AMERICAN UNIVERSITY | WASHINGTON COLLEGE OF LAW

HEALTH LAW & POLICY BRIEF

VOLUME 20 • ISSUE 2 • SPRING 2026

ARTICLE

THE NEXT LAYER OF OVERSIGHT: STATE EXPANSION OF HEALTHCARE TRANSACTION REVIEW LAWS

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Acknowledgments:
We would like to thank our advisor, Maya Manian, for her support. We are also grateful to the American University Washington College of Law for providing a legal education that empowers us to champion what matters.

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VOLUME 20.2

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LETTER FROM THE EDITORS

Dear Reader:

On behalf of the Editorial Board and Staff, we proudly present Volume 20, Issue 2 of the *Health Law & Policy Brief*. Since its formation in 2007, the *Brief* has published articles on an array of topics in health law, food and drug law, and emerging health technologies. Consistent with this mission, Volume 20.2 engages with persistent and evolving challenges at the intersection of healthcare regulation, corporate transactions, and public health policy. In this issue, our authors examine the rapidly expanding landscape of state oversight over health care mergers, acquisitions, and other material change transactions. Volume 20.2 features an article co-authored by Esther Braha, J.D., Emma Pons Claramunt, Esq., and Ari J. Markenson, J.D., M.P.H.

The authors' article, *The Next Layer of Oversight: State Expansion of Healthcare Transaction Review Laws*, surveys the wave of state Transaction Review Laws (TRLs) reshaping how health care deals are scrutinized. Tracing the long history of health care regulation, the article identifies the public policy drivers behind these new frameworks. It then maps the common structural elements of enacted TRLs before examining the legal challenges, failed legislative efforts, and what the future of these state regulatory frameworks may hold.

We would like to thank Ms. Braha, Ms. Pons Claramunt, and Mr. Markenson for their insight, scholarship, and hard work in producing this piece. We would also like to thank the *Health Law & Policy Brief*'s article editors and staff members who worked so diligently on this issue.

To all our readers, we hope that you enjoy this issue, that the never-ending complexities of this area of law inspire your own scholarship, and that you continue to anticipate and scrutinize the challenges that our healthcare system continues to withstand.

Sincerely,

Tyanna Robinson
Editor-in-Chief

Elizabeth McHugh
Executive Editor

* * *

THE NEXT LAYER OF OVERSIGHT: STATE EXPANSION OF HEALTHCARE TRANSACTION REVIEW LAWS

Esther Braha, J.D., Emma Pons Claramunt, Esq., & Ari J. Markenson, J.D., M.P.H.

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INTRODUCTION

Healthcare services involve humans, their lives, their health, and their overall physical and mental well-being. For those very reasons, essentially since the beginning of professional and organized healthcare services, federal, state, and local governments have sought to oversee and regulate the provision of such services.[1] Moreover, advances in medical science, technology, and the business of healthcare have led to significant changes in the sophistication of healthcare services and associated business transactions.[2] The healthcare industry is one of the most heavily regulated in the United States and will likely remain so for the foreseeable future.[3]

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[1] Robert I. Field, *Why is Health Care Regulation so Complex?*, 33 PHARM. THR. 607, 607 (2008).

[2] *See* Mohd Javaid et al., Health informatics to enhance the healthcare industry's culture: An extensive analysis of its features, contributions, applications and limitations, 1 INFORM. HEALTH 123, 123-24 (2024) ("Numerous sectors have undergone fast technological change, and healthcare is no exception").

[3] *See* Mercatus Center, QuantGov RegData United States 5.0 (2022) (author's calculation) (probability-weighted industry restrictions aggregated to 2-digit NAICS sectors); Mercatus Center, QuantGov State RegData: Definitive Edition (2022) (author's calculations) (probability-weighted regulatory restrictions aggregated to 2-digit NAICS sectors and summed across all states); American Hospital Association & Manatt Health, Regulatory Overload: Assessing the Regulatory Burden on Health Systems, Hospitals and Post-acute Care Providers 6 (Oct. 2017); Ephrat Livni, *Regulation Nation: What Industries Are Most Carefully Overseen?*, FINDLAW (Mar. 21, 2019), https://www.findlaw.com/legalblogs/small-business/regulation-nation-what-industries-are-most-carefully-overseen/.

