in accordance with subsections (5) and (7) of this section. The authority shall notify the department of the outcome of the authority's review. (b) The department shall make the final determination in material change transactions involving the sale, merger or acquisition of a domestic health insurer and shall coordinate with the authority to incorporate the authority's review into the department's final determination. (4) An entity shall submit to the authority a notice of a material change transaction, other than a transaction described in subsection (3) of this section, in the form and manner prescribed by the authority, no less than 180 days before the date of the	(6) Following a preliminary review, the authority or the department shall approve a transaction or approve a transaction with conditions designed to further the goals described in subsection (1) of this section based on criteria prescribed by the authority by rule, including but not limited to: (a) If the transaction is in the interest of consumers and is urgently necessary to maintain the solvency of an entity involved in the transaction; or (b) If the authority determines that the transaction does not have the potential to have a negative impact on access to affordable health care in this state or the transaction is likely to meet the criteria in subsection (9) of this section. (7)(a) Except as provided in paragraph (b) of this subsection, if a transaction does not meet the criteria in subsection (6) of this section, the authority shall conduct a comprehensive review and may appoint a review board of stakeholders to conduct a comprehensive review and make recommendations as provided in subsections (11) to (18) of this section. The authority shall complete the comprehensive review no later than 180 days after receipt of the notice unless the parties to the transaction agree to an extension of time. (b) The authority or the department may intervene in a transaction described in ORS 415.500 (6)(a)(C) in which the final authority rests with another state and, if the transaction is approved by the other state, may place conditions on health care entities operating in this state with respect to the insurance or health care industry market in this state, prices charged to patients residing in this state and the services available in health care facilities in this state, to serve the public good. (8) The authority shall prescribe by rule: (a) Criteria to exempt an entity from the requirements of subsection (4) of this section if there is an emergency situation that threatens immediate care services and the

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Oregon (cont.)	**ENACTED**				(B) The material may not be disclosed under ORS 192.311 to 192.478; or (C) The material is not subject to disclosure under ORS 705.137. (c) The authority shall maintain the confidentiality of all confidential information and documents that are not publicly available that are obtained in relation to a material change transaction and may not disclose the information or documents to any person, including a member of the review board, without the consent of the person who provided the information or document. Information and documents described in this paragraph are exempt from disclosure under ORS 192.311 to 192.478. (14) The authority or the Department of Justice may retain actuaries, accountants or other professionals independent of the authority who are qualified and have expertise in the type of material change transaction under review as necessary to assist the authority in conducting the analysis of a proposed material change transaction. The authority or the Department of Justice shall designate the party or parties to the material change transaction that shall bear the reasonable and actual cost of retaining the professionals. (15) A review board may hold up to two public hearings to seek public input and otherwise engage the public before making a determination on the proposed transaction. A public hearing must be held in the service area or areas of the health care entities that are parties to the material change transaction. At least 10 days prior to the public hearing, the authority shall post to the authority's website information about the public hearing and materials related to the material change transaction, including: (a) A summary of the proposed transaction; (b) An explanation of the groups or individuals likely to be impacted by the transaction;

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Oregon (cont.)	**ENACTED**				board. If the authority modifies the recommendations of the review board, the authority shall explain the modifications in the final order and the reasons for the modifications. A party to the material change transaction may contest the final order as provided in ORS chapter 183. (19) A health care entity that is a party to an approved material change transaction shall notify the authority upon the completion of the transaction in the form and manner prescribed by the authority. One year, two years and five years after the material change transaction is completed, the authority shall analyze: (a) The health care entities' compliance with conditions placed on the transaction, if any; (b) The cost trends and cost growth trends of the parties to the transaction; and (c) The impact of the transaction on the health care cost growth target established under ORS 442.386. (20) The authority shall publish the authority's analyses and conclusions under subsection (19) of this section and shall incorporate the authority's analyses and conclusions under subsection (19) of this section in the report described in ORS 442.386 (6). (21) This section does not impair, modify, limit or supersede the applicability of ORS 65.800 to 65.815, 646.605 to 646.652 or 646.705 to 646.805. (22) Whenever it appears to the Director of the Oregon Health Authority that any person has committed or is about to commit a violation of this section or any rule or order issued by the authority under this section, the director may apply to the Circuit Court for Marion County for an order enjoining the person, and any director, officer, employee or agent of the person, from the violation, and for such other equitable relief as the nature of the case and the interest of the public may require.

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Oregon (cont.)	**ENACTED**				(23) The remedies provided under this section are in addition to any other remedy, civil or criminal, that may be available under any other provision of law. (24) The authority may adopt rules necessary to carry out the provisions of this section. ORS § 415.501
Pennsylvania	**PROPOSED 2025**	SB 322	"Against the public interest." A covered transaction that, as determined by the Attorney General, results in any of the following: (1) A significant reduction in competition or a significant increase in costs for health care payers, purchasers or consumers. (2) An unfair method of competition in or affecting health care commerce or an unfair or deceptive act or practice in or affecting health care commerce. (3) A significant reduction in the quality of care. (4) A significant reduction in access to or availability of health care services for payers, purchasers or consumers. (5) A significant reduction in access to care in a rural, low-income or disadvantaged community. (6) A health care leaseback agreement. "Covered transaction." A transaction or a series of transactions involving at least one health care entity and one covered entity, and includes any of the following:	(a) Duties of health care entity.--Prior to entering into a covered transaction, a health care entity shall complete one of the following: (1) file a notification in accordance with subsection (b) and observe the waiting period under subsection (c); or (2) obtain a written determination from the Attorney General that the covered transaction is not against the public interest. (b) Notice.--Notification of a covered transaction shall be submitted to the Attorney General and the department on a form and in a manner developed by the Attorney General. The notification shall include all of the following, as applicable: (1) All organic documents, including articles of incorporation, bylaws, operating agreements and other documents related to governance and ownership of each party. (2) All complete transaction documents with attachments, including collateral or ancillary agreements involving officers, directors or employees. (3) All documents signed by the principals, or the principal's agents, that are necessary to determine the proposed transaction's effect, if any, on affiliates, whether nonprofit or for profit.	(a) General rule.--Except as provided under subsection (b), a person may not enter into a covered transaction that is against the public interest. (b) Exception.--An action prohibited under subsection (a) may be permitted when, as determined by the Attorney General, there is no feasible alternative to prevent a health care entity's closure or a greater loss of health care services. [...] (c) Waiting period.--Prior to entering into a covered transaction, a health care entity shall undergo a 90-day waiting period, which shall begin on the date the Attorney General receives the notification required under subsection (b). Within two business days, the Attorney General shall confirm receipt of the notification with the health care entity that submitted the notification. Upon the expiration of the waiting period provided for under this subsection, and any extension of a waiting period under subsection (d), the covered transaction may proceed unless the Attorney General determines the covered transaction is against the public interest. [...] Section 303. Public input. (a) Public hearing.--Prior to the expiration of the respective waiting period under section 302(c), along with any extension granted under section 302(d), the Attorney General may conduct one or more public hearings on the proposed covered transaction. (b) Accessibility.—

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Pennsylvania (cont.)	**PROPOSED 2025**		(1) The sale, transfer, lease or other encumbrance of a material amount of a health care entity's assets, including real property, employment groups, emergency departments or other units. (2) A change in control of a health care entity. (3) A capital distribution or similar reduction of a health care entity's equity capital by a material amount or the incursion of an obligation that commits the health care entity to making a capital distribution or similar reduction of equity by a material amount. "Health care entity." The term includes: (1) A person that directs, or through an affiliate directs, control of one or more health care facilities. (2) A practitioner organization, representing eight or more health care practitioners, valued at or above a material amount.	(4) Any of the following that comprise part or all of the transaction: (i) Asset contribution agreements. (ii) Operating agreements. (iii) Management contracts. (5) All information necessary to evaluate the effects of the transaction on each component of an integrated delivery system if that transaction involves a hospital, including any changes in contracts between the integrated delivery system entities and related physician groups. (6) All financial documents of the transaction parties and related entities, if applicable, including audited financial statements, ownership records, business projection data, current capital asset valuation data and any records upon which future earnings, existing asset values and fair market value analysis can be based. (7) All fairness opinions and independent valuation reports of the assets and liabilities of the parties, prepared on the parties' behalf. (8) A list of all donor restricted assets, together with origination documents and current fund balances. (9) All relevant contracts that may affect value, including business contracts and employee contracts, such as buy-out provisions, profit-sharing agreements and severance packages. (10) All information and representations disclosing related party transactions that are necessary to assess whether the	(1) A public hearing required under subsection (a) shall be live-streamed on the Attorney General's publicly accessible Internet website. (2) A video recording of the public hearing shall be posted on the Attorney General's publicly accessible Internet website. (c) Specific entities.--If a covered transaction involves the acquisition of a health care facility, the Attorney General may hold a public hearing in any county in which the acquired entity is located to hear comments from interested parties. Interested parties shall include employees of the health care entity, legal aid organizations, public officials and health advocacy organizations within a county in which the health care facility is located. The Attorney General may request testimony at a hearing from State agencies subject to section 306(d). (d) Notice.--At least 14 days before the date of the public hearing, the Attorney General shall provide written notice of the date, time and place of the public hearing: (1) On the Attorney General's publicly accessible Internet website. (2) Through social and broadcast media. (3) Through publication in one or more newspapers of general circulation in the affected community. (4) To the governing body of each county in which the health care entity is located. (e) Substantive changes to proposal.--If a substantive change in the covered transaction is submitted to the Attorney General after the initial public hearing, the Attorney General may conduct an additional public hearing to hear comments from interested parties with respect to the change. Section 304. Determination and restraining prohibited transactions. (a) Determination.--No later than the final date of expiration of the respective waiting period under section 302(c), along with any extension granted under section 302(d), the

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Pennsylvania (cont.)	**PROPOSED 2025**			transaction is at arm's length or involves selfdealing. (11) All documents relating to noncash elements of the transaction, including pertinent valuations of security for loans and stock restrictions. (12) All tax-related information, including the existence of tax-free debt subject to redemption and disqualified person transactions yielding tax liability. (13) A list of ongoing litigation, including full court captions, involving the transaction parties or the transaction parties' related entities, that may affect the interests of the parties. (14) All information in the possession of the transacting parties relative to the perspective of the health care entity's patient base and communities served, or their representatives. (15) All information, including internal and external reports and studies, bearing on the effect of the proposed transaction on the availability or accessibility of health care in the affected community. (16) A complete list of all insurance plans under contract and the policies' expiration dates. (17) Organizational charts of the parties to the transaction, as they exist both preconsummation and postconsummation of the transaction, detailing the relationship between the principal parties, including any subsidiary.	Attorney General shall determine whether the covered transaction is likely to have an impact that is against the public interest. (b) Department review.--Prior to making a determination whether a covered transaction is against the public interest, the Attorney General shall consult and request feedback from the department regarding the covered transaction's potential impact on the existing patient base and affected community. (c) Action.--If the Attorney General, in consultation with the department, determines that the proposed covered transaction is against the public interest under subsection (a), the Attorney General, on behalf of the Commonwealth, may: (1) commence an action in a court of competent jurisdiction to enjoin the covered transaction; or (2) enter into a voluntary agreement with the covered entity and the health care entity, which shall be filed with Commonwealth Court, that imposes conditions or otherwise mitigates the aspects that make the covered transaction against the public interest. (d) Monitoring.— (1) A voluntary agreement entered into under subsection (c) shall include an initial monitoring period of not more than five years. The monitoring period may be extended for additional periods of not more than five years at the discretion of the Attorney General. (2) The Attorney General shall consult with the department prior to setting the length of the initial monitoring period and any extension. (3) During the monitoring period, the Attorney General and the department shall monitor, evaluate and assess the covered entity and health care entity's compliance with the terms and conditions of the voluntary agreement. (e) Costs of monitoring.—

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Pennsylvania (cont.)	**PROPOSED 2025**			(18) All additional documents that the Attorney General deems necessary for review purposes.	(1) The covered entity shall pay for the costs of the Attorney General and the department's monitoring, evaluation and assessment of the covered entity and health care entity's compliance with the terms and conditions of the voluntary agreement during a monitoring period established under subsection (d). (2) The Attorney General, in consultation with the department, shall determine the amount of the compliance monitoring cost under this subsection, which shall be paid by the covered entity and placed in an escrow account during the monitoring period.
Texas	**PROPOSED 2025**	HB 2747	(8) "Material change transaction" means a transaction that entails a material change to ownership, operations, or governance structure of a legal entity. a) This chapter applies only to the following material change transactions, whether occurring as a single transaction or a series of related transactions within a consecutive 12-month period (1) a merger that includes one or more health care entities; (2) a sale or other acquisition, including by lease, transfer, exchange, option, receipt through conveyance, and creation of a joint venture, of: (A) one or more health care entities, including insolvent health care entities; or (B) a material amount of the assets or operations of one or more health care entities;	Sec. 15A.0051. REQUIRED NOTICE OF PROPOSED MATERIAL CHANGE TRANSACTIONS. (a) A health care entity shall submit written notice to the attorney general of any material change transaction involving the entity not less than 90 days before the date the change is to take effect. (b) The attorney general by rule shall prescribe the method and form of the written notice required under this section.	(b) The attorney general may bring an action to: (1) recover the civil penalty imposed by Subsection (a); and (2) restrain or enjoin a person from violating Section 15A.0051. Sec. 15A.0101. STUDIES ON HEALTH CARE MARKETS. (a) The attorney general may conduct studies on the following topics: (1) the conditions of a health care market in this state or in a region or political subdivision of this state, including: (A) the degree of health care entity ownership or other concentration; (B) the strength of competitive forces on price and quality of health care services; and (C) trends in the price, quality, and availability of health care services; and (2) the impacts of completed material change transactions on a market. (b) The attorney general may request necessary documents or other information from health care and other relevant entities involved in the health care market to conduct the studies required by this section.

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Texas (cont.)	**PROPOSED 2025**		(3) a contract or other arrangement, including an association, partnership, or joint venture, that results in a person acquiring direct or indirect control over all or a substantial part of a health care entity's operations or governance; (4) the formation of a partnership, joint venture, accountable care organization, parent organization, or management services organization for the purpose of administering contracts with health carriers, third-party administrators, pharmacy benefit managers, or health care providers; (5) the sale, purchase, lease, affiliation, or transfer of control of a health care entity's board of directors or other governing body; or (6) a real estate sale or lease agreement involving a material amount of health care entity assets. (b) This chapter does not apply to the following: (1) a clinical affiliation of health care entities formed solely to collaborate on clinical trials; (2) a graduate medical education program; or (3) an offer of employment to, or the hiring of, not more than one physician.		

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Texas	**PROPOSED 2025**	HB 4408	"Material change transaction" means a transaction that entails a material change to ownership, operations, or governance structure involving health plans, health insurers, hospitals or hospital systems, physician organizations, health care providers, health care facilities, pharmacy benefit managers, and other health care entities.	SUBCHAPTER B. TRANSPARENCY REPORTING IN OWNERSHIP AND CONTROL OF HEALTH CARE ENTITIES Sec. 550A.0101. REQUIRED INFORMATION REGARDING OWNERSHIPAND CONTROL OF HEALTH CARE ENTITIES. Except as provided by Section 550A.0102, each health care entity shall report to the secretary of state annually and on the execution of a material change transaction, in the form and manner the secretary of state requires, the following information: (1) the legal name of the health care entity; (2) the business address of the health care entity; (3) the locations of the health care entity's operations; (4) the applicable business identification numbers ofthe health care entity, including: (A) the taxpayer identification number; (B) the national provider identifier number; (C) the employer identification number; (D) the Centers for Medicare and Medicaid Services certification number; (E) the national association of insurance commissioners identification number; (F) a personal identification number associated with a license issued by the Texas Department of Insurance; and (G) the pharmacy benefit manager identification number associated with a license or registration of the pharmacy benefit manager in this state; (5) the name and contact information of arepresentative of the health care entity;	(b) Not later than July 1 of each year, the secretary of state shall post on the secretary of state's publicly accessible Internet website a report that includes the following information for the preceding year: (1) the number of health care entities reporting for that year, disaggregated by the business structure of each specified health care entity; (2) the names, addresses, and business structure of any entity with an ownership or controlling interest in each health care entity; (3) any change in ownership or control for each health care entity; (4) any change in the tax identification number of a health care entity; (5) as applicable, the name, address, tax identification number, and business structure of other affiliates under common control, subsidiaries, and management services entities of the health care entity, including the business type and tax identification number of each entity; and (6) an analysis of trends in horizontal and vertical consolidation, disaggregated by business structure and provider type. (c) The secretary of state may share information reported to the secretary of state under this subchapter with the attorney general, state agencies, and state officials to reduce or avoid duplication in reporting requirements or to facilitate oversight or enforcement. A tax identification number that is an individual's social security number and is shared with the attorney general, a state agency, or a state official under this subchapter is confidential. The secretary of state may, in consultation with the relevant state agencies, merge similar reporting requirements as appropriate. Sec. 550A.0105. CIVIL PENALTY. (a) A health care entity that fails to provide a complete report under Section 550A.0101, or submits a report

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Texas (cont.)	**PROPOSED 2025**			(6) the name, business address, and business identification numbers described by Subdivision (4) for each person that, with respect to the relevant health care entity: (A) has an ownership or investment interest; (B) has a controlling interest; (C) is a management services organization; or (D) is a significant equity investor, including: (i) a private equity fund or other investorwith direct or indirect ownership of a health care entity or provider; (ii) an investor with direct or indirect possession of equity totaling more than 10 percent of a provider's organization; or (iii) a private equity fund or investor that operates a health care entity under a lease, management, or operating agreement; (7) a current organizational chart showing the business structure of the health care entity, including: (A) any person described by Subdivision (6); (B) each affiliate of the health care entity; and (C) each subsidiary of the health care entity; (8) for a health care entity that is a provider organization or a health care facility the following information regarding each health care provider affiliated with the provider organization or health care facility: (A) the name, license type, specialty, national provider identifier number, and other applicable identification numbers	containing false information, is liable to this state for a civil penalty. The amount of the civil penalty assessed under this section may not exceed: (1) $50,000 for each violation for a health care entity consisting of independent health care providers or provider organizations without any third-party ownership or control entities, with not more than 10 physicians, and with not more than $10 million in annual revenue; and (2) $500,000 for each violation for a health care entity not described by Subdivision (1). (b) The attorney general may bring an action to: (1) recover the civil penalty imposed under this section; or (2) restrain or enjoin the person from violating this chapter.

