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Recent Developments in State Laws and Potential Risks for Healthcare Investors

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The trend of acquisition, or consolidation, of physicians' practices, hospitals and other medical services providers by investment firms has sparked regulatory scrutiny and—even more recently—legislative action by various States. Private equity investments in healthcare skyrocketed from $43 billion in annual deal volume in 2017 to $151 billion in 2021. In the last year alone, States have taken significant legislative action directed at regulating or restricting private investment in healthcare.

At the far end of the spectrum, the most restrictive bills would ban private investment in healthcare altogether. While some States have considered such drastic policies, none have permanently banned private equity firms from healthcare markets. Maine got closest. In June of 2025, it enacted a year-long temporary moratorium preventing private equity firms and real estate investment trusts from owning or operating hospitals. Proponents claim that the law gives legislators time to develop protections for Maine hospitals, though it may chill private investment in Maine's healthcare industry in the future.

While Maine stands alone for now, many States have taken a more targeted aim at regulating

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firms' healthcare investments. These laws vary in the restrictions they impose, ranging from: (1) reporting requirements; to (2) limits on restrictive covenants in medical professionals' employment contracts; and to (3) limits on corporate influence through service organizations. We briefly discuss these categories of laws, and potential implications for firms seeking to invest in the healthcare industry.

Increased Oversight of Healthcare Transactions: Many States have sought to exercise control over private equity transactions in healthcare through transaction review laws modeled after the federal Hart-Scott-Rodino Act. At least 15 states—California, Colorado, Connecticut, Hawaii, Illinois, Indiana, Massachusetts, Minnesota, Oregon,

Nevada, New Mexico, New York, Rhode Island, Vermont, and Washington—have enacted laws that require reporting of certain healthcare transactions prior to closing.

States vary in important ways as to what transactions must be reported, when they must be reported, and whether they must be approved to go forward. A few of those variations are discussed below:

- *Value of Transaction*: Most state reporting laws depend on the financial value of the transaction, or the finances of the health care entity. But States differ in how they set those thresholds. Indiana, for example, requires healthcare entities with more than $10 million in assets to report mergers or acquisitions with another healthcare entity. New York, on the other hand, does not require transactions that result in less than $25 million in increased in-state revenue to be reported. Colorado, Connecticut, New Mexico, Rhode Island, and Vermont mandate reporting of covered transactions—regardless of their financial value.
- *Entities Subject to Reporting Requirements*: State reporting laws also vary depending on what healthcare entities are involved in the transaction. Three States, Colorado, Hawaii and Rhode Island, require reporting for transactions involving hospitals or hospital systems. But most States with healthcare reporting laws—including Connecticut, Illinois, Massachusetts, Minnesota, Nevada, Vermont, and Washington—require companies to report transactions involving healthcare *entities*, which include hospitals *and* other healthcare provider organizations, including group practices. Another five states—California, Indiana, New Mexico, New York, and Oregon—sweep even more broadly and require firms to report transactions involving entities performing healthcare-related services, including health and accident insurers, healthcare plan providers, and pharmacy benefit managers.
- *Notification Periods and Pre-Closing Approval*: States also vary as to when parties must provide notice of their transactions. All States require parties to file in advance of closing. But the notice periods can range from 30 days (Connecticut, Illinois, Nevada, and New York) to 180 days (Oregon). Three states—New Mexico, Oregon, and Rhode Island—require approval from state regulators before a deal can close, which may significantly extend closing timelines. New Mexico requires regulators to issue a decision on a deal application within 120 days of the application while Rhode Island and Oregon provide a longer period of 180 days for a decision.

Limits on Restrictive Covenants: There has also been a significant effort by lawmakers to regulate the use of restrictive covenants—clauses in employment agreements that limit an employee's actions after their employment, *e.g.*, noncompetes. Many states have enacted healthcare-specific laws that ban certain restrictive covenants in healthcare professionals' agreements. But there is significant variance between each State's laws. Notable differences include:

- *Temporal and Geographic Limits*: Some states permit non-competes up to a certain length of time, but there is significant variance. For example, Pennsylvania prohibits restrictions longer than one year, but Louisiana permits non-competes for up to five years for specialty physicians. Louisiana also limits the geographic scope of non-competes, providing that practitioners cannot be prevented from practicing "more than two contiguous parishes" from their former employer's business.
- *Covered Employers*: States vary regarding which employers are subject to limitations on restrictive covenants. For example, Oregon

made an express exemption for hospitals in a 2025 law prohibiting restrictive covenants in healthcare employment agreements. But other States have not made such an exception. Wyoming legislators have stated that a recent non-compete law applying to "employment, partnership or corporate agreements between physicians" includes non-physician employers, like hospitals. Some states have also enacted laws specifically directed at healthcare worker platforms, which allow professionals to sign up for shifts as independent contractors at facilities. Those laws prohibit platforms from requiring users to agree to non-competes that would prohibit the use of other platforms or other employment.

- *Covered Employees*: There are also differences in which employees are subject to these laws. Most states have focused on restrictive covenants that limit a *physician's* ability to practice medicine, but other states' laws cover nurses, physicians' assistants, and dentists.

Enhancements to CPOM Rules: States have also reconsidered exceptions to existing Corporate Practice of Medicine ("CPOM") laws that are designed to prevent business interests from interfering with medical decision-making. These laws prohibit non-physicians or corporations from owning majority stakes in healthcare practices or allowing non-licensed physicians to make medical decisions.

In many states with CPOM laws, private investors can still invest and own stakes in medical practices through management services organizations ("MSOs") that manage the operational functions of clinics, including revenue management, staffing, billing, and price setting. Legislators in at least five states have proposed new legislation meant to close the MSO loophole. These bills have failed in each state other than Oregon, which enacted a comprehensive law in May.

Oregon's law and similar bills have principally focused on limiting MSOs' decision-making power. Under Oregon's law, MSOs cannot make the final decision on hiring, scheduling, diagnostic coding, billing policies, or negotiating payor contracts. Other bills have proposed limiting MSO's decision-making regarding the time and care physicians provide patients.

Conclusion

Though federal scrutiny and enforcement activity against private equity firms in healthcare have dominated headlines, firms should remain vigilant about state legislation. Legislators have demonstrated a keen interest in regulating private investment in healthcare and show no signs of slowing down. Firms should pay close attention to developments in relevant states and adjust their compliance practices accordingly.

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