As the healthcare industry undergoes significant changes, it has experienced unprecedented consolidation and an increase in business transactions, leading to an ever-growing number of states adopting additional and new regulations.[4] We discuss the more recent history and public policy surrounding the new healthcare transaction review laws (TRLs) that are the primary subject of this article in Part I below.[5] However, we begin with some context surrounding the history and development of laws regulating the licensure of healthcare providers and the transfer of licensure in transactions.[6] Further, we introduce what TRLs are, discuss common elements and exceptions, and consider what the future of this type of state regulation may hold.[7]

Laws regulating the practice and business of healthcare services in the United States have a long history. In fact, they begin in the colonial period, pre-dating the creation of the federal union. New York is an early pioneer in legislative enactments relating to the provision of healthcare services and its associated businesses.[8] Throughout history, such laws have been designed to protect the citizenry from the detrimental effects of unqualified providers by primarily setting minimum standards for education and training for individual licensees and setting operational

[4] George Tewfik et al., *The Risks and Benefits of Physician Practice Acquisition and Consolidation: A Narrative Review of Peer-Reviewed Publications Between 2009 and 2022 in the United States*, 17 J. MULTIDISCIP. HEALTHC. 2271 (2024).

[5] *See infra* Part I.

[6] *See infra* pp. 3-9.

[7] *See infra* Parts II-IV.

[8] *See* J.B. Bardo, A History of the Legal Regulation of Medical Practice in New York State, 43 BULL. N. Y. ACAD. MED. 924, 924 (1967) (describing legislative enactments as early as 1797 imposing regulations in medicine).

standards for institutions.[9] Additionally, as the sophistication of the provision of services and the businesses that provide such services changes, the healthcare industry experiences regulatory developments for transferring a license from a seller to a buyer.[10]

On June 10, 1760, "An Act to Regulate the Practice of Physick and Surgery in the City of New York" was passed as one of the earliest legislative controls over the practice of medicine.[11] Further legislation was passed to continue to "professionalize" medicine. On March 27, 1792, "An Act to Regulate the Practice of Physic and Surgery, within the City and County of New York" was passed expressing that "[w]hereas many ignorant and unskillful persons do presume to administer physick and practise surgery, in the City and County of New-York, to the detriment and hazard of the lives and limbs citizens thereof, for the prevention of such abuses in future, 1. be it enacted…"[12] On April 10, 1813, the New York Legislature passed "An Act to incorporate Medical Societies, for the purpose of regulating the practice of physic and surgery in this state" as a further measure

[9] *See generally id.* at 925-28 (explaining how establishing licensure provided a legal mechanism to expel members for misconduct or gross ignorance effectively deterring such behavior by providers and institutions throughout history).

[10] *See infra* note 30 and accompanying text (describing contemporary changes to licensure conferral).

[11] THE COLONIAL LAWS OF N.Y. FROM THE YEAR 1664 TO THE REVOLUTION, ch. 803, 1131–32 (James B. Lyon ed., 1894).

[12] *See generally* ACT TO REGULATE THE PRACTICE OF PHYSIC AND SURGERY IN THIS STATE, ch. 21, 1792 N.Y. LAWS 338 (Thomas Greenleaf, ed., 1792).

to consolidate and regulate minimum standards for the medical profession and licensure.[13]

As time passed into the twentieth century, the business of providing professional services changed.[14] No longer are individual professionals practicing for their own account, either from small office practices, through house-calls, or as visiting physicians to hospitals.[15] Physicians begin to form specific professional businesses and create larger and more complex single-specialty and multi-specialty practices.[16] However, non-professional ownership in professional service businesses or interference in professional decision-making is prohibited in most states.[17] That restriction exists primarily in the prohibition on the corporate practice of medicine doctrine.[18] Approximately 33 states continue to enforce some form of the prohibition.[19] Investor (non-

[13] *See generally* An Act to Incorporate Medical Societies for the Purpose of Regulating the Practice of Physic and Surgery in this State, ch. 94, 1813 N.Y. LAWS (36th Sess.) 115 (Mar. 13, 1813).

[14] Julie Hyppolite et al., Physician Employment Eclipses Practice Ownership: The Ongoing Trend and Its Effect on Family Medicine, 104 AM. FAM. PHYSICIAN 351 (2021).

[15] *See id.*

[16] Carol K. Kane, *Recent Changes in Physician Practice Arrangements: Shifts Away from Private Practice and Towards Larger Practice Size Continue Through 2022*, AM. MED. ASS'N, POL'Y RSCH. PERSPS. (2023), https://www.ama-assn.org/system/files/2022-prp-practice-arrangement.pdf; W. Pete Welch et al., *Proportion of Physicians in Large Group Practices Continued to Grow in 2009–11*, 32 HEALTH AFF. 1659 (2013).