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Texas (cont.)	**PROPOSED 2025**			described by Subdivision (4) applicable to the health care provider; (B) the address of the health care provider's principal practice location; and (C) whether the health care provider is employed or contracted by the health care entity; (9) the name and address of each affiliated health care facility by license number, license type, and capacity in each major health care service area; and (10) comprehensive financial reports of the health care entity and any affiliate, including audited financial statements, cost reports, annual costs, annual receipts, realized capital gains and losses, accumulated surplus, and accumulated reserves.	
Vermont	**PROPOSED 2025**	HB 71	(12)(A) "Material change transaction" means any of the following, occurring during a single transaction or in a series of related transactions involving a health care entity within the State that has total assets, annual revenues, or anticipated annual revenues for new entities, of at least $1,000,000.00, including both in-state and out-of-state assets and revenues: (i) a corporate merger including one or more health care entities; (ii) an acquisition of one or more health care entities, including insolvent health care entities; (iii) any affiliation, arrangement, or contract that results in a change of control for a health care entity;	§ 9525. NOTICE (a) Notice required. Any health care entity shall, prior to consummating any material change transaction, submit written notice to the Green Mountain Care Board and the Attorney General not fewer than 180 days before the date of the proposed material change transaction. Notice shall be considered received on the first business day after the Green Mountain Care Board determines that notice is complete. (b) Contents of notice. Written notice shall include and contain the information the Green Mountain Care Board and the Attorney General determine is required. The health care entity may include any additional information supporting the written notice of the material change transaction. Notice is complete when the	(d) Public notice. Within 10 days after receiving written notice of a material change transaction, the Green Mountain Care Board shall post on a publicly available website information about the material change transaction, including: (1) a summary of the proposed transaction, including the identity of the parties to the transaction; (2) an explanation of the groups or individuals likely to be impacted by the transaction; (3) information about services currently provided by the health care entity, commitments by the health care entity to continue such services, and any services that will be reduced or eliminated; (4) details about any public hearings regarding the proposed transaction; (5) how to submit public comments regarding the proposed transaction; and (6) any other information from the notice and other materials submitted by the health care entity that the Green

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Vermont (cont.)	**PROPOSED 2025**		(iv) the formation of a partnership, joint venture, accountable care organization, parent organization, or management services organization for the purpose of administering contracts with health insurers, third-party administrators, pharmacy benefit managers, or health care providers; (v) a sale, purchase, lease, affiliation, or transfer of control of a board of directors or governing body of a health care entity; (vi) a real estate sale or lease agreement involving a material amount of assets of a health care entity; or (vii) the closure of a health care facility, or the closure, discontinuance, or significant reduction of any essential health service provided by a health care entity that is either a provider organization or health care facility or any new contracts or clinical or contractual affiliations that will eliminate or significantly reduce essential services. (B) "Material change transaction" does not include any of the following: (i) a clinical affiliation of health care entities formed solely for the purpose of collaborating on clinical trials; (ii) graduate medical education programs;	Green Mountain Care Board and the Attorney General determine that all required information has been received. (c)(1)(A) Each party to the proposed transaction shall provide to the Green Mountain Care Board and the Attorney General: (i) a copy of the party's audited financial statements and the details of all other transactions related to the proposed transaction, such as investments and loans to organizations in the party's portfolio, as well as any other information provided to the party's investors regarding the proposed transaction; (ii) information regarding any and all plans the party has to earn investor returns, payouts, dividends, or related private payments during the operation of and upon exit from the ownership of or contract with a health care provider; and (iii) a plain language summary of all of the means by which the party plans to generate profits related to the proposed transaction.	Mountain Care Board or the Attorney General determines would be in the public interest, except for materials designated confidential under subsection (c) of this section. § 9526. PRELIMINARY REVIEW (a) Within 30 days following receipt of a notice of material change transaction as set forth in section 9525 of this chapter, and unless otherwise provided in subsection (b) of this section, the Green Mountain Care Board, in consultation with the Attorney General, shall do one of the following: (1) Approve the material change transaction and notify the health care entity in writing that a comprehensive review is not required for the material change transaction. (2) Approve the material change transaction subject to conditions set by the Green Mountain Care Board and notify the health care entity in writing of the conditions under which the transaction may be completed. (3) Notify the health care entity in writing that the transaction is subject to a comprehensive review. The Green Mountain Care Board or the Attorney General, or both, may request additional information necessary to perform a comprehensive review under section 9527 of this chapter. (b)(1) A comprehensive review shall be required when any of the following applies to the material change transaction: (A) the transaction will result in the transfer of assets valued above $1,000,000.00; (B) the transaction occurs in a highly consolidated market for any 13 line of services offered by any party to the material change transaction; (C) the transaction will cause a significant change in market share, such that any resulting health care entity possesses market power upon completion;

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Vermont (cont.)	**PROPOSED 2025**		(iii) the mere offer of employment to, or hiring of, an individual health care provider; or (iv) situations in which the health care entity directly, or indirectly through one or more intermediaries, already controls, is controlled by, or is under common control with, all other parties to the transaction, such as a corporate restructuring. (20) "Significant equity investor" means: (A) any private equity fund with a direct or indirect ownership or investment interest in a health care facility; (B) an investor, group of investors, or other entity with a direct or indirect possession of equity in the capital, stock, or profits totaling more than 10 percent of a provider or provider organization; or (C) any private equity fund, investor, group of investors, or other entity with a direct or indirect controlling interest in a health care entity or that operates the business or substantially all the property of a health care entity under a lease, management, or operating agreement.		(D) the transaction will otherwise lessen competition, including effects of vertical or cross-market transactions among different product or geographic markets; (E) either party to the material change transaction possesses market power prior to the transaction; or (F) the Green Mountain Care Board or the Attorney General, or both, at their sole discretion, determine that the material change transaction is likely to have a material impact on the cost, quality, equity, or access to health care services in any region in the state. § 9527. COMPREHENSIVE REVIEW PROCESS (a) Not later than 90 days after determining that a transaction is subject to a comprehensive review, the Green Mountain Care Board shall conduct one or more public hearings or public meetings, one of which shall be in the county in which the health care entity is located, to hear comments from interested parties. (b) The Green Mountain Care Board shall conduct a cost and market impact review of the proposed transaction in consultation with the Attorney General. The cost and market impact review shall examine factors relating to the proposed transaction, the transacting parties, and their relative market position, including: (1) the market share of each transacting party and the likely effects of the transaction on competition; (2) any previous transaction involving any transacting party, including acquisitions of or mergers with similar health care providers, whether or not in the same state; (3) the prices charged by any of the transacting parties for services, including their relative prices compared to others' prices for the same services in the same geographic area; (4) the quality of the services provided by any health care provider or providers that are party to the transaction, including patient experience;

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Vermont (cont.)	**PROPOSED 2025**				(5) the cost and cost trends of the transacting entities in comparison to total health care expenditures statewide; (6) the availability and accessibility of services similar to those provided, or proposed to be provided, through any provider or provider organization that is party to the transaction within its primary service areas and dispersed service areas; (7) the impact of the material change transaction on competing options for the delivery of health care services within the transacting parties' primary service areas and dispersed service areas; (8) the role of the transacting parties in serving at-risk, underserved, and government payer patient populations; (9) the role of the transacting parties in providing low-margin or negative-margin services within their primary service areas and dispersed 5 service areas; (10) any consumer concerns, including complaints or other allegations that any provider or provider organization that is party to the transaction has engaged in any unfair method of competition or any unfair or deceptive act or practice; (11) the transaction parties' compliance with prior conditions and legal requirements related to competitive conduct, including compliance with corporate practice of medicine requirements under subchapter 3 of this chapter and reporting requirements regarding health care entity ownership and control under subchapter 4 of this chapter; (12) the impact of the transaction on the clinical workforce, including wages, staffing levels, supply, patient access, and continuity of patient-care relationships; (13) the impact of any real estate sale or lease agreement related to the transaction on the financial condition of each health care entity that is party to the transaction and its ability to maintain patient care operations; (14) in the case of a proposed closure or discontinuance of a health care facility or any essential health services, the impact of the closure on health care access, outcomes,

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Vermont (cont.)	**PROPOSED 2025**				costs, and equity for those in the health care facility's service area, and the health care facility's plan for ensuring equitable access, quality, affordability, and availability of essential health services within the service area; and (15) any other factors that the Green Mountain Care Board or the Attorney General determines to be in the public interest. [...] (f)(1) Not more than 120 days after determining that the transaction is subject to a comprehensive review under this section, the Green Mountain Care Board shall produce a cost and market impact review report containing the findings and conclusions of the cost and market impact review, provided that the health care entity has complied with the requests for information or documents pursuant to this section within 21 days following the request or by a later date set by mutual agreement of the health care entity and the Green Mountain Care Board or the Attorney General, as applicable. The cost and market impact review report shall be posted publicly and shall not disclose confidential information. (2) The Green Mountain Care Board may adopt rules creating an expedited process for conducting a cost and market impact review for transactions resulting in a transfer of assets not to exceed $1,500,000.00 if there are few competitive concerns or involving a distressed provider in danger of closing, or both. § 9528. APPROVAL AUTHORITY 18 (a)(1) The Green Mountain Care Board, in consultation with the Attorney General, shall have discretion to approve, conditionally approve, or disapprove of any material change transaction for which the Green Mountain Care Board receives notice under section 9525 of this chapter. Any conditions imposed pursuant to this section shall specify a

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Vermont (cont.)	**PROPOSED 2025**				time period for compliance, an expiration date, or that the condition applies indefinitely. (2) Notwithstanding subdivision (1) of this subsection, in the case of a material change transaction involving a health insurer that would be subject to review and approval by the Department of Financial Regulation, the Green Mountain Care Board shall make a recommendation to the Department of Financial Regulation based on the Green Mountain Care Board's review whether the transaction should be approved, disapproved, on conditionally approved. (b) The Green Mountain Care Board shall inform the health care entity of its determination within 30 days following receipt of notice under section 9525 of this chapter or, in the case of comprehensive review, within 60 days following the completion of the cost and market impact review. No proposed material change transaction shall be completed before the Green Mountain Care Board has informed the health care entity of its determination. (c) In making its determination, Green Mountain Care Board, in consultation with the Attorney General, may consider any factors that the Board or the Attorney General deems relevant, including: (1) the likely impact, as described in the cost and market impact review report where applicable, of the material change transaction on: (A) health care costs, prices, and affordability; (B) the availability or accessibility of health care services to the affected community; (C) provider cost trends and containment of total State health care spending; (D) access to services in medically underserved areas; (E) rectifying historical and contemporary factors contributing to a lack of health equities or access to services;

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Vermont (cont.)	**PROPOSED 2025**				accomplish the legitimate health care purposes of the relevant health care entity and the contract or arrangement provides for compensation or reimbursement that is consistent with the fair market value of the services rendered or products delivered; or (5) the transaction would result in one or more health care entities that does not accept, or that places limitations on, patients covered by Medicaid, original Medicare, or Medicare Advantage. § 9529. POST-TRANSACTION OVERSIGHT (a) Enforcement by the Office of the Attorney General. (1) The Attorney General may subpoena any records necessary to enforce any provisions of this chapter or to investigate suspected violations of any provisions of this chapter or any conditions imposed by conditional approval pursuant to section 9528 of this chapter. The Attorney General may audit the books, documents, records, and data of any entity that is subject to a conditional approval under section 9528 of this chapter to monitor compliance with the conditions. (2)(A) The Attorney General may enforce any requirement of this chapter and any conditions imposed by a conditional approval pursuant to section 9528 of this chapter to the fullest extent provided by law, including damages. In addition to any legal remedies the Attorney General may have, the Attorney General shall be entitled to specific performance, injunctive relief, and other equitable remedies a court deems appropriate for any violations or imminent violation of any requirement of this chapter or breach of any of the conditions and shall be entitled to recover the Office of the Attorney General's attorney's fees and costs incurred in remedying each violation. (B) In addition to the remedies set forth in subdivision (A) of this subdivision (a)(2), the Attorney General may impose administrative penalties for any violation of this chapter or of any conditions imposed pursuant to a conditional

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Vermont (cont.)	**PROPOSED 2025**				approval under section 9528 of this chapter and may rescind or deny approval for any other past, pending, or future material change transactions involving the health care entity or an affiliate. (3) Nothing in this subsection shall be deemed to narrow, abrogate, or otherwise alter the authority of the Attorney General to prosecute violations of antitrust or consumer protection requirements. (b) Compliance monitoring. In order to effectively monitor ongoing compliance with the terms and conditions of any transaction subject to prior notice, approval, or conditional approval under this chapter, the Green Mountain Care Board and the Attorney General may, in their sole discretion, conduct a review or audit and may contract with experts and consultants to assist in this regard. (c) Annual reporting. Annually following the completion of the material change transaction approved or conditionally approved by the Green Mountain Care Board after a comprehensive review under section 9527 of this chapter, the health care entity or other person that acquired direct or indirect control over the health care entity shall submit a report to the Green Mountain Care Board and the Attorney General that: (1) demonstrates compliance with conditions placed on the transaction, if any; (2) analyzes cost trends and cost growth trends of the parties to the transaction; and (3) analyzes any changes or effects of the transaction on patient access, availability of services, workforce, quality, or equity. (d) Costs. The Green Mountain Care Board and the Attorney General shall be entitled to charge costs to the transacting parties for all actual, reasonable, and direct costs incurred in monitoring ongoing compliance with the terms and conditions of the sale or transfer of assets, including contractor and administrative costs.

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State	Status	Bill/Statute	Relevant Definitions	Notice	Review, Approval, and Enforcement
Washington	**ENACTED**	WASH. REV. CODE § 19.390.030 et. seq. (2019)	(2) For the purposes of this section, a material change includes a merger, acquisition, or contracting affiliation between two or more entities of the following types: (a) Hospitals; (b) Hospital systems; or (c) Provider organizations. (3) A material change includes proposed changes identified in subsection (2) of this section between a Washington entity and an out-of-state entity where the out-of-state entity generates ten million dollars or more in health care services revenue from patients residing in Washington state, and the entities are of the types identified in subsection (2) of this section. Any party to a material change that is licensed or operating in Washington state shall submit a notice as required under this section. (4) For purposes of subsection (2) of this section, a merger, acquisition, or contracting affiliation between two or more hospitals, hospital systems, or provider organizations only qualifies as a material change if the hospitals, hospital systems, or provider organizations did not previously have common ownership or a contracting affiliation. Rev. Code Wash. (ARCW) § 19.390.030	(1) Not less than sixty days prior to the effective date of any transaction that results in a material change, the parties to the transaction shall submit written notice to the attorney general of such material change. Rev. Code Wash. (ARCW) § 19.390.030 (1) The written notice provided by the parties, as required by RCW 19.390.030, must include: (a) The names of the parties and their current business addresses; (b) Identification of all locations where health care services are currently provided by each party; (c) A brief description of the nature and purpose of the proposed material change; and (d) The anticipated effective date of the proposed material change. (2) Nothing in this section prohibits the parties to a material change from voluntarily providing additional information to the attorney general. Rev. Code Wash. (ARCW) § 19.390.040	The attorney general shall make any requests for additional information from the parties under RCW 19.86.110 within thirty days of the date notice is received under RCW 19.390.030 and 19.390.040. Nothing in this section precludes the attorney general from conducting an investigation or enforcing state or federal antitrust laws at a later date.

