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States Intensify Healthcare PE Oversight

Private equity (PE) investment in healthcare has expanded substantially over the past 15 years, drawing growing scrutiny from state legislatures across the U.S. Following a significant wave of legislative activity in 2025, state capitols opened 2026 with a new round of proposals that would further expand transaction oversight, strengthen prohibitions on the corporate practice of medicine (CPOM), and increase transparency requirements for PE-backed healthcare entities. This *Health Capital Topics* article surveys the evolving state regulatory landscape governing PE involvement in healthcare and examines key legislative developments in 2026.

Background

PE firms have expanded their footprint across the healthcare sector through acquisitions of physician practices, hospitals, home health agencies, and other provider organizations. From 2010 to 2019, there were approximately $750 billion in PE healthcare deals in the U.S.[1] In 2023 alone, over 780 PE healthcare services deals were announced or closed.[2] PE acquisitions of physician practices alone increased sixfold between 2012 and 2021, from 75 deals to 484 deals.[3]

These trends have drawn sustained attention from state legislators, who have raised concerns that PE ownership structures may prioritize financial returns at the expense of patient care quality and access. The CPOM doctrine – a legal principle that only licensed physicians may own or control a medical practice – has become a central instrument through which states seek to limit PE influence over clinical decision-making. Under typical PE investment structures, a management services organization (MSO) provides administrative and operational support to a physician-owned professional corporation (PC), allowing non-physician investors to generate returns without technically owning the practice – a structure that some states argue circumvents the intent of CPOM restrictions. States have increasingly moved to restrict or more tightly regulate these PC-MSO arrangements.[4]

A Shifting Federal Landscape

State legislative activity has intensified in part against the backdrop of a shifting federal regulatory environment. In March 2024, the U.S. Department of Justice's (DOJ's) Antitrust Division, the Federal Trade Commission (FTC), and the U.S. Department of Health and Human Services (HHS) jointly issued a request for information examining corporate consolidation – including PE investment – in the healthcare sector, signaling federal interest in potential oversight.[5] However, a change in presidential administrations in January 2025 diminished that momentum at the federal level.[6] Market analysts have observed that the current administration's skepticism toward federal regulation of healthcare markets may position states as the primary venue for PE oversight efforts in the near term,[7] leaving states to fill what many legislators characterize as a regulatory vacuum.

2025 Recap

In 2025, at least seven states – California, Indiana, Maine, Massachusetts, New Mexico, Oregon, and Washington – enacted laws requiring greater oversight of PE acquisitions in healthcare.[8] As of mid-2025, at least 15 states had some form of healthcare transaction review law on the books, representing a marked increase from prior years.[9]

Several of the 2025 enactments are particularly notable as models for future legislation. On January 8, 2025, Massachusetts Governor Maura Healey signed H. 5159 into law, adding notice requirements for transactions involving "significant equity investors" and subjecting PE groups and MSOs to the civil investigative demand authority of the Massachusetts Attorney General's Office.[10] In June 2025, Oregon enacted Senate Bill 951, which explicitly prohibits MSOs controlled by PE from exercising de facto control over a medical practice's clinical decision-making, staffing levels, billing policies, and contract negotiations with third-party payors.[11] Maine enacted a one-year moratorium on PE and real estate investment trust (REIT) acquisition of hospitals to allow time for the legislature to consider longer-term structural solutions.[12]

2026: New Proposals Expand PE Oversight

As 2026 legislative sessions got underway, numerous additional states (beyond those that enacted legislation in 2025) introduced proposals that would further expand transaction oversight, antitrust enforcement, or CPOM restrictions for PE-backed healthcare entities.[13] The proposals span a range of regulatory approaches.