[17] *Corporate Practice of Medicine: A 50 State Survey*, AM. HEALTH L. ASS'N (3d ed. 2024).

[18] *Id.*

[19] *Id.*

professional) interest in the business of providing professional medical services begins primarily in the mid-1980s and only increases to its current level today.[20] The business structures involving non-professional ownership through practice management entities, including management services organizations (MSOs), and concerns surrounding those structures are among the primary drivers of the recent trend to enact TRLs.[21] We will expand on these issues throughout this article.

Pivoting to institutional providers, as inpatient healthcare services began to "professionalize" as well, on May 9, 1913, New York passed "An Act to amend the Public Health Law, generally,"[22] The law seeks to further define and structure the state public health department and local public health boards to provide oversight of the provision of healthcare services, including in institutions such as communicable disease hospitals.[23] In parallel, the New York Social Welfare Law and its predecessor include provisions setting forth the obligation of boards of health to oversee the licensing and operation of public and private hospitals.[24] Rolling forward, in 1953, New York continues to be at the forefront of provider regulation with a new structure for

[20] Inst. of Med., *For-Profit Enterprise in Health Care* (Bradford H. Gray ed., Nat'l Acads. Press 1986).

[21] *See infra* Part II.

[22] Act of May 9, 1913 (An Act to amend the public health law, generally), ch. 559, 1913 N.Y. Laws 1408 (amending Pub. Health Law) (effective Jan. 1, 1914).

[23] *See id.*

[24] *See* N.Y. SOC. WELFARE LAW § 21 (McKinney 1941) (repealed 1966).

its public health law, including regulation of state-run communicable disease hospitals.[25] The new legislation sets out minimum standards, particularly for the governance and operation of such hospitals.[26]

New York was not only the first to establish minimum standards for individual and institutional healthcare providers, but it was also the first in the nation to begin to control, through a government process, the establishment of "need" for a healthcare service before it is approved to be provided.[27] On April 22, 1964, New York passed the nation's first "Certificate of Need" (CON) law.[28] The new law provided that "[t]he board shall not approve a certificate of incorporation unless it is satisfied, insofar as it is applicable, as to (i) the public need for the existence of the institution at the time and place and under the circumstances proposed.."[29] As time passed, New York added requirements to the CON/Licensure process that governed a change of ownership (CHOW) of the licensed provider.[30]

Not too long after New York's establishment of a CON process, Congress, on January 4,

[25] *See generally* Act of Apr. 17, 1953 (An Act in relation to the Public Health, constituting Chapter forty-five of the consolidated laws), ch. 879, 1953 N.Y. LAWS 1524 (codified at N.Y. PUB. HEALTH LAW ART. 28) (effective July 1, 1953).

[26] *See id.*

[27] *See* Metcalf-McCloskey Act, ch. 730 N.Y. LAWS (1964) (amending PUBLIC HEALTH LAW §§ 2902, 2904).

[28] *See id.*

[29] *See id.*

[30] N.Y. PUB. HEALTH LAW § 2801-(a)(4) (McKinney 2025).

1975, passed the National Health Planning and Resources Development Act of 1974 (NHPRDA).[31] The NHPRDA, in response to a perceived oversupply and uncoordinated planning of institutional health care services, now mandates that all states implement CON processes.[32] The law was repealed in 1986.[33] However, thirty-five states and the District of Columbia continue to have some form of CON process.[34]

Currently, all fifty states and the District of Columbia have existing licensure rules for health care service providers.[35] These state licensure processes establish minimum standards to protect patients, ensure a consistent structure to operations, and, in most states, address the need

[31] National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, 88 Stat. 2225 (1975).

[32] James F. Blumstein & Frank A. Sloan, *Health Planning and Regulation Through Certificate of Need: An Overview*, 1978 UTAH L. REV. 3, 6-7, 21 (1978) (finding that federal investments had produced increases in healthcare costs and failed to ensure adequate distribution of health resources and mandating that all states establish CON programs).

[33] Pub. L. No. 99-660, tit. VII, § 701(a), 100 Stat. 3743, 3799 (1986) (repealing Title XV of the Public Health Service Act, as added by the National Health Planning and Resources Development Act of 1974, Pub L. No. 93-641, 88 Stat. 2225 (1975), effective Jan. 1, 1987).

[34] *Certificate of Need State Laws*, NAT'L CONF. STATE LEGISLATURES (Apr. 29, 2025), https://www.ncsl.org/health/certificate-of-need-state-laws.