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State	Status	Bill/Statute	Relevant Definitions	Notice	Review, Approval, and Enforcement
Wisconsin	**PROPOSED 2025**	SB 45	(17) Private equity fund means a publicly traded or non publicly traded company that collects capital investments from individuals or entities and purchases a direct or indirect ownership share or controlling interest of a health care entity. (19) Significant equity investor means any of the following: (a) Any private equity fund with a direct or indirect ownership or investment interest in a health care entity. (b) Any investor, group of investors, or other entity with a direct or indirect possession of equity in the capital, stock, or profits totaling more than 10 percent of a health care provider or provider organization. (c) Any private equity fund, investor, group of investors, or other entity with a direct or indirect controlling interest in a health care entity or that operates the business or substantially all of the property of a health care entity under a lease, management, or operating agreement. The Department is granted authority to define what constitutes a "material change transaction" in rule.	SECTION 2208. 150.992 of the statutes is created to read: 150.992 Material change transactions. (1) NOTICE. (a) Any health care entity shall, before consummating any material change transaction, submit written notice to the department not fewer than 180 days before the date of the proposed material change transaction. The department shall promulgate rules to define, for purposes of this subchapter, what entities are considered health care entities and what constitutes a material change transaction. 150.996 Transparency in ownership and control of health care entities. (1) REPORTING OF OWNERSHIP AND CONTROL. Each health care entity shall report to the department on an annual basis and upon the consummation of a material change transaction involving the entity as set forth in s. 150.992, in a form and manner required by the department, all of the following information, as applicable: (a) Legal name of entity. (b) Business address of entity. (c) Locations of operations. (d) Business identification numbers of the entity, as applicable, including all of the following: 1. Taxpayer identification number. 2. National provider identifier. 3. Employer identification number.	(d) The department shall post on its publicly available website information about the material change transaction no less than 30 days before the anticipated implementation of the material change transaction or, if the department is notified less than 30 days before the anticipated implementation, as soon as is practicable. The department shall include in the information posted on its website under this paragraph at least all of the following information regarding the material change transaction: 1. A summary of the proposed transaction, including the identity of the parties to the transaction. 2. A description of the groups or individuals likely to be affected by the transaction. 3. Information about services currently provided by the health care entity, commitments by the health care entity to continue such services, and any services that will be reduced or eliminated. 4. Details about any public hearings and how to submit comments. 5. Any other information from the notice and other materials submitted by the health care entity that the attorney general or the department determines would be in the public interest, except for materials designated confidential under par. (c). (e) For purposes of calculating time periods under this section, notice shall be considered received on the first business day after the department determines that notice is complete. (2) PRELIMINARY REVIEW. (a) Within 30 days after receiving notice as described in sub. (1), the department shall do one of the following: 1. Approve the material change transaction and notify the health care entity in writing that a comprehensive review is not required for the material change transaction.

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State	Status	Bill/Statute	Relevant Definitions	Notice	Review, Approval, and Enforcement
Wisconsin (cont.)	**PROPOSED 2025**			4. Centers for Medicare and Medicaid Services certification number. 5. National Association of Insurance Commissioners identification number. 6. A personal identification number associated with a license issued by the commissioner of insurance. 7. Pharmacy benefit manager identification number associated with a license or registration of the pharmacy benefit manager in this state. (d) for each person or entity that, with respect to the relevant health care entity, has an ownership or investment interest, has a controlling interest, is a management services organization, or is a significant equity investor. (e) Name and contact information of a representative of the entity. (f) The name, business address, and business identification numbers listed in par. (g) A current organizational chart showing the business structure of the health care entity, including all of the following: 1. Any entity listed in par. (f). 2. Affiliates, including entities that control or are under common control as the health care entity. 3. Subsidiaries. (h) For a health care entity that is a provider organization or a health care facility, all of the following information: 1. a. The affiliated health care providers identified by name, license type, specialty,	2. Approve the material change transaction subject to conditions set by the department and notify the health care entity in writing of the conditions under which the transaction may be completed. 3. Notify the health care entity in writing that the transaction is subject to a comprehensive review. The department may request additional information necessary to perform a comprehensive review under sub. (3). (b) Nothing in this section limits or infringes upon the existing authority of any state agency or the attorney general to review any transactions. (b) A comprehensive review is required when any of the following applies to the material change transaction: 1. The transaction will result in the transfer of assets valued above $20 million. 2. The transaction occurs in a highly consolidated market for any line of services offered by any party to the material change transaction. 3. The transaction will cause a significant change in market share such that any resulting health care entity possesses market power upon completion. 4. The transaction will otherwise reduce competition, including effects of vertical or cross-market transactions among different product or geographic markets. 5. Either party to the material change transaction possesses market power prior to the transaction. 6. The department, at its sole discretion, determines that the material change transaction is likely to have a material impact on the cost of, quality of, equity of, or access to health care services in any region in the state. (c) No later than 90 days after determining a material change transaction is subject to a comprehensive review, the department shall conduct the review and shall conduct one or more public hearings or public meetings, one of

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State	Status	Bill/Statute	Relevant Definitions	Notice	Review, Approval, and Enforcement
Wisconsin (cont.)	**PROPOSED 2025**			national provider identifier, and other applicable identification number listed in par. (d). b. The address of the principal practice location. c. Whether the health care provider is employed or contracted by the entity. 2. The name and address of affiliated health care facilities by license number, license type, and capacity in each major service area. (i) The names, national provider identifier, if applicable, and compensation of all of the following: a. The members of the governing board, board of directors, or similar governance body for the health care entity. b. Any entity that is owned or controlled by, affiliated with, or under common control as the health care entity. c. Any entity listed in par. (f). (j) Comprehensive financial reports of the health care entity and any ownership or control entities, including audited financial statements, cost reports, annual costs, annual receipts, realized capital gains and losses, accumulated surplus, and accumulated reserves. (2) EXCEPTIONS. All of the following health care entities are exempt from the reporting requirements under sub. (1): (a) A health care entity that is an independent provider organization, without any ownership or control entities, consisting of 2 or fewer physicians, provided that if that	which shall be in the county in which the health care entity is located, to hear comments from interested parties. (d) Not more than 90 days after determining that the material change transaction is subject to a comprehensive review under this subsection, the department shall produce a cost and market impact review report containing the findings and conclusions of the cost and market impact review, provided that the health care entity has complied with the requests for information or documents pursuant to this subsection within 21 days of the request or by a later date set by mutual agreement of the health care entity and the department. The cost and market impact review report shall be posted publicly and may not disclose confidential information. (e) The cost and market impact review may examine factors relating to the proposed material change transaction, transacting parties, and their relative market position, including any of the following: 1. The market share of each transacting party and the likely effects of the material change transaction on competition. 2. Any previous material change transaction involving any transacting party, including acquisitions or mergers of similar health care providers, whether or not in the same state. 3. The prices charged by each transacting party for services, including their relative prices compared to others[prices for the same services in the same geographic area. 4. The quality of the services provided by any health care provider party to the material change transaction, including patient experience. 5. The cost and cost trends of any health care entity party in comparison to total health care expenditures statewide. 6. The availability and accessibility of services similar to those provided, or proposed to be provided, through any health care provider or provider organization party within its primary service areas and dispersed service areas.

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State	Status	Bill/Statute	Relevant Definitions	Notice	Review, Approval, and Enforcement
Wisconsin (cont.)	**PROPOSED 2025**			health care entity experiences a material change transaction under s. 150.992, the health care entity is subject to reporting under sub. (1) upon the consummation of the transaction. (b) A health care provider or provider organization that is owned or controlled by another health care entity, if the health care provider or provider organization is shown in the organizational chart submitted under sub. (1) (g) and the owning or controlling health care entity reports all the information required under sub. (1) on behalf of the controlled or owned entity. Health care facilities are not subject to this exception. (3) RULES. (a) The department shall promulgate any rules necessary to implement this section, specify the format and content of reports, and impose penalties for noncompliance. The department may require additional reporting of data or information that it determines is necessary to better protect the public's interest in monitoring the financial conditions, organizational structure, business practices, and market share of each registered health care entity. (b) The department may assess administrative fees on health care entities in an amount to help defray the costs in overseeing and implementing this section.	7. The impact of the material change transaction on competing options for the delivery of health care services within the primary service areas and dispersed service areas of the transacting parties. 8. The role of the transacting parties in serving at-risk, underserved, and government-payer patient populations. 9. The role of the transacting parties in providing low-margin or negativemargin services within its primary service areas and dispersed service areas. 10. Consumer concerns, including complaints or other allegations that any provider or provider organization party has engaged in any unfair method of competition or any unfair or deceptive act or practice. 11. The parties' compliance with prior conditions and legal requirements related to competitive conduct, including compliance with s. 150.994, reporting requirements regarding health care entity ownership and control under s. 150.996, or restrictions on anticompetitive contracting provisions. 12. The impact of the material change transaction on the clinical workforce, including wages, staffing levels, supply, patient access, and continuity of patientcare relationships. 13. The impact of a real estate sale or lease agreement on the financial condition of any health care entity party and its ability to maintain patient care operations. 14. In the case of a proposed closure or discontinuance of a health care facility or any essential health services, the impact of the closure on health care access, outcomes, costs, and equity for those in the health care facility's service area and the health care facility's plan for ensuring equitable access, quality, affordability, and availability of essential health services within the service area. 15. Any other factors that the department determines, by rules promulgated by the department, to be in the public interest.

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State	Status	Bill/Statute	Relevant Definitions	Notice	Review, Approval, and Enforcement
Wisconsin (cont.)	**PROPOSED 2025**				(4) APPROVAL AUTHORITY. (a) The department may at its discretion approve, conditionally approve, or disapprove of any material change transaction for which the department receives notice under sub. (1). Any conditions imposed under this subsection shall specify a time period for compliance, an expiration date, or that the condition applies indefinitely. (c) In making the determination under this subsection, the department may consider any factors that the department determines to be relevant, including any of the following: 1. The likely impact, as described in the cost and market impact review report, where applicable, of the material change transaction on any of the following: a. Health care costs, prices, and affordability. b. The availability or accessibility of health care services to the affected community. c. Health care provider cost trends and containment of total state health care spending. d. Access to services in medically underserved areas. e. Rectifying historical and contemporary factors contributing to a lack of health equities or access to services. f. The functioning and competitiveness of the markets for health care and health insurance. g. The potential effects of the material change transaction on health outcomes, quality, access, equity, or workforce for residents of this state. h. The potential loss of or change in access to essential services. 2. Whether the material change transaction is contrary to or violates any applicable law, including state antitrust laws, laws restricting the corporate practice of medicine, or consumer protection laws. 3. Whether the benefits of the transaction are likely to outweigh any anticompetitive effect from the transaction. 4. Whether the transaction is in the public interest.

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State	Status	Bill/Statute	Relevant Definitions	Notice	Review, Approval, and Enforcement
Wisconsin (cont.)	**PROPOSED 2025**				(d) This subsection does not limit or alter any existing authority of the attorney general or any state agency to enforce any other law, including state or federal antitrust law, or to review nonprofit transactions. (5) POST-TRANSACTION OVERSIGHT. (a) Enforcement by the attorney general. 1. The attorney general may subpoena any records necessary to enforce any provisions of this section or to investigate suspected violations of any provisions of this section or any conditions imposed by conditional approval pursuant to sub. (4). 2. The attorney general may enforce any requirement of this section and any conditions imposed by a conditional approval pursuant to sub. (4) to the fullest extent provided by law, including damages. In addition to any legal remedies the attorney general may have, the attorney general shall be entitled to specific performance, injunctive relief, and other equitable remedies a court deems appropriate for any violations or imminent violation of any requirement of this section or breach of any of the conditions and shall be entitled to recover its attorney fees and costs incurred in remedying each violation. 3. In addition to the remedies set forth in subd. 2., any person who violates this section or of any conditions imposed pursuant to a conditional approval under sub. (4) is subject to a forfeiture of $10,000 per day, which the attorney general may seek to recover by action on behalf of the state. The attorney general may also rescind or deny approval for any other past, pending, or future material change transactions involving the health care entity or an affiliate. 4. Nothing in this paragraph shall narrow, abrogate, or otherwise alter the authority of the attorney general to prosecute violations of antitrust or consumer protection requirements.

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Wisconsin (cont.)	**PROPOSED 2025**				(b) Enforcement by the department. 1. The department may audit the books, documents, records, and data of any entity that is subject to a conditional approval under sub. (4) to monitor compliance with the conditions. 2. Any entity that violates any provision of this section, any rules adopted pursuant thereto, or any condition imposed pursuant to a conditional approval under sub. (4) shall be subject to a forfeiture of $10,000 per day for any violation of this section. 3. The department may refer any entity to the attorney general to review for enforcement of any noncompliance with this section and any conditions imposed by conditional approval pursuant to sub. (4). (c) Monitoring. In order to effectively monitor ongoing compliance with the terms and conditions of any material change transaction subject to prior notice, approval, or conditional approval under sub. (4), the department may, in its sole discretion, conduct a review or audit and may contract with experts and consultants to assist in this regard. (d) Reporting. One year, 2 years, and 5 years following the completion of the material change transaction approved or conditionally approved by the department after a comprehensive review under sub. (3), and upon future intervals determined at the discretion of the department, the health care entity or any person, corporation, partnership, or other entity that acquired direct or indirect control over the health care entity shall submit reports to the department that do all of the following: 1. Demonstrate compliance with conditions placed on the material change transaction, if any. 2. Analyze cost trends and cost growth trends of the transacting parties.

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Wisconsin (cont.)	**PROPOSED 2025**				3. Analyze any changes or effects of the material change transaction on patient access, availability of services, workforce, quality, or equity. (e) Costs. The department shall be entitled to charge costs to the transacting parties for all actual, reasonable, and direct costs incurred in monitoring ongoing compliance with the terms and conditions of the sale or transfer of assets, including contractor and administrative costs. (b) Not later than December 31, 2028, and annually thereafter, the department shall post on its publicly available website a report with respect to the previous one-year period, including all of the following information: 1. The number of health care entities reporting for the year, disaggregated by the business structure of each specified entity. 2. The names, addresses, and business structure of any entities with an ownership or controlling interest in each health care entity. 3. Any change in ownership or control for each health care entity. 4. Any change in the tax identification number of a health care entity. 5. As applicable, the name, address, tax identification number, and business structure of other affiliates under common control, subsidiaries, and management services entities for the health care entity, including the business type and the tax identification number of each. 6. An analysis of trends in horizontal and vertical consolidation, disaggregated by business structure and provider type. (c) The department may share information reported under this section with the attorney general, other state agencies, and other state officials to reduce or avoid duplication in reporting requirements or to facilitate oversight or enforcement under state law. Any tax identification numbers that are individual social security numbers may be

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Wisconsin (cont.)	**PROPOSED 2025**				shared with the attorney general, other state agencies, or other state officials that agree to maintain the confidentiality of such information. The department may, in consultation with the relevant state agencies, merge similar reporting requirements where appropriate. (5) ENFORCEMENT. (a) Audit and inspection authority. The department is authorized to audit and inspect the records of any health care entity that has failed to submit complete information pursuant to this section or if the department has reason to question the accuracy or completeness of the information submitted pursuant this section. (b) Random audits. The department shall conduct annual audits of a random sample of health care entities to verify compliance with, accuracy, and completeness of the reported information pursuant to this section. (c) Penalty for failure to report. If a health care entity fails to provide a complete report under sub. (1), or submits a report containing false information, the entity shall be subject to all of the following civil penalties, as appropriate: 1. Health care entities consisting of independent health care providers or provider organizations without any 3rd-party ownership or control entities, with 10 or fewer physicians or less than $10 million in annual revenue, a forfeiture of up to $50,000 for each report not provided or containing false information. 2. For all other health care entities, a forfeiture of up to $500,000 for each report not provided or containing false information.