Hawaii S.B. 3175 would create a framework for state oversight of material healthcare mergers, acquisitions, and other consolidation transactions. Material healthcare

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transactions – defined to include those resulting in a change of control, governance, or material influence over a healthcare entity – would require notice to the state not less than 180 days before the effective date.[14] The bill further targets vertical consolidation in healthcare, which it defines as a transaction between entities operating at different levels of the healthcare supply chain.[15] Such transactions would require legislative approval if they would result in a combined entity controlling 25% or more of any relevant healthcare service or insurance market within Hawaii, or if they would produce price increases exceeding medical inflation benchmarks.[16]

Indiana S.B. 219 would enact Indiana's version of the Uniform Antitrust Pre-Merger Notification Act, requiring federal Hart-Scott-Rodino Act (HSR) filings – the federal pre-merger notification mechanism requiring advance notice to DOJ and the FTC for transactions above specified size thresholds – to also be submitted to the Indiana Attorney General when the entity's principal place of business is in Indiana or where Indiana annual net sales meet a specified threshold.[17] The proposed law would not replace Indiana's existing healthcare entity transaction reporting legislation, but would operate in parallel with it.[18]

New York Governor Kathy Hochul's proposed Fiscal Year 2027 budget bill, S.B. 9007, would expand the state's existing material transactions law to require ongoing post-close reporting on cost, quality, access, equity, and competition for high-impact deals, alongside potential streamlining of the state's Certificate of Need (CON) review process.[19]

Pennsylvania H.B. 2115 would require, 120-day pre-merger notice and concurrent HSR filings to the Pennsylvania Attorney General for transactions involving a material change in ownership among healthcare facilities, systems, or provider organizations.[20] The proposal would authorize the Attorney General to seek injunctive relief and to pursue civil penalties of at least $100,000 per violation.[21]

Rhode Island H.B. 7172 would establish notice requirements for "covered care entities," a category that includes healthcare facilities and providers, behavioral health organizations, residential facilities, and MSOs, involved in a material change in ownership or control.[22] The bill would also require enhanced disclosures from "significant equity investors," defined as PE companies with a direct or indirect ownership interest in a covered care entity, provider organization, or MSO, as well as investors or investor groups holding, directly or indirectly, 10% or more of the equity, profits, or governance rights in such an entity.[23]

While the foregoing proposals focus primarily on transaction transparency and pre-merger notice, Vermont H. 583 takes a more structural approach, representing the most comprehensive 2026 proposal from a CPOM standpoint. The bill would prohibit a range of transactions commonly associated with PE-backed healthcare structures, including the acquisition of healthcare entities through debt that becomes the entity's obligation and the issuance of dividends financed by debt that becomes an obligation of the healthcare entity.[24] The bill would also codify a CPOM prohibition and impose detailed restrictions on MSO-physician practice arrangements, including prohibitions on straw ownership, arrangements in which physician owners hold less than a majority ownership interest in an MSO, stock restriction agreements, and certain restrictive covenants such as noncompete and nondisparagement provisions.[25] Material change transactions of at least $1 million would require prior notice to the Vermont Attorney General and the Green Mountain Care Board, and healthcare entities would be subject to biennial public reporting requirements on ownership, control, and financials.[26]

Virginia H.B. 1458 takes a more measured approach, directing a stakeholder work group to study PE's impact on healthcare and evaluate ownership transparency requirements in Virginia, in other states, and at the federal level.[27] Policy recommendations are due by November 1, 2026, signaling potential 2027 legislative action in that state.[28]

Conclusion

The proliferation of state-level requirements creates substantial compliance complexity for healthcare organizations and PE investors operating across multiple states.[29] Proponents of expanded state oversight argue that such regulation is necessary to protect patients and communities, citing research indicating that PE acquisitions of healthcare providers have, in some instances, been associated with higher costs and lower quality outcomes.[30] PE firms, on the other hand, contend that their investment helps upgrade technology, improve operational efficiency, and expand access to care in rural and underserved communities.[31]

Whether the current wave of state legislation will ultimately converge into a coherent national framework, or whether federal inaction will produce an increasingly complex regulatory patchwork that varies state by state, remains to be seen.[32]

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