[35] Healthcare Facility and Provider Licensing—State Law Requirements, LEXISNEXIS PRAC. GUIDANCE (Feb. 14, 2023), https://www.lexisnexis.com/community/insights/legal/b/practical-guidance/posts/healthcare-facility-and-provider-licensing-state-law-requirements.

for particular types of services.[36] Additionally, every state, whether in a CON law, licensure law, or both, currently has some form of definition of what constitutes a CHOW of the licensed provider and what regulatory approval process must be undertaken in such circumstances.[37] In many of these states, and dependent on the structure of the transaction, the approval process is a pre-closing process.[38] This means that the buyer and seller cannot close the deal until the appropriate regulator approves the transaction and the license, a CON transfer, or both.[39]

Taken together, the same underlying health policy themes involving protecting consumers of healthcare services and the health system overall and ensuring safety, quality, and access (the Underlying Health Policy Interests) permeate the earliest regulation of the medical professions to

[36] Kathleen Leslie et al., Design, Delivery and Effectiveness of Health Practitioner Regulation Systems: An Integrative Review, 21 HUM. RES. FOR HEALTH 72 (2023); State Health Workforce Toolkit: Licensing and Regulation, NAT'L GOVERNORS ASS'N (2023), https://www.nga.org/state-health-workforce-toolkit/licensing-and-regulation/ (explaining that state licensure is designed to protect the public and ensure patient safety by setting minimum requirements); *see also Certificate of Need State Laws*, *supra* note 34 (describing how CON programs require proof of community need for particular types of services before a provider is permitted to operate).

[37] State laws differ in terms of their CON and CHOW regulations. *See, e.g.*, 28 P.A. CODE § 51.4 (2026); ME. REV. STAT. tit. 22 § 329 (2016); N.Y. PUB. HEALTH LAW § 2801-a (2025); TENN. CODE ANN. § 71-5-132 (2026); TEX. HEALTH & SAFETY CODE ANN. § 242.033 (West 2015).

[38] *Id.*

[39] *Id.*

the more recent licensure and license transfer processes.[40]

Additionally, non-profit healthcare providers typically have separate approval processes relating to transactions, particularly in a non-profit to for-profit conversion.[41] State attorneys general (AG) offices are often the regulator involved in determining the post-transaction use of charitable assets in furtherance of the mission of the non-profit that is not surviving the transaction.[42]

Given the historical and significant existing regulation of healthcare provider licensure and license transfers, why have almost a third of U.S. states chosen to enact some form of new law, a TRL, regulating healthcare transactions? A more fulsome answer to this question can be found in Part I below.[43] However, as healthcare transactions have become more sophisticated and involve, particularly, more for-profit dollars, whether from private investors or public markets, many states are beginning to express that existing regulation does not adequately address the Underlying Health

[40] *See* The Colonial Laws of N.Y., *supra* note 11 at 455; *Certificate of Need State Laws*, *supra* note 34.

[41] *See Not-For-Profit Hospitals: Conversion Issues Prompt Increased State Oversight*, U.S. GOV'T ACCOUNTABILITY OFF. 1 (1997); Ken Marlow, Lanta Wang & Rex Burgdorfer, Defending the Deal: The Attorney General Review Process in Nonprofit Hospital Conversions, AHLA Connections, Apr. 2016, at 12.

[42] *See id.*

[43] *See infra* Part I.B.

Policy Interests.[44]

Note, we have included a matrix that sets out some basic elements of the enacted TRLs and proposed and failed bills in **Appendix A**.[45]

I. RECENT TRL HISTORY AND PUBLIC POLICY

As mentioned, TRLs are laws that provide for a multifaceted review targeting specific types of healthcare transactions.[46] TRLs have been implemented in different ways in each state that has passed one.[47] However, they have originated from some common public policy themes.[48]

A. *Origins of Transaction Review Laws (TRLs)*

A.1 Early Adoption – Protection of Nonprofit Hospital Assets and Public Interest

In the 1990s, a surge in the conversion of non-profit hospitals to for-profit ownership prompted some states, concerned about the potential loss of community assets, to enact laws and

[44] Erin C. Fuse Brown & Katherine L. Gudiksen, Models for Enhanced Health Care Market Oversight — State Attorneys General, Health Departments, and Independent Oversight Entities (Milbank Mem'l Fund, Jan. 2024).

[45] *See infra* Appendix A.

[46] *See Legislative Approaches to Curb Corporate Influence in Health Care*, AMER. MED. ASS'N 6 (2025).