Approach 2. Preserve the independent clinical judgment of physicians by strengthening the corporate practice of medicine doctrine

State	Status	Bill/Statute	Ownership structure	Non-interference with clinical decision-making	Enforcement
California	**ENROLLED 2025**	SB 351		(c) (1) A private equity group or hedge fund, or an entity controlled directly, in whole or in part, by a private equity group or hedge fund, shall not enter into a contract or other agreement or arrangement with a physician or dental practice doing business in this state if the contract or other agreement or arrangement would enable the person or entity to interfere with the professional judgment of physicians or dentists in making health care decisions, as set forth in paragraph (1) of subdivision (a), or exercise control over or be delegated the powers set forth in paragraph (2) of subdivision (a). (2) Any provision within a contract or other agreement that violates subdivision (a) is void, unenforceable, and against public policy. (d) (1) Any contract involving the management of a physician or dental practice doing business in this state by, or the sale of real estate or other assets owned by a physician or dental practice doing business in this state to, a private equity group or hedge fund, or any entity controlled directly or indirectly, in whole or in part, by a private equity group or hedge fund, shall not include any clause barring any provider in that practice from doing either of the following: (A) Competing with that practice in the event of a termination or resignation of that provider from that practice. (B) Disparaging, opining, or commenting on that practice in any manner as to any issues involving quality of care, utilization of care, ethical or professional challenges in the practice of medicine or dentistry, or revenue-increasing strategies employed by the private equity group or hedge fund. (2) Any provision of a contract that violates paragraph (1) is void, unenforceable, and against public policy.	(e) The Attorney General shall be entitled to injunctive relief and other equitable remedies a court deems appropriate for enforcement of this section and shall be entitled to recover attorney's fees and costs incurred in remedying any violation of this section.

Approach 2. Preserve the independent clinical judgment of physicians by strengthening the corporate practice of medicine doctrine

State	Status	Bill/Statute	Ownership structure	Non-interference with clinical decision-making	Enforcement
California (cont.)	**ENROLLED 2025**			(3) This subdivision shall not affect the validity of either of the following: (A) An otherwise enforceable sale of business noncompete agreement. However, a contract described in this subdivision shall not operate as an employee noncompete agreement. (B) An otherwise valid provision within a contract that prohibits the disclosure of material nonpublic information about the private equity group or hedge fund that is not generally available to the public, except to the extent that the provision seeks to either prohibit a disclosure of confidential information that is required by law, or to prohibit a disclosure described in subparagraph (B) of paragraph (1). [...] (f) This section is intended to ensure that clinical decisionmaking and treatment decisions are exclusively in the hands of licensed health care providers and to safeguard against nonlicensed individuals or entities, such as private equity groups and hedge funds, exerting influence or control over care delivery. (g) This section does not narrow, abrogate, or otherwise lower the bar on the corporate practice of medicine or dentistry as set forth in the Business and Professions Code or the Corporations Code, or any other applicable state or federal law. (h) This section does not prohibit an unlicensed person or entity from assisting, or consulting with, a physician or dental practice doing business in this state with respect to the decisions and activities described in paragraph (2) of subdivision (a), provided that the physician or dentist retains the ultimate responsibility for, or approval of, those decisions and activities. 1192.	
California	**PROPOSED 2024**	AB 3129		**1190.40.**	(e) The Attorney General shall be entitled to injunctive relief, and other equitable remedies, a

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State	Status	Bill/Statute	Ownership structure	Non-interference with clinical decision-making	Enforcement
California (cont.)	**PROPOSED 2024**			(a) A private equity group or hedge fund involved in any manner with a physician, psychiatric, or dental practice doing business in this state, including as an investor in that physician, psychiatric, or dental practice or as an investor or owner of the assets of that practice, shall not do either of the following with respect to that practice: (1) Interfere with the professional judgment of physicians, psychiatrists, or dentists in making health care decisions, including any of the following: (A) Determining what diagnostic tests are appropriate for a particular condition. (B) Determining the need for referrals to, or consultation with, another physician, psychiatrist, dentist, or licensed health professional. (C) Being responsible for the ultimate overall care of the patient, including treatment options available to the patient. (D) Determining how many patients a physician, psychiatrist, or dentist shall see in a given period of time or how many hours a physician, psychiatrist, or dentist shall work. (2) Exercise control over, or be delegated the power to do, any of the following: (A) Owning or otherwise determining the content of patient medical records. (B) Selecting, hiring, or firing physicians, psychiatrists, dentists, allied health staff, and medical assistants based, in whole or in part, on clinical competency or proficiency. (C) Setting the parameters under which a physician, psychiatrist, dentist, or physician, psychiatric, or dental practice shall enter into contractual relationships with third-party payers. (D) Setting the parameters under which a physician, psychiatrist, or dentist shall enter into contractual	court deems appropriate for enforcement of this section and shall be entitled to recover attorney's fees and costs incurred in remedying any violation of this section.

Approach 2. Preserve the independent clinical judgment of physicians by strengthening the corporate practice of medicine doctrine

State	Status	Bill/Statute	Ownership structure	Non-interference with clinical decision-making	Enforcement
California (cont.)	**PROPOSED 2024**			relationships with other physicians, psychiatrists, or dentists for the delivery of care. (E) Making decisions regarding coding and billing procedures for patient care services. (F) Approving the selection of medical equipment and medical supplies for the physician, psychiatric, or dental practice. (b) The corporate form of that physician, psychiatric, or dental practice as a sole proprietorship, a partnership, foundation, or a corporate entity of any kind shall not affect the applicability of this section. (c) A private equity group or hedge fund, or an entity controlled directly or indirectly, *directly,* in whole or in part, by a private equity group or hedge fund, shall not enter into a *an* agreement or arrangement with a physician, psychiatric, or dental practice doing business in this state if the agreement or arrangement would enable the person or entity to interfere with the professional judgment of physicians, psychiatrists, or dentists in making health care decisions, as set forth in paragraph (1) of subdivision (a) or exercise control over or be delegated the powers set forth in paragraph (2) of subdivision (a). [...]	
Connecticut	**PROPOSED 2025**	CT SB 261		**Section 1** That the general statutes be amended to impose restrictions on private equity firms buying, operating or holding a controlling interest in hospitals, including, but not limited to, (1) restrictions on the ability of a private equity firm to lease the property back to the hospital for a fee after purchasing the land rights, and (2) preventing health care facilities, health care providers and health care provider organizations from directly or indirectly interfering with, controlling or otherwise directing the professional judgment or clinical decisions of health care clinicians with	

Approach 2. Preserve the independent clinical judgment of physicians by strengthening the corporate practice of medicine doctrine

State	Status	Bill/Statute	Ownership structure	Non-interference with clinical decision-making	Enforcement
Connecticut (cont.)	**PROPOSED 2025**			independent practice authority. Statement of Purpose: To limit the ability for private equity firms to purchase medical care facilities and further protect health care clinicians from the corporate practice of medicine.	
Massachusetts	**PROPOSED 2025**	S 1628 / SD 2325	(b) A clinician with independent practice authority may practice at a health care practice that meets the following requirements: (1) the health care practice is wholly owned and controlled by one or more clinicians with independent practice authority who hold a certificate of registration that (i) is issued by the board of registration in medicine or the board of registration in nursing pursuant to the requirements of sections 2 and 80B of this chapter, and (ii) has not been suspended or revoked; or (2) the health care practice is conducted through a business organization formed as: (i) a professional corporation pursuant to chapter 156A; (ii) a nonprofit organization, a nonprofit hospital services corporation organized under chapter 176A, a nonprofit medical services corporation organized under chapter 176B; (iii) a limited liability company organized under chapter 156C; provided, however, that there are no LLC provisions limiting or eliminating the licensee's liability for intentional tort or negligence;	(2) An entity that provides compensation to one or more clinicians with independent practice authority, including, but not limited to a health care facility licensed pursuant to sections 51, 51M, 51N or 51, shall not directly or indirectly interfere with, control, or otherwise direct the professional judgment or clinical decisions of such clinicians with independent practice authority. Conduct prohibited under this paragraph shall include, but not be limited to, controlling, either directly or indirectly through discipline, punishment, threats, adverse employment actions, coercion, retaliation or excessive pressure, regarding: (i) the amount of time spent with patients, including the time permitted to triage patients in the emergency department or evaluate admitted patients; (ii) the time period within which a patient must be discharged; (iii) decisions involving the patient's clinical status, including, but not limited to, whether the patient should be kept in observation status, whether the patient should receive palliative care and where the patient should be placed upon discharge; (iv) the diagnosis, diagnostic terminology or codes that are entered into the medical record; or (v) any other conduct the department of public health determines by regulation would interfere with, control or otherwise direct the professional judgement or clinical decisions of clinicians with independent practice authority. Such entities shall not limit the range of clinical orders available to clinicians either directly or by configuring the medical record to prohibit or significantly limit the clinical order options available. […]	(e) All health care practices shall provide written certification that the health care practice meets the requirements in this section to the board of registration in medicine or the board of registration in nursing at the time of formation and on a biennial basis thereafter. If a practice's owners consist of individuals registered solely with the board of registration in medicine or the board of registration in nursing, the practice shall provide the certification to the applicable 85 board. If the practice's owners consist of individuals registered with both boards, the practice shall provide the certification to the board of registration in medicine, which shall transmit a copy to the board of registration in nursing. Health care practices shall, at the time that such clinicians with independent practice authority are hired or affiliated with the practice and within 30 days of providing certification to the applicable board pursuant to this section, provide a copy of the most recent certification to all clinicians with independent practice authority who: (i) engage in providing health services at the practice; and (ii) do not hold any ownership interest in the practice. (f) All health care practices shall file with the applicable board a registration application containing such information as the board may reasonably require, including, but not limited to:

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State	Status	Bill/Statute	Ownership structure	Non-interference with clinical decision-making	Enforcement
Massachusetts (cont.)	**PROPOSED 2025**		(iv) a partnership organized under chapter 108A, including, but not limited to, a registered limited liability partnership; provided, however, that the partnership has no provisions limiting or eliminating the licensee's liability for intentional torts or negligence; or (v) an organization similar to those organizations described in clauses (i) through (iv) of this subsection and organized under a comparable law of any other United States jurisdiction; organized under a comparable law of any other jurisdiction within the United States; provided, however, that all shares of the organization shall be owned by clinicians with independent practice authority. (c) It shall constitute the unauthorized practice of medicine in violation of section 6 of this chapter for any person or entity to own a health care practice other than a clinician with independent practice authority who holds a certificate of registration that is issued by the board of registration in medicine or the board of registration in nursing pursuant to the requirements of sections 2 or 80B and has not been suspended or revoked. This section shall not apply to a health care facility or entity that holds a license issued by the department of public health pursuant to sections 51, 51M, 51N or 52 of chapter 111 [...]	Section 4B. (a) A health care practice shall maintain ultimate control over clinical decisions. (b) A management services organization shall not exercise control over, or be delegated the power to do, any of the following: (i) owning or otherwise determining the content of patient medical records; (ii) selecting, hiring or firing any owner of or clinician associated with the health care practice based, in whole or in part, on clinical competency or proficiency; (iii) setting the parameters under which a practice shall enter into contractual relationships with clinicians for the delivery of care; (iv) making final decisions regarding coding and billing of procedures for patient care services; or (v) approving the selection of medical equipment and medical supplies for the practice. (c) A health care practice shall maintain ultimate decision-making authority over: (i) personnel decisions involving clinicians, including, but not limited to, employment status, compensation, hours or working conditions; (ii) coding or billing decisions; (iii) the selection and use of property, including, but not limited to, real property, medical equipment or medical supplies for the delivery of patient care services; (iv) the number of patients seen in a given period of time or the amount of time spent with each patient; (v) the appropriate diagnostic test for medical conditions; (vi) the use of patient medical records; and (vii) referral decisions. (d) A violation of this section shall constitute the unauthorized practice of medicine in violation of section 6 or the unauthorized practice of nursing in	(i) the identity of the applicant and of the clinicians with independent practice authority which constitute the practice; (ii) any management services organization under contract with the health care practice; (iii) a certified copy of the health care practice's certificate of organization, if any, as filed with the secretary of the commonwealth, or any applicable partnership agreement; (iv) the address of the health care practice; (v) the services provided by the health care practice; and (vi) any information the board, in consultation with the health policy commission and the center of for health information and analysis, deems relevant for the state health plan and focused assessments pursuant to section 22 of chapter 6D and the health care resources inventory pursuant to section 9 of chapter 12C. The application shall be accompanied by a fee in an amount to be determined pursuant to section 3B of chapter 7. All health care practices registered in the commonwealth shall renew their certificates of registration with the board every 2 years. The board shall share information relevant to the state health plan and focused assessments pursuant to section 22 of chapter 6D with the commission and information relevant to the health care resources inventory pursuant to section 9 of section 12C with the center. (g) All health care practices with more than 1 clinician with independent practice authority that constitutes the practice shall designate a clinician with independent practice authority at the practice to serve as medical director;

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State	Status	Bill/Statute	Ownership structure	Non-interference with clinical decision-making	Enforcement
Massachusetts (cont.)	**PROPOSED 2025**			violation of section 80E, 80H or 80J. Any provision of a contract or agreement that has the effect of violating this section shall be void and unenforceable. If a court of competent jurisdiction finds a policy, contract or contract provision void and unenforceable pursuant to this section, the court shall award the plaintiff reasonable attorney's fees and costs.	provided, however, that the designated clinician shall hold a certificate of registration that (i) is issued by the Board of Registration in Medicine or the Board of Registration in Nursing pursuant to the requirements of sections 2 or 80B of this chapter that is not suspended or revoked; and (2) is present in the state and is substantially engaged in delivering care or managing the practice. The director shall be responsible for implementing policies and procedures to ensure compliance with local ordinances and state and federal statutes and regulations governing the practice of medicine or the practice of nursing, including regulations promulgated and policies established by the applicable board. The board may impose discipline against the licenses of the medical director and the clinicians with independent practice authority who own and control the health care practice for failure of the practice to comply with local ordinances and state and federal statutes and regulations governing the practice of medicine or the practice of nursing, including regulations promulgated and policies established by the applicable board.
New Mexico	**PROPOSED 2025**	SB 450	B. "health care entity" means a person that provides or supports the provision of health care services to patients in New Mexico, including a hospital, health care provider, in-state or out-of-state telemedicine provider, health care staffing company, health care provider organization, health care facility, management services organization or organization of health care providers or facilities; provided	A. A health care entity shall not indirectly or directly interfere with, control or otherwise direct the professional judgment or clinical decisions of a health care provider. B. A health care entity doing business in this state shall not: (1) interfere with the professional judgment of a health care provider making health care decisions, including any of the following: (a) determining what diagnostic tests are appropriate for a particular condition;	SECTION 4. PRIVATE RIGHT OF ACTION--DAMAGES--ENFORCEMENT BY ATTORNEY GENERAL.— A. A person who has suffered injury by reason of an act or practice in violation of the Corporate Practice of Medicine Act may sue in district court. Upon a showing that the Corporate Practice of Medicine Act is being or has been violated and a showing that the plaintiff has suffered injury, the court may award damages, punitive damages and injunctive relief and shall

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State	Status	Bill/Statute	Ownership structure	Non-interference with clinical decision-making	Enforcement
New Mexico (cont.)	**PROPOSED 2025**		that "health care entity" does not mean a federally qualified health center or an independent health care practice;	(b) determining the need for referrals to, or consultation with, another licensed health care provider; (c) being responsible for the ultimate overall care of the patient, including treatment options available to the patient; and (d) determining how many patients a health care provider shall see in a given time period; or (2) exercise control over or be delegated the power to do any of the following: (a) own or otherwise determine the content of patient medical records; (b) select, hire or fire health care providers, allied health staff or medical assistants based, in whole or in part, on clinical competency or proficiency; (c) set the parameters pursuant to which a health care provider shall enter into contractual relationships with third-party payers; (d) set the parameters pursuant to which a health care provider shall enter into contractual relationships with other health care providers for the delivery of care; (e) make decisions regarding coding and billing procedures for patient care services; and (f) approve the selection of medical equipment and medical supplies for a health care provider.	award the cost of the suit, including reasonable attorney fees. B. Whenever the attorney general has reasonable belief that a person is engaging in or about to engage in an act or practice in violation of the Corporate Practice of Medicine Act and enforcement proceedings would be in the public interest, the attorney general may bring an action in the name of the state alleging violations of that act. An enforcement action by the attorney general may be brought in the district court of the county in which the person that allegedly is engaging in or about to engage in an act or practice in violation of the Corporate Practice of Medicine Act resides or has its principal place of business or in the district court in any county in which the person allegedly is engaging in, has engaged in or is about to engage in an act or practice in violation of the Corporate Practice of Medicine Act. In an action filed by the attorney general pursuant to the Corporate Practice of Medicine Act, the attorney general may petition the district court for temporary or permanent injunctive relief and restitution. The attorney general acting on behalf of the state shall not be required to post bond when seeking a temporary or permanent injunction in an action brought pursuant to this section. C. The relief provided in this section is in addition to remedies otherwise available pursuant to common law or other New Mexico statute
New York	**PROPOSED 2025**	AB 9012	(b) (1) In a professional corporation: (i) physicians who are licensed in this state to practice medicine shall hold the majority of each class of shares which are entitled to vote; ii)	.	

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State	Status	Bill/Statute	Ownership structure	Non-interference with clinical decision-making	Enforcement
New York (cont.)	**PROPOSED 2025**		physicians who are licensed in this state to practice medicine shall be a majority of the directors; and (iii) all officers, except the secretary and treasurer, if any, shall be physicians who are licensed in this state to practice medicine. The same person may hold any two or more offices. (2) Except as otherwise provided by law, the department of health may require that physicians who are licensed in this state to practice medicine hold more than a majority of each class of shares that is entitled to vote. (3) Except as otherwise provided by law, the department of health may require that physicians who are licensed in this state to practice medicine be more than a majority of the directors. [...] (c) A corporation which is not organized for the purpose of practicing medicine may be a shareholder of a professional corporation solely for the purpose of effecting a reorganization as defined by 26 USC 368. (d) (1) Except as provided in subparagraph (2) of this paragraph, a professional corporation shall not provide in such professional corporation's articles of incorporation or bylaws, or by means of a contract or other agreement or arrangement, for removing a director, appointed in accordance with		

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State	Status	Bill/Statute	Ownership structure	Non-interference with clinical decision-making	Enforcement
New York (cont.)	**PROPOSED 2025**		subparagraph (1) of paragraph (b) of this section, from such professional corporation's board of directors, or an officer, appointed in accordance with subparagraph (1) of paragraph (b) of this section, from such person's position in such professional corporation, except by a majority vote of the shareholders or, as appropriate, a majority vote of the directors. (2) A professional corporation may remove a director or officer by means other than a majority vote of the shareholders or a majority vote of the directors if such director or officer that is subject to removal: (i) violated a duty of care, a duty of loyalty, or another fiduciary duty to such professional corporation; (ii) was the subject of a disciplinary proceeding by the department of health, the department of education, or the state board for medicine, in this state, or such equivalent entity in another state, in which such director or officer's license to practice medicine in this or another state was suspended or revoked; (iii) engaged in fraud, misfeasance, or malfeasance with respect to the director or officer's performance of duties for or on behalf of such professional corporation; (iv) resigned, separated, or was terminated from employment with such professional corporation; or		

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State	Status	Bill/Statute	Ownership structure	Non-interference with clinical decision-making	Enforcement
New York (cont.)	**PROPOSED 2025**		(v) failed to meet standards or criteria such professional corporation established for a position as a director or officer (e) A professional corporation may relinquish or transfer control over such professional corporation's administrative, business, or clinical operations only if such professional corporation executes a shareholder agreement exclusively between or among and for the benefit of a majority of shareholders who are physicians licensed in this state to practice medicine and such shareholder agreement complies with the provisions of article six of the business corporation law. (f) (1) The provisions of this section shall not apply to: (i) a nonprofit corporation that is organized under the laws of this state to provide medical services to migrant, rural, homeless or other medically underserved populations under 42 USC 254b or 254c, as in effect on the effective date of this section; (ii) a federally-qualified health center, as defined by 42 USC 1396d(l), as in effect on the effective date of this section, that operates in compliance with other applicable state or federal law; or (iii) except as provided in subparagraph (2) of this paragraph, a for-profit or nonprofit business entity		

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State	Status	Bill/Statute	Ownership structure	Non-interference with clinical decision-making	Enforcement
New York (cont.)	**PROPOSED 2025**		that is incorporated or organized under the laws of this state, that provides the entirety of the business entity's medical services through one or more rural health clinics, as defined in 42 USC 1395x, as in effect on the effective date A. 9012 of this section, and that operates in compliance with state and federal laws that apply to rural health clinics. (2) A business entity is exempt under this paragraph for a period of up to one year after the business entity establishes a rural health clinic, even though the rural health clinic that the business entity establishes does not meet all of the elements of the definition set forth in 42 USC 1395x, as in effect on the effective date of this section, if during such one-year period an applicable certification for such rural health clinic is pending. § 3. Section 1508 of the business corporation law is amended by adding a new paragraph (d) to read as follows: (d) The directors and officers of any professional corporation established for the purpose of practicing medicine may include individuals who are not licensed to practice medicine in any state, provided however that at least a simple majority of each class of shares which are entitled to voting rights of such corporation, as well as the president, the chairperson of the board of directors, and the chief		

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State	Status	Bill/Statute	Ownership structure	Non-interference with clinical decision-making	Enforcement
New York (cont.)	**PROPOSED 2025**		executive officer or officers, except the secretary or treasurer, if any, are authorized by law to practice medicine in this state, and are either shareholders of such corporation or engaged in the practice of medicine in such corporation.		
North Carolina	**PROPOSED 2025**	SB 570	§ 90-8.4. Practice of medicine permitted entities; enforcement. (a) Other than sole proprietors and partnerships with other licensees of this Article, licensees shall only practice on behalf of the following entities, as an employee or an independent contractor: (1) Professional corporations, including foreign professional corporations as defined by G.S. 55B-16(b), registered with the Board pursuant to Chapter 55B of the General Statutes or professional limited liability companies registered with the Board pursuant to G.S. 57D-2-02. The ownership requirements shall comply with Chapter 55B of the General Statutes. (2) Entities licensed, certified, or registered with the North Carolina Department of Health and Human Services, Division of Health Service Regulation, including hospitals and mental health facilities. (3) Non-profits or free clinics providing medical services to indigent populations that are not required to be licensed, certified, or registered with the North Carolina Department of	§ 90-8.3. Control over medical decisions of patient care. If a licensee is employed by or is an independent contractor in a contractual agreement with an employer under G.S. 90-8.4(a) to practice medicine or surgery, then the employment agreement or contract shall ensure and require that the licensee has control over all medical decisions of patient care without clinical interference from (i) an individual not licensed to practice medicine or surgery, (ii) a stakeholder of a management services organization, or (iii) an out-of-state physician or medical professional who may be employed by or affiliated with the professional corporation. For purposes of this section, the term "stakeholder" and "management services organization" are defined as in Chapter 55B of the General Statutes."	(b) If the Board receives a complaint or report alleging violation of this section, upon the Board's request, an employer under subdivision (a)(1) or (a)(2) of this section shall provide a response to the Board signed by a majority of shareholders, a majority of the board of directors, or the Chief Medical Officer or Chief Executive Officer, as applicable, that includes all of the following: (1) Explanation of the structure and ownership interests of the entity, including the roles, responsibilities, and relationships between the medical staff, stakeholders as defined by G.S. 55B-2, hospital administration, and hospital governing board. (2) Affirmation that the employer shall not (i) prevent the licensee from meeting the standards of acceptable and prevailing medical practice in this State, (ii) require the licensee to practice beyond his or her area of competence, or (iii) prevent the licensee from complying with any requirement under Article 1 of Chapter 90 of the General Statutes, any rule adopted by the Board, or any other law pertaining to the practice of medicine. (3) Affirmation that the licensee's professional medical judgment takes priority when the interests of the employer and licensee conflict.

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State	Status	Bill/Statute	Ownership structure	Non-interference with clinical decision-making	Enforcement
North Carolina (cont.)	**PROPOSED 2025**		Health and Human Services, Division of Health Service Regulation. (4) Health maintenance organizations established under Chapter 58 of the General Statutes. (5) Federal or State agencies providing health care services, including the North Carolina Department of Public Safety, Division of Adult Correction and Juvenile Justice; United Stated Veterans Health Administration; United States Armed Forces or Public Health Service; or any federally recognized tribe subject to tribal law. (6) Any other employer recognized by the Board pursuant to a rule adopted by the Board. [...]		(4) Affirmation that the employment agreement will not impact the patient's right to choose the patient's health care provider or continuity of care if the employment relationship is terminated. (5) Affirmation that the employer shall not interfere with the patient's right to access the patient's medical records or the right to be notified of the licensee's departure or new practice information. (c) All bylaws requested by the Board are public record under Chapter 132 of the General 29 Statutes. (d) An employer who fails to comply with subsection (b) of this section and, if applicable, with Chapter 55B of the General Statutes, is an unapproved employer and shall not hire licensees of the Board. An employer required to comply with Chapter 55B of the General Statutes that fails 33 to do so may be subject to suspension or revocation of its certificate of registration by the Board. (e) Working as an employee or independent contractor for an unapproved employer is grounds for discipline under G.S. 90-14(a). (f) The Board may consult with the Attorney General's Office to investigate alleged violations of this section or Chapter 55B of the General Statutes and may refer the matter for prosecution. (g) If the Board investigates alleged violations of this section or Chapter 55B of the General Statutes, the Board may inform the Attorney General's Office of its findings. The Attorney General shall review any findings provided by the Board under this section and shall take appropriate action or seek appropriate relief or

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State	Status	Bill/Statute	Ownership structure	Non-interference with clinical decision-making	Enforcement
North Carolina (cont.)	**PROPOSED 2025**				legal remedies if the Board is consulted and agrees with the Attorney General to pursue alleged violations. (h) The Board shall only reinstate approval of employers upon recommendation of the North Carolina Medical Care Commission, the Attorney General, or pursuant to a court finding that the violations of this section have been rectified.
Oregon	**ENACTED 2025**	SB 951 HB 3410		(2)(a) Except as provided in subsection (3) of this section, a management services organization or a shareholder, director, member, manager, officer, employee or contractor of a management services organization may not: […] (G) Exercise de facto control over administrative, business or clinical operations of a professional medical entity in a manner that affects the professional medical entity's clinical decision-making or the nature or quality of medical care that the professional medical entity delivers, which de facto control includes, but is not limited to, exercising ultimate decisionmaking authority over: (i) Hiring or terminating, setting work schedules or compensation for, or otherwise specifying terms of employment of medical licensees; (ii) Setting clinical staffing levels, or specifying the period of time a medical licensee may see a patient, for any location that serves patients; (iii) Making diagnostic coding decisions; (iv) Setting clinical standards or policies; (v) Setting policies for patient, client or customer billing and collection (vi) Advertising a professional medical entity's services under the name of an entity that is not a professional medical entity;	

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State	Status	Bill/Statute	Ownership structure	Non-interference with clinical decision-making	Enforcement
Oregon (cont.)	**ENACTED**			(vii) Setting the prices, rates or amounts the professional medical entity charges for a medical licensee's services; or (viii) Negotiating, executing, performing, enforcing or terminating contracts with third-party payors or persons that are not employees of the professional medical entity.	
Vermont	**PROPOSED 2025**	HB 71	§ 9532. CORPORATE ENTITIES PERMITTED TO EMPLOY 5 PHYSICIANS (a) A medical practice organized for the purpose of practicing medicine may employ physicians and engage in the practice of medicine only if all of the following conditions are met: (1) Licensees who are licensed in this State to practice medicine must hold the majority of each class of shares that are entitled to vote. (2) Licensees who are licensed in this State to practice medicine must comprise a majority of the directors. (3) All officers except the secretary and treasurer, if any, must be licensees who are licensed in this State to practice medicine. The same individual may hold any two or more offices. (b) Notwithstanding any provision of subsection (a) of this section to the contrary, the following entities may employ physicians and engage in the practice of medicine: (1) federally qualified health centers; (2) rural health clinics; (3) free and referral clinics; (4) nonprofit hospitals;	§ 9531. CORPORATE PRACTICE OF MEDICINE PROHIBITED 16 (a) It is unlawful for an individual, corporation, partnership, or 17 any other entity without a license under 26 V.S.A. chapter 23 or 33 to own a 18 medical practice, employ licensees, or otherwise engage in the practice of 19 medicine. 20 (b) Notwithstanding subsection (a) of this section, an individual, 21 corporation, partnership, or any other entity without a license under 26 V.S.A. chapter 23 or 33 that is permitted to employ licensees under section 9532 of this chapter shall not indirectly or directly interfere with, control, or otherwise direct the professional judgment or clinical decisions of a licensee.	§ 9547. ENFORCEMENT OF CHAPTER 13 (a) Enforcement by Attorney General. (1) The Attorney General may subpoena any records necessary to enforce any provisions of this chapter or to investigate suspected violations of any provisions of this chapter or any conditions imposed by conditional approval pursuant to the material transactions review process. (2)(A) The Attorney General may enforce any requirement of this chapter and any conditions imposed by a conditional approval pursuant to the material transactions review process to the fullest extent provided by law, including damages. In addition to any legal remedies the Attorney General may have, the Attorney General shall be entitled to specific performance, injunctive relief, and other equitable remedies a court deems appropriate for any violations or imminent violation of any requirement of this chapter or any violations or breach of any of the conditions and shall be entitled to recover the attorney's fees and costs incurred in remedying each violation. (B) In addition to the remedies set forth in subdivision (A) of this subdivision (a)(2), the Attorney General may impose administrative penalties for violations of this chapter or of any conditions imposed pursuant to a conditional approval and may rescind or deny approval for any other past, pending, or future material change transactions

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State	Status	Bill/Statute	Ownership structure	Non-interference with clinical decision-making	Enforcement
Vermont (cont.)	**PROPOSED 2025**		(5) hospitals and other health care facilities owned or operated, or both, by the State; (6) ambulatory surgical centers; and (7) school-based health clinics, including student health centers at postsecondary schools.		involving the health care entity or an affiliate. (3) Nothing in this subsection shall narrow, abrogate, or otherwise alter the authority of the Attorney General to prosecute violations of antitrust or consumer protection requirements. (b) Administrative enforcement. (1) Any entity that violates any provision of this chapter or any rules adopted pursuant this chapter may be subject to administrative penalties imposed by the Green Mountain Care Board. (2) The Green Mountain Care Board may disapprove any transaction or agreement that violates this chapter. (3) The Green Mountain Care Board may refer any entity to the Attorney General to review for enforcement of any noncompliance with this chapter or rules adopted pursuant to this chapter. (c) Private right of action. (1) Any person aggrieved by a violation of this chapter may bring an action in the Civil Division of the Superior Court without exhaustion of any alternative administrative remedies provided in this chapter. (2) If the court finds that the respondent has intentionally violated any provision of this chapter or any rule adopted pursuant to this chapter, it may award actual damages, punitive damages, or other equitable relief, or a combination of these
Washington	**PROPOSED 2025**	HB 1675	Sec. 1. A new section is added to chapter 18.100 RCW to read as follows: (1) Except as permitted under this chapter and chapter 25.15 RCW, it is unlawful for an individual, corporation, partnership, or any other entity without a license to practice medicine, own a medical practice, employ licensed	(5) (a) A shareholder, director, or officer of a medical practice organized under this chapter may not relinquish control over or otherwise transfer de facto control over any of the medical practice's administrative, business, or clinical operations that may affect clinical decision making or the nature or quality of medical care that the medical practice delivers by means of a contract or other agreement or arrangement; by providing in the medical practice's	Violations of these provisions constitute unprofessional conduct for license holders.