[47] *See* Sarah Jaromin, *The Evolving Landscape of Health Care Transactions*, NAT'L CONF. STATE LEGISLATURES (Aug. 19, 2024), https://www.ncsl.org/health/the-evolving-landscape-of-state-health-care-transaction-laws.

[48] *See id.* (suggesting increasing health care costs and consolidation are motivating state reforms).

regulations governing such transactions.[49] These laws contained measures designed to protect the charitable assets held by non-profit hospitals, ensuring that community resources accumulated under non-profit tax exemptions—such as donations, public subsidies, and grants—continued to serve the public benefit after a transaction.[50] Often, states that enacted new laws focused on conversions did so because of a perception that existing non-profit regulation did not do enough to address the Underlying Health Policy Interests in conversion transactions.[51]

For example, in 1998, Colorado authorized its AG to review any "material change" transaction involving hospitals and to block deals that were inconsistent with a hospital's charitable mission or detrimental to the public interest.[52] Similarly, two decades later, Minnesota expanded the state's longstanding AG oversight of non-profit hospital conversions to reach for-profit and investor-backed entities, granting the AG authority to review, block, or unwind transactions deemed contrary to the public interest, as further discussed in Part I.C and II. F. below.[53]

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[49] Bernice Steinhardt & James O. McClyde, *Not-for-Profit Hospitals: Conversion Issues Prompt Increased State Oversight*, U.S. GEN. ACCT. OFF. 1 (1997), https://www.gao.gov/assets/hehs-98-24.pdf.

[50] *See*, *e.g.,* COLO. REV. STAT. §§ 6-19-101-104 (2024).

[51] *See* U.S. GAO*, Not-for-Profit Hospitals,* GAO/HEHS-98-24*,* at 1 (1997); *see e.g.,* Colo. Rev. Stat. § 6-19-101 (2024) (stating that the statute is intended "to protect the public interest [and] to assure that nonprofit assets of hospitals are preserved to serve the charitable purposes to which they were dedicated").

[52] *See* COLO. REV. STAT. §§ 6-19-101-104 (2024).

[53] *See* MINN. STAT. § 145D.32 (2025); MINN. STAT. §§ 145D.01, Subds. 5–6 (2025); *see infra* Part I.C.

A.2 Response to Consolidation and Private Investment Activity

While certain earlier statutes concentrated on preserving charitable assets, the real pressure point in current TRL activity appears to lie in responding to increasing consolidation and the rising influence of private investment funds, MSOs, and real-estate investment trusts (REITs) across the healthcare sector.[54]

With the increase in private investment, healthcare regulators and policymakers recently began reverting to longstanding historical ethical criticisms about for-profit healthcare that were summed up in a 1986 report of the Institute of Medicine, primarily focused on institutions, entitled "For-Profit Enterprise in Health Care" ("IOM For Profit Report").[55] These criticisms included the main concerns that "[f]or-profit health care institutions are said to (1) exacerbate the problem of access to health care, (2) constitute unfair competition against nonprofit institutions, (3) treat health care as a commodity rather than a right, (4) include incentives and organizational controls that adversely affect the physician-patient relationship, creating conflicts of interest that can diminish the quality of care and erode the patient's trust in his physician and the public's trust in the medical profession, (5) undermine medical education, and (6) constitute a "medical-industrial complex" that threatens to use its great economic power to exert undue influence on public policy concerning health care."[56] As will be discussed below, many TRLs are an attempt to address either all or some of these ethical criticisms through a multifaceted review of a transaction.

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[54] MINN. STAT. §§ 145D.01, Subds. 5–6 (2025) and *See infra* note 57.

[55] Dan W. Brock & Allen Buchanan, Committee on Implications of For-Profit Enterprise in Health Care, Institute of Medicine, *For-Profit Enterprise in Health Care* pt. II, ch. 2, at 224 (Bradford H. Gray ed., Nat'l Acad. Press 1986).

[56] *Id.* at 225.