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State	Status	Bill/Statute	Ownership structure	Non-interference with clinical decision-making	Enforcement
Washington (cont.)	**PROPOSED 2025**		health care providers, or otherwise engage in the practice of medicine. (2) In a professional service corporation organized under this chapter for the purpose of establishing a medical practice, health care providers licensed in this state must: (a) Hold the majority of each class of shares that are entitled to vote; (b) Be a majority of the directors; and (c) Hold all officer positions in the corporation except for secretary and treasurer. (3) Majority shareholders must exhibit meaningful ownership of a medical practice organized under this chapter by being present in the state and substantially engaged in delivering care and managing the practice. (4) A shareholder, director, or officer of a medical practice organized under this chapter may not: (a) Own or control shares in, serve as a director or officer of, be an employee of or an independent contractor with, or otherwise participate in managing both the medical practice and a management services organization with which the medical practice has a contract; (b) Receive substantial compensation or remuneration from a management services organization in return for ownership or management of the medical practice; (c) Transfer or relinquish control over the sale, the restriction of the sale, or	articles of incorporation or bylaws; by forming a subsidiary or affiliated entity; or by other means. (b) Conduct prohibited under (a) of this subsection includes, but is not limited to, relinquishing decision making authority over: (i) Hiring or terminating, setting work schedules and compensation, or otherwise specifying terms of employment of employees who are licensed to practice medicine in this state; (ii) The disbursement of revenue generated from provider fees and other revenue generated by provider services; (iii) Collaboration and negotiation with hospitals and other institutions with which a licensed health care provider employed by the medical practice may deliver clinical care, particularly with regard to controlling a provider's schedules as a means of discipline; (iv) Setting staffing levels, or specifying the period of time a provider may see a patient, for any location that serves patients; (v) Making diagnostic coding decisions; (vi) Setting clinical standards or policies; (vii) Setting policies for patient, client, or customer billing and collection; (viii) Setting the prices, rates, or amounts the medical practice charges for a provider's services; or (ix) Negotiating, executing, performing, enforcing, or terminating contracts with third-party payors or persons that are not employees of the medical practice. (6) This section does not apply to hospitals licensed under chapter 70.41 RCW, private establishments licensed under chapter 71.12 RCW, nursing homes licensed under chapter 18.51 RCW, ambulatory surgical facilities licensed under chapter 70.230 RCW, birthing centers licensed under chapter 18.46 RCW, hospice care centers licensed under	

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State	Status	Bill/Statute	Ownership structure	Non-interference with clinical decision-making	Enforcement
Washington (cont.)	**PROPOSED 2025**		the encumbrance of the sale of the medical practice's shares or assets; (d) Transfer or relinquish control over the issuing of shares of stock in the medical practice, a subsidiary of the medical practice, or an entity affiliated with the medical practice, or the paying of dividends; or (e) Enter into any financial arrangement in violation of chapter 19.68 RCW.	chapter 70.127 RCW, or federally qualified health centers as defined in 42 U.S.C. Sec. 1396d. Sec. 2. A new section is added to chapter 70.41 RCW to read as follows: (1) No person without a license to practice medicine in this state, who is employed by, contracted with, or affiliated with a hospital licensed under this chapter, may interfere with, control, or otherwise direct the professional judgment or clinical decisions of a licensed health care provider employed by, affiliated with, or contracted with the hospital, who is providing care to a patient at the hospital. (2) Conduct prohibited under this section includes, as applicable, but is not limited to, controlling, either directly or indirectly, through policy, discipline, punishment, threats, adverse employment actions, coercion, retaliation, or excessive pressure, any of the following: (a) The period of time a provider may spend with a patient, including the time permitted for a health care provider to triage patients in the emergency department or evaluate admitted patients; (b) The period of time within which a health care provider must discharge a patient; (c) The clinical status of the patient, including whether the patient should be admitted to inpatient status, whether the patient should be kept in observation status, whether the patient should receive palliative care, and whether and where the patient should be referred upon discharge, such as a skilled nursing facility; (d) The diagnoses, diagnostic terminology, or codes that are entered into the medical record by the health care provider; (e) The range of clinical orders available to a health care provider, including by configuring the medical record to	

Approach 2. Preserve the independent clinical judgment of physicians by strengthening the corporate practice of medicine doctrine

State	Status	Bill/Statute	Ownership structure	Non-interference with clinical decision-making	Enforcement
Washington (cont.)	**PROPOSED 2025**			prohibit or significantly limit the options available to the provider; or (f) Any other action specified by rule to constitute impermissible interference or control over the clinical judgment and decision making of a health care provider related to the diagnosis and treatment of a patient. Sec. 3. A new section is added to chapter 71.12 RCW to read as follows: (1) No person without a license to practice medicine in this state, who is employed by, contracted with, or affiliated with a private establishment licensed under this chapter, may interfere with, control, or otherwise direct the professional judgment or clinical decision making of a licensed health care provider employed by, affiliated with, or contracted with the private establishment, who is providing care to a patient at the private establishment. (2) Conduct prohibited under this section includes, as applicable, but is not limited to, controlling, either directly or indirectly, through policy, discipline, punishment, threats, adverse employment actions, coercion, retaliation, or excessive pressure, any of the following: (a) The period of time a provider may spend with a patient, including the time permitted for a health care provider to triage patients in the emergency department or evaluate admitted patients; (b) The period of time within which a health care provider must discharge a patient; (c) The clinical status of the patient, including whether the patient should be admitted to inpatient status, whether the patient should be kept in observation status, whether the patient should receive palliative care, and whether and where the patient should be referred upon discharge;	

Approach 2. Preserve the independent clinical judgment of physicians by strengthening the corporate practice of medicine doctrine

State	Status	Bill/Statute	Ownership structure	Non-interference with clinical decision-making	Enforcement
Washington (cont.)	**PROPOSED 2025**			(d) The diagnoses, diagnostic terminology, or codes that are entered into the medical record by the health care provider; (e) The range of clinical orders available to a health care provider, including by configuring the medical record to prohibit or significantly limit the options available to the provider; or (f) Any other action specified by rule to constitute impermissible interference or control over the clinical judgment and decision making of a health care provider related to the diagnosis and treatment of a patient. Sec. 4. A new section is added to chapter 70.230 RCW to read as follows: (1) No person without a license to practice medicine in this state, who is employed by, contracted with, or affiliated with an ambulatory surgical facility licensed under this chapter, may interfere with, control, or otherwise direct the professional judgment or clinical decision making of a licensed health care provider employed by, affiliated with, or contracted with the ambulatory surgical facility, who is providing care to a patient at the ambulatory surgical facility. (2) Conduct prohibited under this section includes, as applicable, but is not limited to, controlling, either directly or indirectly, through policy, discipline, punishment, threats, adverse employment actions, coercion, retaliation, or excessive pressure, any of the following: (a) The period of time a provider may spend with a patient; (b) The period of time within which a health care provider must discharge a patient; (c) The clinical status of the patient; (d) The diagnoses, diagnostic terminology, or codes that are entered into the medical record by the health care provider;	

Approach 2. Preserve the independent clinical judgment of physicians by strengthening the corporate practice of medicine doctrine

State	Status	Bill/Statute	Ownership structure	Non-interference with clinical decision-making	Enforcement
Washington (cont.)	**PROPOSED 2025**			(e) The range of clinical orders available to a health care provider, including by configuring the medical record to prohibit or significantly limit the options available to the provider; or (f) Any other action specified by rule to constitute impermissible interference or control over the clinical judgment and decision making of a health care provider related to the diagnosis and treatment of a patient. [Applicability to nursing homes, birthing centers, hospice] Upon application for a license or license renewal, an applicant must attest, in a form and manner determined by the commission, that they are aware of regulations related to the corporate practice of medicine included in sections 1 through 7 of this act.	
Wisconsin	**PROPOSED 2025**	SB 45		150.994 Corporate practice of medicine. The corporate practice of medicine is prohibited. The department shall promulgate rules to define what conduct constitutes the corporate practice of medicine for purposes of this section	

Approach 3. Limit the influence management services organizations (MSOs) may exert on physician practices

State	Status	Bill/Statute	MSO structural requirements	MSO controlling/directing/interfering	Unlawful agreements
Massachusetts	**PROPOSED 2025**	S 1628 / SD 2325		Section 4B. (a) A health care practice shall maintain ultimate control over clinical decisions. (b) A management services organization shall not exercise control over, or be delegated the power to do, any of the following: (i) owning or otherwise determining the content of patient medical records; (ii) selecting, hiring or firing any owner of or clinician associated with the health care practice based, in whole or in part, on clinical competency or proficiency; (iii) setting the parameters under which a practice shall enter into contractual relationships with clinicians for the delivery of care; (iv) making final decisions regarding coding and billing of procedures for patient care services; or (v) approving the selection of medical equipment and medical supplies for the practice. (c) A health care practice shall maintain ultimate decision-making authority over: (i) personnel decisions involving clinicians, including, but not limited to, employment status, compensation, hours or working conditions; (ii) coding or billing decisions; (iii) the selection and use of property, including, but not limited to, real property, medical equipment or medical supplies for the delivery of patient care services; (iv) the number of patients seen in a given period of time or the amount of time spent with each patient; (v) the appropriate diagnostic test for medical conditions; (vi) the use of patient medical records; and (vii) referral decisions. (d) A violation of this section shall constitute the unauthorized practice of medicine in violation of	

Approach 3. Limit the influence management services organizations (MSOs) may exert on physician practices

State	Status	Bill/Statute	MSO structural requirements	MSO controlling/directing/interfering	Unlawful agreements
Massachusetts (cont.)	**PROPOSED 2025**			section 6 or the unauthorized practice of nursing in violation of section 80E, 80H or 80J. Any provision of a contract or agreement that has the effect of violating this section shall be void and unenforceable. If a court of competent jurisdiction finds a policy, contract or contract provision void and unenforceable pursuant to this section, the court shall award the plaintiff reasonable attorney's fees and costs.	
New Mexico	**PROPOSED 2025**	SB 450	B. "health care entity" means a person that provides or supports the provision of health care services to patients in New Mexico, including a hospital, health care provider, in-state or out-of-state telemedicine provider, health care staffing company, health care provider organization, health care facility, management services organization or organization of health care providers or facilities; provided that "health care entity" does not mean a federally qualified health center or an independent health care practice;	A. A health care entity shall not indirectly or directly interfere with, control or otherwise direct the professional judgment or clinical decisions of a health care provider. B. A health care entity doing business in this state shall not: (1) interfere with the professional judgment of a health care provider making health care decisions, including any of the following: (a) determining what diagnostic tests are appropriate for a particular condition; (b) determining the need for referrals to, or consultation with, another licensed health care provider; (c) being responsible for the ultimate overall care of the patient, including treatment options available to the patient; and (d) determining how many patients a health care provider shall see in a given time period; or (2) exercise control over or be delegated the power to do any of the following: (a) own or otherwise determine the content of patient medical records; (b) select, hire or fire health care providers, allied health staff or medical assistants based, in whole or in part, on clinical competency or proficiency;	

Approach 3. Limit the influence management services organizations (MSOs) may exert on physician practices

State	Status	Bill/Statute	MSO structural requirements	MSO controlling/directing/interfering	Unlawful agreements
New Mexico (cont.)	**PROPOSED 2025**			(c) set the parameters pursuant to which a health care provider shall enter into contractual relationships with third-party payers; (d) set the parameters pursuant to which a health care provider shall enter into contractual relationships with other health care providers for the delivery of care; (e) make decisions regarding coding and billing procedures for patient care services; and (f) approve the selection of medical equipment and medical supplies for a health care provider.	
North Carolina	**PROPOSED 2025**	SB 570	(5) For a professional corporation rendering professional service pursuant to Article 1 of Chapter 90 of the General Statutes, no stakeholder of the professional corporation shall be a stakeholder of a management services organization with which the professional corporation shall at any time contract for services unless the management services organization is owned and held entirely by licensees of this State." […]	§ 90-8.3. Control over medical decisions of patient care. If a licensee is employed by or is an independent contractor in a contractual agreement with an employer under G.S. 90-8.4(a) to practice medicine or surgery, then the employment agreement or contract shall ensure and require that the licensee has control over all medical decisions of patient care without clinical interference from (i) an individual not licensed to practice medicine or surgery, (ii) a stakeholder of a management services organization, or (iii) an out-of-state physician or medical professional who may be employed by or affiliated with the professional corporation. For purposes of this section, the term "stakeholder" and "management services organization" are defined as in Chapter 55B of the General Statutes.	
Oregon	**ENACTED 2025**	SB 951 HB 3410	(2) (a) Except as provided in subsection (3) of this section, a management services organization or a shareholder, director, member, manager, officer, employee or contractor of a management services organization may not: (A) Own or control individually, or in combination with the management services	(2)(a) Except as provided in subsection (3) of this section, a management services organization or a shareholder, director, member, manager, officer, employee or contractor of a management services organization may not: […] (G) Exercise de facto control over administrative, business or clinical operations of a professional	2) (a) Except as provided in subsection (3) of this section, a management services organization or a shareholder, director, member, manager, officer, employee or contractor of a management services organization may not: […]

Approach 3. Limit the influence management services organizations (MSOs) may exert on physician practices

State	Status	Bill/Statute	MSO structural requirements	MSO controlling/directing/interfering	Unlawful agreements
Oregon (cont.)	**ENACTED 2025**		organization or any other shareholder, director, member, manager, officer, employee or contractor of the management services organization, a majority of shares in a professional medical entity with which the management services organization has a contract for management services, even if the other shareholder, director, member, manager, officer, employee or contractor qualifies for an exemption under subsection (3)(a) of this section; (B) Exercise a proxy or take or exercise on behalf of another person a right or power to vote the shares of a professional medical entity with which the management services organization has a contract for management services; (C) Control or enter into an agreement to control or restrict the sale or transfer of a professional medical entity's shares, interest or assets, or otherwise permit a person other than a medical licensee to control or restrict the sale or transfer of the professional medical entity's shares, interest or assets, except as provided in paragraph (b) of this subsection; (D) Issue shares of stock, or cause a professional medical entity to issue shares of stock, in the professional medical entity, in a subsidiary of the professional medical entity or in an affiliate of the professional medical entity; (E) Pay dividends from shares or an ownership interest in a professional medical entity; (F) Acquire or finance the acquisition of the majority of the shares of a professional medical entity; [...]	medical entity in a manner that affects the professional medical entity's clinical decision-making or the nature or quality of medical care that the professional medical entity delivers, which de facto control includes, but is not limited to, exercising ultimate decisionmaking authority over: (i) Hiring or terminating, setting work schedules or compensation for, or otherwise specifying terms of employment of medical licensees; (ii) Setting clinical staffing levels, or specifying the period of time a medical licensee may see a patient, for any location that serves patients; (iii) Making diagnostic coding decisions; (iv) Setting clinical standards or policies; (v) Setting policies for patient, client or customer billing and collection (vi) Advertising a professional medical entity's services under the name of an entity that is not a professional medical entity; (vii) Setting the prices, rates or amounts the professional medical entity charges for a medical licensee's services; or (viii) Negotiating, executing, performing, enforcing or terminating contracts with third-party payors or persons that are not employees of the professional medical entity.	(B) Exercise a proxy or take or exercise on behalf of another person a right or power to vote the shares of a professional medical entity with which the management services organization has a contract for management services; (C) Control or enter into an agreement to control or restrict the sale or transfer of a professional medical entity's shares, interest or assets, or otherwise permit a person other than a medical licensee to control or restrict the sale or transfer of the professional medical entity's shares, interest or assets, except as provided in paragraph (b) of this subsection; (D) Issue shares of stock, or cause a professional medical entity to issue shares of stock, in the professional medical entity, in a subsidiary of the professional medical entity or in an affiliate of the professional medical entity; (E) Pay dividends from shares or an ownership interest in a professional medical entity; (F) Acquire or finance the acquisition of the majority of the shares of a professional medical entity; or [...] (b) Conditions under which a professional medical entity may enter into an agreement with a shareholder of the professional medical entity and a management services organization to control or restrict a transfer or sale of the professional medical entity's stock, interest or assets include: (A) The suspension or revocation of a shareholder's or member's professional

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State	Status	Bill/Statute	MSO structural requirements	MSO controlling/directing/interfering	Unlawful agreements
Oregon (cont.)	**ENACTED 2025**		(c) The activities described in paragraph (a) of this subsection do not prohibit: (A) A management services organization from: (i) Providing services to assist in carrying out the activities described in paragraph (a) of this subsection if the services the management services organization provides do not constitute an exercise of de facto control over the administrative, business or clinical operations of a professional medical entity in a manner that affects the professional medical entity's clinical decision-making or the nature or quality of medical care that the professional medical entity delivers; (ii) Purchasing, leasing or taking an assignment of a right to possess the assets of a professional medical entity in an arms-length transaction with a willing seller, lessor or assignor; (iii) Providing support, advice and consultation on all matters related to a professional medical entity's business operations, such as accounting, budgeting, personnel management, real estate and facilities management and compliance with applicable laws, rules and regulations; or (iv) Advising and providing direction concerning a professional medical entity's participation in value-based contracts, payor arrangements or contracts with suppliers and vendors; (B) Collection of quality metrics as required by law or in accordance with an agreement to which a professional medical entity is a party; or		license in this or another state if the shareholder or member is a medical licensee; (B) A shareholder's or member's disqualification from holding stock or an interest in the professional medical entity; (C) A shareholder's or member's exclusion, debarment or suspension from a federal health care program or an investigation that could result in the shareholder's or member's exclusion, debarment or suspension if the shareholder or member is a medical licensee; (D) A shareholder's or member's indictment for a felony or another crime that involves fraud or moral turpitude; (E) The professional medical entity's breach of a contract for management services with a management services organization or a shareholder's or member's breach of the contract for management services with the professional medical entity or a management services organization on behalf of the professional medical entity; or (F) The death, disability or permanent incapacity of a shareholder or member who is a medical licensee.

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State	Status	Bill/Statute	MSO structural requirements	MSO controlling/directing/interfering	Unlawful agreements
Oregon (cont.)	**ENACTED 2025**		(C) Setting criteria for reimbursement under a contract between a professional medical entity and an insurer. (3) Subsection (2) of this section does not apply to: (a) An individual who provides medical services or health care services for or on behalf of a professional medical entity if the individual: (A) Does not own or control more than 10 percent of the total shares of or interest in the professional medical entity; and (B) Is compensated at the market rate for the medical services or health care services and the individual's employment and services that the individual provides to the management services organization are entirely consistent with the individual's professional obligations, ethics and duties to the professional medical entity and the individual's patients; (b) An individual who owns shares or an interest in a professional medical entity and a management services organization with which the professional medical entity has a contract for management services if the individual's ownership of shares or an interest in the management services organization is incidental and without relation to the individual's compensation as a shareholder, director, member, manager, officer or employee of, or contractor with, the management services organization; (c) A professional medical entity and the shareholders, directors, members, managers, officers or employees of the professional medical entity if the professional medical entity functions as a management services		

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State	Status	Bill/Statute	MSO structural requirements	MSO controlling/directing/interfering	Unlawful agreements
Oregon (cont.)	**ENACTED 2025**		organization or owns a majority of the shares of or interest in the management services organization; (d) A physician who serves as a director or officer of a management services organization with which a professional medical entity has a contract for management services and who owns less than 25 percent of the ownership interest in, and is a director or officer of, the professional medical entity if: (A) The professional medical entity owns less than 49 percent of the ownership interest that has voting rights in the management services organization; (B) The physician does not receive compensation from the management services organization for serving as a director or officer of the management services organization; (C) An action of the management services organization that materially affects the professional, ownership or governance interests of minority owners in the management services organization requires a vote of more than a majority of the shares of the management services organization that are entitled to vote, including the shares held by professional medical entities with voting rights in the management services organization; (D) The management services organization and all of the professional medical entities that have voting rights in the management services organization were incorporated or organized, and entered into agreements for the provision of medical services, before January 1, 2024; and		

Approach 3. Limit the influence management services organizations (MSOs) may exert on physician practices

State	Status	Bill/Statute	MSO structural requirements	MSO controlling/directing/interfering	Unlawful agreements
Oregon (cont.)	**ENACTED 2025**		(E) The physician, all of the professional medical entities with voting rights in the management services organization and the actions of the management services organization complied with the requirements set forth in subparagraphs (A) to (D) of this paragraph before, on and after January 1, 2024; or (e) A management services organization that has a contract for management services with a professional medical entity if the professional medical entity is solely and exclusively (A) A PACE organization or engaged in providing professional health care services to a PACE organization, as defined in 42 C.F.R. 460.6, as in effect on the effective date of chapter 295, Oregon Laws 2025 (Enrolled Senate Bill 951), and authorized in this state as a PACE organization; (B) A mental health or substance use disorder crisis line provider; (C) An urban Indian health program in this state that is funded under 25 U.S.C. 1601 et seq., as in effect on the effective date of [this 2025 Act] chapter 295, Oregon Laws 2025 (Enrolled Senate Bill 951); (D) A recipient of a Tribal Behavioral Health or Native Connections program grant from the federal Substance Abuse and Mental Health Services Administration; (E) An entity that: (i) Provides behavioral health care, other than a hospital, that the Oregon Health Authority has certified to provide behavioral health care; (ii) Has a contract for management services with an entity described in sub-subparagraph		

Approach 3. Limit the influence management services organizations (MSOs) may exert on physician practices

State	Status	Bill/Statute	MSO structural requirements	MSO controlling/directing/interfering	Unlawful agreements
Oregon (cont.)	**ENACTED 2025**		(i) of this subparagraph that is a nonprofit entity; or (iii) Is a licensed opioid treatment program, a licensed medical provider that primarily provides office-based or medication-assisted treatment services, a provider of withdrawal management services or a sobering center; (F) A hospital, as defined in ORS 442.015, or a hospital-affiliated clinic, as defined in ORS 442.612; (G) A long term care facility, as defined in ORS 442.015, or an affiliate of a long term care facility; or (H) A residential care facility, as defined in ORS 443.400, or an affiliate of a residential care facility. (4) Subsection (2)(a)(A)[, (B) and (C)] and (B) of this section does not apply to: (a) An entity that is engaged in the practice of telemedicine, as defined in ORS 677.494, and does not have a physical location where patients receive clinical services in this state other than a physical location that would be necessary to comply with 21 U.S.C. 829(e), as in effect on the effective date of [this 2025 Act] chapter 295, Oregon Laws 2025 (Enrolled Senate Bill 951); and (b) A coordinated care organization, as defined in ORS 414.025, that before January 1, 2026, owned or controlled shares or an interest in a professional medical entity or had the power to manage or direct the management of the professional medical entity by contract or otherwise. [...] (b) A medical licensee or professional medical entity that suffers an ascertainable loss of		

Approach 3. Limit the influence management services organizations (MSOs) may exert on physician practices

State	Status	Bill/Statute	MSO structural requirements	MSO controlling/directing/interfering	Unlawful agreements
Oregon (cont.)	**ENACTED 2025**		money or property as a result of a violation of a prohibition set forth in subsection (2)(a) of this section may bring an action against a management services organization with which the medical licensee or professional medical entity has a contract for management services, or a shareholder, director, member, manager, officer or employee of the management services organization, in a circuit court of this state to obtain: (A) Actual damages equivalent to the medical licensee's or professional medical entity's loss; (B) An injunction against an act or practice that violates the prohibition; and (C) Other equitable relief the court deems appropriate. (c) The trier of fact in an action under paragraph (b) of this subsection may award punitive damages. (d) A court may award attorney fees and costs to a plaintiff that prevails in an action under paragraph (b) of this subsection		
Vermont	**PROPOSED 2025**	HB 71	§ 9533. REGULATION OF CONTRACTS BETWEEN MEDICAL PRACTICES AND MANAGEMENT SERVICES ORGANIZATIONS (a) Prohibition on straw ownership. (1) Each licensee owner of a medical practice shall exhibit meaningful ownership of the medical practice. (2) Meaningful ownership means that each licensee owner is duly licensed and present in this State and is substantially engaged in delivering medical care or managing the medical practice, or both. (b) Prohibition on dual ownership or interests.	(2) Conduct prohibited under subdivision (1) of this subsection includes relinquishing ultimate decision-making authority over: (A) hiring or termination, setting work schedules and compensation, or otherwise specifying terms of employment of employees who are licensed to practice medicine in this State or who are licensed in this State as a physician assistant or advanced practice registered nurse; (B) the disbursement of revenue generated from physician fees and other revenue generated by physician services; (C) collaboration and negotiation with hospitals and other health care facilities in which the licensees of	(f) Prohibition on relinquishing control of medical practice. (1) A medical practice shall not, by means of a contract or other agreement or arrangement, by providing in the medical practice's articles of incorporation or bylaws, by forming a subsidiary or affiliated entity, or by other means, relinquish control over or otherwise transfer de facto control over any of the medical practice's administrative, business, or clinical operations that may affect clinical decision making or the nature or quality of medical care that the medical practice delivers.

Approach 3. Limit the influence management services organizations (MSOs) may exert on physician practices

State	Status	Bill/Statute	MSO structural requirements	MSO controlling/directing/interfering	Unlawful agreements
Vermont (cont.)	**PROPOSED 2025**		(1) Except as provided in subdivision (2) of this subsection, a shareholder, director, or officer of a medical practice shall not do any of the following: (A) own or control shares in, serve as a director or officer of, be an employee of or an independent contractor with, or otherwise participate in managing both the medical practice and a management services organization with which the medical practice has a contract; or (B) receive substantial compensation or remuneration from a management services organization in return for ownership or management of the medical practice. (2) Subdivision (1) of this subsection shall not apply to the shareholders, directors, or officers of a medical practice if the medical practice owns a majority of the interest in the management services organization or separate legal entity[...]	the medical practice may deliver clinical care, including controlling licensee schedules as a means of discipline; (D) setting staffing levels, or specifying the period of time that a licensee may spend with a patient, for any location that serves patients; (E) making diagnostic coding decisions; (F) setting clinical standards or policies; (G) setting policies for patient, client, or customer billing and collection; (H) setting the prices, rates, or amounts the medical practice charges for a licensee's services; or (I) negotiating, executing, performing, enforcing, or terminating contracts with third- party payers or persons who are not employees of the medical practice. (3) The conduct described in subdivision (2) of this subsection does not prohibit: (A) collection of quality metrics as required by law or in accordance with an agreement to which the medical practice is a party; or (B) setting criteria for reimbursement under a contract between the medical practice and an insurer or a payer or entity that otherwise reimburses the medical practice for providing medical care. (4) A medical practice may relinquish or transfer control over the medical practice's administrative, business, or clinical operations that will not affect clinical decision making or the nature or quality of medical care that the medical practice delivers, provided that the medical practice executes a shareholder agreement exclusively between or among and for the benefit of a majority of shareholders who are physicians licensed in this State to practice medicine and the shareholder agreement.	

Approach 3. Limit the influence management services organizations (MSOs) may exert on physician practices

State	Status	Bill/Statute	MSO structural requirements	MSO controlling/directing/interfering	Unlawful agreements
Washington	**PROPOSED 2025**	HB 1675	(4) A shareholder, director, or officer of a medical practice organized under this chapter may not: (a) Own or control shares in, serve as a director or officer of, be an employee of or an independent contractor with, or otherwise participate in managing both the medical practice and a management services organization with which the medical practice has a contract; (b) Receive substantial compensation or remuneration from a management services organization in return for ownership or management of the medical practice; (c) Transfer or relinquish control over the sale, the restriction of the sale, or the encumbrance of the sale of the medical practice's shares or assets; (d) Transfer or relinquish control over the issuing of shares of stock in the medical practice, a subsidiary of the medical practice, or an entity affiliated with the medical practice, or the paying of dividends; or (e) Enter into any financial arrangement in violation of chapter 19.68 RCW. [...] (7) For the purposes of this section, "management services organization" means any organization or entity that contracts with a professional service corporation to perform management or administrative services relating to, supporting, or facilitating the provision of health care services.		(4) A shareholder, director, or officer of a medical practice organized under this chapter may not: (c) Transfer or relinquish control over the sale, the restriction of the sale, or the encumbrance of the sale of the medical practice's shares or assets; (d) Transfer or relinquish control over the issuing of shares of stock in the medical practice, a subsidiary of the medical practice, or an entity affiliated with the medical practice, or the paying of dividends; or (e) Enter into any financial arrangement in violation of chapter 19.68 RCW.

Approach 4. Support fair contracting in agreements physicians enter with employers or MSOs

For more state laws on restrictive covenants, see the AMA Managed Care Legal Database at https://managedcarelegaldatabase.org

State	Status	Bill/Statute	Non-competes	Non-disclosure and non-disparagement agreements
California	**ENACTED**	CA Bus & Prof Code § 16600	"…every contract by which anyone is restrained from engaging in a lawful profession, trade, or business of any kind is to that extent void."	
Oregon	**ENACTED 2025**	SB 951 HB 3410	(d) "Noncompetition agreement" means a written agreement between a medical licensee and another person under which the medical licensee agrees that the medical licensee, either alone or as an employee, associate or affiliate of a third person, will not compete with the other person in providing products, processes or services that are similar to the other person's products, processes or services for a period of time or within a specified geographic area after termination of employment or termination of a contract under which the medical licensee supplied goods to or performed services for the other person […] "Recruitment investment" means costs to an entity that are equivalent to 20 percent or more of the annual salary of an employee with whom the entity has entered into a noncompetition agreement if the entity incurs the costs for: (A) Marketing to and recruiting the employee; (B) Providing the employee with a sign-on or relocation bonus; (C) Educating or training the employee in the entity's procedures; (D) Providing support staff, technology acquisitions or upgrades and license fees related to the employee's employment; or (E) Similar or related items. […] (2)(a) Notwithstanding ORS 653.295 (1) and (2), and except as provided in paragraph (b) of this subsection, a noncompetition agreement that restricts the practice of medicine or the practice of nursing is void and unenforceable between a medical licensee and: (A) A person, as defined in ORS 442.015; (B) A management services organization; or (C) A hospital, as defined in ORS 442.015, or a hospital-affiliated clinic, as defined in ORS 442.612.	(e) "Nondisclosure agreement" means a written agreement under the terms of which a medical licensee must refrain from disclosing partially, fully, directly or indirectly to any person, other than another party to the written agreement or to a third-party beneficiary of the agreement: (A) A policy or practice that a party to the agreement required the licensee to use, in patient care, other than individually identifiable health information that the medical licensee may not disclose under the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as in effect on the effective date of [this 2025 Act] chapter 295, Oregon Laws 2025 (Enrolled Senate Bill 951); (B) A policy, practice or other information about or associated with the medical licensee's employment, conditions of employment or rate or amount of pay or other compensation; or (C) Any other information the medical licensee possesses or to which the medical licensee has access by reason of the medical licensee's employment by, or provision of services for or on behalf of, a party to the agreement, other than information that is subject to protection under applicable law as a trade secret of, or as otherwise proprietary to, another party to the agreement or to a third-party beneficiary of the agreement. (f) "Nondisparagement agreement" means a written agreement under which a medical licensee must refrain from making to a third party a statement about another party to the agreement or about another person specified in the agreement as a third-party beneficiary of the agreement, the effect of which causes or threatens to cause harm to the other party's or person's reputation, business relations or other economic interests. (3) (a) Except as provided in paragraph (b) of this subsection, a nondisclosure agreement or nondisparagement agreement between a medical licensee and a management services organization, or between a medical licensee and a hospital, as defined in ORS 442.015, or hospital-affiliated clinic, as defined in

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State	Status	Bill/Statute	Non-competes	Non-disclosure and non-disparagement agreements
Oregon (cont.)	**ENACTED 2025**		[…] (b) A noncompetition agreement between a medical licensee and another person that restricts the practice of medicine or the practice of nursing is valid and enforceable to the extent and under the terms provided in ORS 653.295 if: (A) The medical licensee is a shareholder or member of the other person or otherwise owns or controls an ownership or membership interest and the medical licensee's ownership or membership interest in the other person is equivalent to 1.5 percent or more of the entire ownership or membership interest that exists in the other person; (B) The noncompetition agreement: (i) Is with a professional medical entity that provides the medical licensee with documentation of the professional medical entity's recruitment investment; and (ii) Has a term that is not longer than: (I) Five years after the date on which the medical licensee was hired if the medical licensee engages directly in providing medical services, health care services or clinical care in a county of this state that is designated as a health professional shortage area, as defined in 42 U.S.C. 254e, as in effect on the effective date of chapter 295, Oregon Laws 2025 (Enrolled Senate Bill 951); or (II) Three years after the date on which the medical licensee was hired if the medical licensee does not engage directly in providing medical services, health care services or clinical care as described in sub-sub-subparagraph (I) of this sub-subparagraph; or (C) The medical licensee does not engage directly in providing medical services, health care services or clinical care.	ORS 442.612, if either the hospital or the hospital-affiliated clinic employs a medical licensee, is void and unenforceable. (b) A nondisclosure agreement or nondisparagement agreement described in paragraph (a) of this subsection is valid and enforceable against a medical licensee if: (A) A management services organization, hospital or hospital-affiliated clinic terminated the medical licensee's employment or the medical licensee voluntarily left employment with the management services organization, hospital or hospital-affiliated clinic, except that the management services organization, hospital or hospital-affiliated clinic may not enforce a nondisclosure agreement or nondisparagement agreement against a medical licensee for the medical licensee's good faith report of information that the medical licensee believes is evidence of a violation of a state or federal law, rule or regulation to: (i) A hospital or hospital-affiliated clinic; or (ii) A state or federal authority; or (B) The nondisclosure agreement or nondisparagement agreement is part of a negotiated settlement between the medical licensee and a management services organization, hospital or hospitalaffiliated clinic. (c) Paragraph (a) of this subsection does not limit or otherwise affect any cause of action that: (A) A party to, or third-party beneficiary of, the agreement may have with respect to a statement of a medical licensee that constitutes libel, slander, a tortious interference with contractual relations or another tort for which the party has a cause of action against the medical licensee; and (B) Does not depend upon or derive from a breach or violation of an agreement described in paragraph (a) of this subsection.
Massachusetts	**ENACTED**	M.G.L. Chapter 112, Section 12X	Any contract or agreement which creates or establishes the terms of a partnership, employment, or any other form of professional relationship with a physician registered to practice medicine pursuant to section two, which includes any restriction of the right of such physician to practice medicine in any geographic area for any period of time after the termination of such partnership, employment or professional relationship shall be void and	

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Massachusetts (cont.)	**ENACTED**		unenforceable with respect to said restriction provided, however, that nothing herein shall render void or unenforceable the remaining provisions of any such contract or agreement.	
Massachusetts	**PROPOSED 2025**	S 1628 / SD 2325		Nondisclosure or non-disparagement agreements regarding subsections (i) through (v), inclusive, between a clinician with independent practice authority and any person or entity shall be considered void and unenforceable. If a court of competent jurisdiction finds a policy, contract or contract provision void and unenforceable pursuant to this section, the court shall award the plaintiff reasonable attorney's fees and costs. Nothing in this section shall limit the ability of any of person to bring any action relating to defamation, disclosure of confidential or proprietary information or trade secrets or similar torts.
Montana	**ENACTED 2025**	HB 198	"28-2-724. Prohibition of contracts that restrict practice -- applicability -- exceptions. (1) A contract that creates or establishes the terms of employment, a partnership, or any other form of professional relationship with a health care provider described in subsection (2), may not restrict the right of the health care provider, after the termination of the employment, partnership, or other form of professional relationship, to: (a) practice or provide services for which the provider is licensed, in any geographic area and for any period; (b) treat, advise, consult with, or establish a provider-patient relationship with any current patient of the employer or with a patient affiliated with a partnership or other form of professional relationship; or (c) solicit or seek to establish a provider-patient relationship with any current patient of the employer or with a patient affiliated with a partnership or other form of professional relationship."	
New Hampshire	**ENACTED**	N.H. Rev. Stat. § 329:31-a	Any contract or agreement which creates or established the terms of a partnership, employment, or any other form of professional relationship with a physician…which includes any restriction to the right of such physician to also practice medicine in any geographic area for any period of time after the termination of such partnership, employment, or professional relationship shall be void and unenforceable with respect to said restriction; provided however, that nothing herein shall render void or unenforceable	

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New Hampshire (cont.)	**ENACTED**		the remaining provision of any such contract or agreement. The requirements of this section shall apply to new contracts or renewals of contracts entered into on or after the effective date of this section.	
New York	**PROPOSED 2025**	AB 9012		(g) A professional corporation or medical services corporation shall not take any retaliatory action, as defined by section seven hundred forty of the labor law, against a medical licensee as retaliation for, or as a consequence of, such medical licensee's violation of a nondisclosure agreement or non-disparagement agreement or because such medical licensee, in good faith, disclosed or reported information that such medical licensee believes is evidence of a violation of a federal or state law, rule or regulation to: (1) the management services organization; 2) a hospital, as defined in section twenty-eight hundred one of the public health law; or (3) a state or federal authority.
South Dakota	**ENACTED**	SD Codified L § 53-9-11.1	A contract that creates or establishes the terms of employment, a partnership, or any other form of professional relationship, with a health care provider, may not restrict the right of the health care provider to: Practice or provide services for which the provider is licensed, in any geographic area and for any period of time, after the termination of the employment, partnership, or other form of professional relationship.[...] NOTE: The prohibition of this section does not apply to a contract in connection with the sale and purchase of a practice.	
Texas	**ENACTED**	Tex. Bus. & Com. Code § 15.501	Section 15.501. Covenants not to compete against health care practitioners (a) In this section, "health care practitioner" means: (1) a person licensed by the State Board of Dental Examiners to practice dentistry in this state; (2) a person licensed under Chapter 301, Occupations Code, to engage in professional or vocational nursing; or (3) a physician assistant licensed under Chapter 204, Occupations Code.	