Additionally, private investment, REIT, and MSO transactions often fall outside traditional regulatory frameworks, revealing gaps in certificate of need (CON) regulations, licensure requirements, and federal antitrust oversight.[57] In response, many states have begun enacting new oversight requirements.[58] For example, Massachusetts enacted a law extending the state's Health Policy Commission's (HPC) Cost and Market Impact Review (CMIR) process to encompass

[57] *See* Vicki Veltri & Maureen Hensley-Quinn, *Addressing Corporatization of Health Care, Consolidation, and Closures: Updated NASHP Market Oversight Model Legislation*, NAT'L ACAD. FOR STATE HEALTH POL'Y (July 29, 2024) (describing state market-oversight provisions designed to reach private equity companies, MSOs, sale-leaseback agreements, and REIT-related structures); Michael Fenne, *2025 State Healthcare Policy Review: Tracking Private Equity Oversight and Reform*, PRIV. EQUITY STAKEHOLDER PROJECT 3–8 (Nov. 2025) (surveying recent state laws and proposals targeting private equity ownership, MSO arrangements, sale-leasebacks, REITs, and material-change transaction oversight*)*.

[58] Aimee D. Montague, Katherine L. Gudiksen & Jaime S. King, *State Action to Oversee Consolidation of Health Care Providers*, MILBANK MEM'L FUND (Aug. 5, 2021), https://www.milbank.org/publications/state-action-to-oversee-consolidation-of-health-care-providers/; Noah Hostert, *How States Strengthened Their Health Care Markets in the 2025 Legislative Session*, MILBANK MEM'L FUND (Aug. 27, 2025), https://www.milbank.org/publications/how-states-strengthened-their-health-care-markets-in-the-2025-legislative-session/ (discussing states with legislation enacted or effective and states that may expand healthcare transaction oversight).

private-equity and MSO-related transactions.[59]

Similarly, California recently enacted two new laws strengthening oversight of investor-backed entities beyond licensed facilities.[60] One of these laws prohibits private equity groups or hedge funds involved with physicians from interfering with professional judgment, including decisions regarding patient care, coding, and billing.[61] It also grants the AG authority to seek injunctive relief if a contract enables such interference.[62] Under the new requirements, private equity groups and hedge funds must now provide the California Office of Health Care Access (OHCA) with at least a 90-day notice before completing any transaction involving a healthcare entity or an MSO.[63]

A.3 The Model Act for State Oversight of Proposed Healthcare Mergers

The *Model Act for State Oversight of Proposed Healthcare Mergers*originally published in 2021 and updated in 2024 (the Model Act)—provides a harmonized framework for reviewing

[59] An Act Enhancing the Market Review Process, ch. 343, §§ 22, 24, 2024 Mass. Acts 1724, 1731 (2024).

[60] California Health Care Quality and Affordability Act, ch. 641, sec. 1, §§ 127500.2, 127501, 127505, 2025 Cal. Stat. 6749, 6749-52 (2025); Health Facilities, ch. 409, sec. 1, §§ 1190-91, 2025 Cal. Stat. 5384, 5384-86 (2025).

[61] § 1191, 2025 Cal. Stat. at 5386.

[62] *See id.*

[63] *See id.*

healthcare transactions.[64] Developed by the National Academy for State Health Policy (NASHP), whose membership primarily consists of state health commissioners, the model law aims to enhance transparency and regulatory oversight of proposed mergers, particularly those involving investor-backed entities.[65] The original version provided a framework for states interested in developing and implementing new TRLs.[66] The updated 2024 version incorporates lessons from recent state-level legislation and evolving market trends, thus offering continued guidance for states seeking to strengthen their review processes.[67]

In particular, the Model Act addresses corporate and private equity entry into healthcare markets, growing consolidation, and the closure of key service lines or facilities by expanding oversight of corporate changes of control of healthcare provider groups (including MSOs), as well as real-estate sale-leasebacks involving healthcare entities and planned facility or service-line closures.[68] It also seeks to strengthen the corporate practice of medicine and physician non-

[64] *Model Act for State Oversight of Proposed Health Care Mergers*, NAT'L ACAD. FOR STATE HEALTH POL'Y (July 26, 2024), https://nashp.org/a-model-act-for-state-oversight-of-proposed-health-care-mergers/.

[65] *See generally*, *A Tool for States to Address Health Care Consolidation: Improved Oversight of Health Care Provider Mergers*, NAT'L ACAD. STATE HEALTH POL'Y: BLOG, https://nashp.org/a-tool-for-states-to-address-health-care-consolidation-improved-oversight-of-health-care-provider-mergers/ (last accessed Apr. 2, 2026).