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State	Status	Bill/Statute	Non-competes	Non-disclosure and non-disparagement agreements
Texas (cont.)	**ENACTED**		(b) A covenant not to compete relating to the practice of dentistry or nursing, or practice as a physician assistant, as applicable, is not enforceable against a health care practitioner unless the covenant: (1) provides for a buyout of the covenant by the health care practitioner in an amount that is not greater than the practitioner's total annual salary and wages at the time of termination of the practitioner's contract or employment; (2) expires not later than the one-year anniversary of the date the contract or employment has been terminated; (3) limits the geographical area subject to the covenant to no more than a five-mile radius from the location at which the health care practitioner primarily practiced before the contract or employment terminated; and (4) has terms and conditions that are clearly and conspicuously stated in writing.	
Vermont	**PROPOSED 2025**	HB 71	(1) Noncompetition agreements. (A) Except as provided in subdivision (B) of this subdivision (d)(1), a noncompetition agreement between a licensee and another person is void and unenforceable. (B) Notwithstanding subdivision (A) of this subdivision (d)(1), a noncompetition agreement between a licensee and another person is valid and enforceable if the licensee is a shareholder or member of the other person or otherwise owns or controls an ownership or membership interest that is equivalent to 25 percent or more of the entire ownership or membership interest that exists in the other person.	(15) "Nondisclosure agreement" means a written agreement under the terms of which a licensee must refrain from disclosing partially, fully, directly, or indirectly to any person, other than another party to the written agreement or to a person specified in the agreement as a third-party beneficiary of the agreement: (A) a policy or practice that a party to the agreement required the licensee to use in patient care, other than individually identifiable health information that the licensee must not disclose under the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191; (B) a policy, practice, or other information about or associated with the licensee's employment, conditions of employment, or rate or amount of pay or other compensation; or (C) any other information the licensee possesses or to which the licensee has access by reason of the licensee's employment by, or provision of services for or on behalf of, a party to the agreement, other than information that is subject to protection under applicable law as a trade secret of, or otherwise proprietary to, another party to the agreement or to a person specified in the agreement as a third-party beneficiary of the agreement.

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Vermont (cont.)	**PROPOSED 2025**			(16) "Nondisparagement agreement" means a written agreement under which a licensee must refrain from making to a third party a statement about another party to the agreement or about another person specified in the agreement as a third-party beneficiary of the agreement, the effect of which causes or threatens to cause harm to the other party's or person's reputation, business relations, or other economic interests. (2) Nondisclosure and nondisparagement agreements. (A) Except as provided in subdivision (B) of this subdivision (d)(2), a nondisclosure agreement or nondisparagement agreement between a licensee and a management services organization is void and unenforceable. (B) Subdivision (A) of this subdivision (d)(2) shall not be deemed to limit or otherwise affect any cause of action that: (i) a party to, or third-party beneficiary of, the agreement may have with respect to a statement of a licensee that constitutes libel, slander, a tortious interference with contractual relations, or another tort for which the party has a cause of action against the licensee; and (ii) does not depend upon or derive from a breach or violation of an agreement described in subdivision (1) of this subsection (d).

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State	Status	Legislation	Relevant Provisions
Federal	**Introduced 2024**	"Health Over Wealth Act"	(l) REQUIREMENTS FOR HOSPITALS RELATING TO DISCONTINUATION OF SERVICES OR CLOSURE.— (1) REQUIREMENTS.— (A) IN GENERAL.—For purposes of subsection (a)(1)(Z), except as provided in subparagraph (B), the requirements described in this subsection are that a hospital— (i) notify the Secretary, in accordance with paragraph (2), not less than 90 days prior to the discontinuation of services or full hospital closure; (ii) prohibit the discontinuation of essential services (as defined in paragraph 16 (6)) during the notification period (as defined in such paragraph) unless there is a clear harm posed to patient or employee health or safety in the hospital continuing to furnish such services; (iii) respond to any inquiries by the Secretary relating to the implementation of this subsection, including the determination of essential services under paragraph 25 (6)(C); and (iv) if applicable— (I) submit a mitigation plan and related information as described in paragraph (3); and (II) participate in the public comment and review process (including, if applicable, the alternative mitigation plan) described in paragraph (4). (B) APPLICATION IN CASE OF CATASTROPHIC EVENTS.—In the case where a discontinuation of services or closure of a hospital is due to an unforeseen catastrophic event (as defined by the Secretary), the requirements described in subparagraph (A) shall apply, except— (i) the hospital shall provide the notification under clause (i) of such subparagraph not later than 30 days after the cat astrophic event or as soon as feasible as determined by the Secretary; and (ii) clause (ii) of such subparagraph (relating to prohibiting the discontinuation of services) shall not apply. (2) NOTIFICATION INFORMATION.—For purposes of paragraph (1)(A)(i), the notification under such paragraph shall include the following information with respect to a hospital: (A) DISCONTINUATION OF SERVICES.—In the case where the hospital is discontinuing services (without full hospital closure): (i) The services that will be discontinued and number of hospital beds impacted. (ii) The number of individuals furnished such services annually and a breakdown of the type of insurance used by such individuals for such services. (iii) The number of impacted employees and what labor organization represents them (and the contact information for such organization). (iv) The names and addresses of any organized health care coalitions and community groups that represent the communities impacted by the discontinuation of such services. (v) Alternative providers of such services, including provider type, contact information, and distance and transportation time by car and public transit from the hospital. (B) FULL HOSPITAL CLOSURE.—In the case of full hospital closure: (i) Hospital ownership entities. (ii) The full extent of services that will no longer be furnished by the hospital. (iii) The number of individuals furnished services annually by the hospital, a description of the services furnished, and a breakdown of the type of insurance used by such individuals for such services. (iv) The number of impacted employees and, if applicable, what labor organizations represent them (and the contact information for each such organization).

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State	Status	Legislation	Relevant Provisions
Federal (cont.)	**Introduced 2024**		(v) The names and addresses of any organized health care coalitions and community groups that represent the communities impacted by the closure. (vi) Alternative providers, including provider type, contact information, and distance and transportation time by car and public transit from the hospital. (vii) Steps taken prior to the decision to close in order to avoid closure. (viii) Distribution of liquidation proceeds (cash or assets) or any payments (cash or assets) made to employees, owners, or contractors related to the closure. (3) SUBMISSION OF MITIGATION PLAN AND RELATED INFORMATION FOR ESSENTIAL SERVICES.— (A) NOTIFICATION BY SECRETARY.—If the Secretary determines that the discontinuation of services or closure of an applicable hospital would negatively impact access to essential services, the Secretary shall notify the applicable hospital of such determination. (B) SUBMISSION OF MITIGATION PLAN AND RELATED INFORMATION.—If an applicable hospital receives a notification under subparagraph (A), the applicable hospital shall, not later than 15 days after receiving such notification, submit to the Secretary, the State health department, and the local department of public health— (i) a plan to— (I) preserve access to essential services for impacted communities through partnerships, commitments from surrounding facilities, transportation plan access, and preparation for surge response; and (II) support employees in transitioning to new positions within health care; (ii) information on workforce and public engagement to ensure awareness of the discontinuation of services or closure; (iii) a description of potential alternatives to the discontinuation of services or closure that the hospital considered and an explanation of why those alternatives are not a viable option; and (iv) a local market study to ascertain regional bed supply, payor mix distribution among all providers, demographic trends, and remaining health systems in the area. SEC. 3403. RISK MITIGATION AND ACCOUNTABILITY. (a) RISK MITIGATION.— (1) DEFINITION OF ESSENTIAL SERVICES.—In this subsection, the term ‘essential services’, with respect to a health care provider of a health care entity owned by or affiliated with a covered firm, means services that are necessary for preserving health care access, health care quality, and patient safety, as determined by the Secretary, including services for which the Secretary determines— (A) there are no equivalent services available within the same travel time; (B) that loss of the services would result in meaningful reductions in surge capacity that will negatively impact access to services, health care quality, and patient safety; (C) that loss of the services would limit health care access, health care quality, and patient safety for specific demographics of individuals based on sex, sexuality, race, nationality, age, or disability status; or (D) that loss of the services would have a meaningful impact on the ability of health care entities to provide care in the surrounding geographical area of the health care provider.

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State	Status	Legislation	Relevant Provisions
Federal (cont.)	**Introduced 2024**		(2) MECHANISM TO ENSURE RISK MITIGATION.—The Secretary shall establish a mechanism to ensure that the risks of covered firms with respect to which there is a private equity fund that is a control person of the covered firm are mitigated. Such mechanism may require each such covered firm— (A) to establish an escrow account with sufficient funding to cover operating and capital expenditures for not less than 5 years, including, in the case of the closure of a health care provider of a health care entity owned by or affiliated with such covered firm or if there are reductions of essential health services at such a health care provider, sufficient funding— (i) to pay out contract obligations to health care providers and other staff of such health care entity; and (ii) to provide supplemental funding to community health care or non-profit health care providers in the surrounding geographical area impacted by such closure or service reductions; (B) to obligate a minimum capital investment in any health care entity that is owned by or affiliated with such covered firm; or (C) to carry out such other activities as the Secretary determines appropriate to ensure that such covered firm provides a financial contribution sufficient to mitigate the impact of a potential closure, reduction of essential services, workforce shortage, or reduction in quality or safety of care or health care access (b) LIMITATION ON THE USE OF REAL ESTATE INVESTMENT TRUSTS IN HEALTH CARE.— (1) PROHIBITION.—No health care entity or covered firm may enter into agreement to sell to, or lease from, a real estate investment trust (as defined in section 856 of the Internal Revenue Code of 1986) an interest in real property if the terms of such sale or lease would lead to long-term weakened financial status of the health care entity or place the public health at risk. (2) REVIEW OF SALE OR LEASE TERMS.— (A) IN GENERAL.—The Secretary shall require each health care entity, or the covered firm that owns such health care entity, seeking to enter into an agreement described in paragraph (1) to submit to the Secretary for review the terms of the sale or lease, as applicable. ‘ (B) STANDARD.—In conducting a review of a sale or lease under subparagraph (A), the Secretary shall determine whether the terms of such sale or lease would lead to long-term weakened financial status of the health care entity or place the public health at risk.
Connecticut	**PROPOSED 2025**		**Section 1** That the general statutes be amended to impose restrictions on private equity firms buying, operating or holding a controlling interest in hospitals, including, but not limited to, (1) restrictions on the ability of a private equity firm to lease the property back to the hospital for a fee after purchasing the land rights
Massachusetts	**PROPOSED 2024**	MA S. 2871	Section 23. (a) A provider or a provider organization in which a private equity firm has a financial interest shall not: (i) meet or exceed the maximum adjusted debt to adjusted EBITDA ratio [defined as the highest ratio of total adjusted debt to adjusted earnings before interest, taxes, depreciation and amortization the commission determines that a provider or provider organization is permitted to have without becoming financially unstable; provided, however, that the commission, in consultation with the center, shall establish a standard method of calculating and reporting total adjusted debt and adjusted earnings before interest, taxes, depreciation and amortization; and provided further, that the methodology and reporting shall include capitalized lease obligations]; (ii) otherwise become highly leveraged, as determined by the commission; (iii) transact with an unsafe financial actor;

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State	Status	Legislation	Relevant Provisions
Massachusetts (cont.)	**PROPOSED 2024**		(iv) for the period during which the private equity firm has a financial interest in the provider or provider organization, (A) provide capital distributions, including, but not limited, to cash dividends, stock dividends that are not strictly dilutive or any other similar distributions, (B) perform stock buybacks, stock redemptions or similar transactions or (C) pay to a private equity firm management fees or similar fees or costs; or (v) perform any other action or exceed any other metric the commission determines may cause a provider or provider organization to become financially distressed Section 245. (a) Pursuant to section 23 of chapter 6D, a private equity firm shall deposit, upon submission of a notice of material change pursuant to section 13 of chapter 6D, a bond with the department of public health. (b) Until such bond has been deposited, the department of public health shall not issue a license to such provider or provider organization under this chapter, the department of mental health shall not issue a license to such provider or provider organization under chapter 19, and any determination of need application submitted under sections 25B to 25G, inclusive, of said chapter or material change notice submitted under section 13 of chapter 6D shall be deemed incomplete. Notwithstanding any general or special law to the contrary, if the bond has not been deposited, but the department of public health would otherwise be eligible to collect the bond, the department shall be permitted to collect from the private equity firm the amount it would have been able to collect had the bond been deposited. (c) The health policy commission shall determine the amount of the bond, which shall equal 1 year of the provider or provider organization's average or estimated operating expenses, plus the estimated cost of hiring an independent supervisor and reasonable staff to supervise and facilitate collecting and spending the bond. The private equity firm shall maintain the bond for as long as it has a financial interest in the provider or provider organization, and for 7 years thereafter. (d) The department of public health may collect the bond if the health policy commission provides the department of public health with notification pursuant to subsection (c) of section 23 of chapter 6D, or if the provider or provider organization in which the private equity firm has or had a financial interest declares bankruptcy. The department of public health, in consultation with the health policy commission and the center for health information and analysis, shall use the bond proceeds to support the continued provision of health services to patients served by the provider or provider organization. Prior to spending the bond, the department of public health shall seek input from the public, including, but not limited to, providers, provider organizations and patients in the affected region, regarding how to spend the bond. The department of public health may, in consultation with the health policy commission and center for health information and analysis, select an independent supervisor and reasonable staff to supervise and facilitate collecting and spending the bond.
Massachusetts	**PROPOSED 2025**	S 1628 / SD 2325	(h) The board of registration in medicine and board of registration in nursing may promulgate regulations to establish minimum requirements for the conduct of a health care practice, including, but not limited to: (i) compliance with section 4A of chapter 112; (ii) maintenance and access to medical records; and (iii) in the event of a planned closure of the health care practice or an unplanned event that prevents the health care practice from continuing operations, the development of a continuity plan to: (1) ensure access to medical records,

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State	Status	Legislation	Relevant Provisions
Massachusetts (cont.)	**PROPOSED 2025**		(2) provide notice to patients; and (3) assist patients with transitioning to a new provider. If a practice's owners consist of individuals registered solely with the board of registration in medicine or the board of registration in nursing, the practice shall comply with the applicable board's regulations. If the practice's owners consist of individuals registered with both boards, the practice shall comply with the regulations issued by the board of registration in medicine. Each board shall consult with the other when promulgating regulations.