[66] *See id.*

[67] *See id.*

[68] *Id.*

compete rules and requires transparency of healthcare ownership and control structures.[69]

Specifically, the Model Act sets out a detailed list of issues that oversight agencies should evaluate when reviewing potential material changes.[70] This comprehensive list includes factors such as: (i) market concentration and the effects of competition; (ii) the transaction history of the parties; (iii) relative pricing and the transaction's potential price impact; (iv) the quality of services provided by any party to the transaction, including patient experience; (v) the cost and cost trends of the healthcare entity in comparison to total statewide healthcare expenditures; (vi) the availability, accessibility, and competitiveness of healthcare services in the affected service areas;

(vii) the parties' obligations to underserved and government-payer patient populations; (viii) the provision of low-margin essential services by the transacting parties; (ix) consumer protection concerns, including any history of deceptive practices; (x) the parties' compliance with prior regulatory conditions, such as corporate practice of medicine requirements, reporting obligations regarding healthcare entity ownership and control, or restrictions on anticompetitive contracting provisions; (xi) clinical workforce implications, including wages, staffing, and continuity of care;

(xii) the financial impact of real-estate arrangements on the entity's ability to maintain patient care operations; (xiii) the access, equity, outcomes, and affordability consequences of any proposed facility closure; and (xiv) any additional factors that oversight agencies may deem to be in the public interest.[71]

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[69] *Id.*

[70] *See id.*

[71] *Id.*

Many states discussed in this article have already incorporated these oversight considerations into their laws, examining factors related to the proposed transaction, the parties, and their relative market position.[72] For example, California requires healthcare entities planning material change transactions to provide at least 90-day pre-closing notice to the OHCA.[73] The OHCA may review statewide healthcare cost and cost trends, the effects of market concentration and competition, and the parties' transaction history before allowing the transaction to proceed.[74]

Similarly, Colorado requires hospitals and other healthcare entities to provide notice before significant transactions, such as the sale of a majority of hospital assets or a series of related transactions.[75] This notice allows the Colorado AG to protect the public interest, ensure nonprofit hospital assets remain dedicated to their charitable purposes, and provide public notice of material changes.[76] The review may consider factors such as the parties' transaction history, impacts on underserved populations, and transfers from nonprofit to for-profit entities.[77]

In Massachusetts, healthcare entities pursuing material change transactions, including

[72] *See id.; e.g.*, *supra* Part 1.A.1 (discussing Colorado and Minnesota).

[73] CAL. CODE REGS. tit. 22, § 97435 (2024).

[74] *Id.;* CAL. HEALTH & SAFETY CODE § 127507 (West 2024).

[75] COLO. REV. STAT. § 6-19-102-03 (2024).

[76] COLO. REV. STAT. § 6-19-101 (2024) ("This article is intended to protect the public interest, to assure that nonprofit assets of hospitals are preserved to serve the charitable purposes to which they were dedicated, and to provide the public notice of all transfers of assets of hospitals that constitute covered transitions as defined in this article").

[77] *Id.*

acquisitions by private equity firms or MSOs, must notify the HPC, which may initiate a CMIR.[78] This oversight can address changes in access to care for underserved populations, service quality, patient experience, and the provision of low-margin services.[79]

Along those same lines, Minnesota has implemented a tiered notice system that requires healthcare entities to provide pre-closing notice based on current or projected revenue.[80] This allows the AG to assess implications like those listed in the Model Act, including workforce impacts and other operational considerations.[81]

Interestingly, there are clear parallels between the ethical criticisms raised in the IOM For Profit Report and the review factors outlined in the Model Act.[82]

B. *Underlying Public Policy Objectives*

Whether in response to specific events or concerns in general, a growing number of states are adopting TRLs to address several public policy considerations that either are not addressed at all or are not adequately addressed by existing law, including concerns over perceived gaps in oversight of the individuals and entities involved in the transfer of and operation of healthcare

[78] Mass. Gen. Laws ch. 6D § 13; 958 C.M.R. § 7.00; Act Enhancing Market Review Process, H.B. 5159, Mass. Gen. Ct. (2024).

[79] *See id.*

[80] *See infra* note 129.

[81] MINN. STAT. § 145D.01 (2023).

[82] *See id*; *see supra* note 57.

services.[83] States are also becoming more concerned about the limits of federal antitrust enforcement in addressing state-specific healthcare markets.[84] TRLs enable states not only address underlying health policy interests, but also address more recent public policy goals, including preventing anti-competitive behavior and monopolization, and increasing transparency to the state and the public.[85]

B.1 Maintaining Access to Affordable Quality Healthcare

Ensuring patient accessibility and availability of healthcare services is one of the underlying health policy interests states have expressed when enacting a TRL.[86] Many states are focused on doing more to preserve access, ensure quality of care, and contain costs.[87] States, such as Massachusetts and Minnesota, have elements of their TRLs that are designed to monitor the impact healthcare transactions may have on the public's access to care and ensure there is no reduction in the quality of care or an increase in costs to patients.[88] In Minnesota, the TRL provides the Commissioner of Health with the authority to collect and analyze data arising from healthcare transactions and to assess whether such transactions will affect the cost and quality of healthcare

[83] Ari Jonathan Markenson, Gregory W. Packer Jr. & Pamela Polevoy, *State Healthcare Transaction Review Laws: A New Landscape*, A.B.A., (June 25, 2024), https://www.americanbar.org/groups/business_law/resources/business-law-today/2024- june/state-healthcare-transaction-review-laws-a-new-landscape/. *See e.g.* MINN. STAT. § 145D.01 (2023).

[84] *Id*.

[85] *See supra* note 58.

[86] MASS. GEN. LAWS ch. 6D § 13(c)–(e); MINN. STAT. §§ 145D.01–.02

[87] *Id.*

[88] *Id.*

services.[89] Additionally, the Commissioner can make recommendations to the legislature based on its findings.[90]

As a measure of maintaining access to healthcare, states are also evaluating potential price increases and cost increases that may result from healthcare transactions.[91] Pursuant to the relevant TRLs, both Massachusetts and California will review transactions to see if they have an impact on the state's ability to control the rise of healthcare costs.[92] Both states authorize the relevant regulatory authority to conduct a CMIR, which assesses, among other factors, the quality of services, costs, and accessibility to similar healthcare services.[93] This review is linked to a cost-growth benchmark, a way for states to ensure that transactions do not have a negative impact on healthcare services.[94]

In monitoring healthcare transactions, states like California are also focusing on health equity by monitoring how certain transactions will affect underserved populations and Medicare and Medicaid patients.[95] In its legislative findings upon enacting a new state statute, the California Legislature noted trends in the rise of healthcare costs, specifically a 45% increase in premiums

[89] MINN. STAT. § 145D.01(6).

[90] MINN. STAT. § 145D.02.

[91] CAL. HEALTH & SAFETY CODE § 127507.2 (West 2024); MASS. GEN. LAWS ch. 6D § 13(c)–(e).

[92] *Id.*

[93] *Id.*

[94] Cal. Code Regs. Tit. 22, § 97441.

[95] CAL. HEALTH & SAFETY CODE § 127500.5 (West 2023).

and a 70% increase in PPO deductibles.[96] It also noted concerns with health disparities and quality (particularly for Californians of color), health care affordability and accessibility in underserved communities.[97] These findings reflect the policy concerns that the State addressed when it implemented a TRL.[98]

Lastly, and as mentioned in Early Adoption – Protection of Nonprofit Hospital Assets and Public Interest, to preserve public access to healthcare, states are prioritizing the safeguarding of nonprofit assets of healthcare service providers during transactions.[99] For example, Vermont requires nonprofit hospitals to seek approval from a state board (Green Mountain Care Board) and either the AG or the court prior to carrying out a conversion.[100] There is a list of factors for the AG to consider when deciding whether to approve or disapprove the transaction.[101] These factors include whether the nonprofit hospital will receive fair market value for the charitable assets, whether the conversion may result in private inurement, and whether the proceeds will be used for public benefit.[102] These factors reflect Vermont's legislative goals of protecting nonprofit assets during transactions and grant the AG the authority to disapprove any transactions that interfere

[96] *Id.*

[97] *Id.*

[98] *See also id.* (describing potential state policy concerns).

[99] U.S. Gov't Accountability Off., *Not-for-Profit Hospitals: Conversion Issues Prompt Increased State Oversight*, GAO/HEHS-98-24**,** at 1 (1997), https://www.gao.gov/assets/hehs-98-24.pdf.

[100] VT. STAT. ANN. tit. 18, § 9420 (West 2026).

[101] *Id.* § 9420(j).

[102] *Id.* § 9420(j)(2), (4)-(5).

with their objective.[103]

B.2 Preserving Competition and Preventing Monopolization

States are also enacting TRLs to address the increasing threat of monopolization and anticompetitive consolidation in healthcare.[104] States are specifically concerned with transactions that may harm markets and competition.[105] Many states include an antitrust review component in their enacted TRL, authorizing state officials to review covered transactions for concerns of monopolization or anticompetitive effects.[106] For example, Illinois authorized the AG to review covered transactions and investigate suspected anticompetitive behaviors such as price fixing or an "attempt to acquire monopoly power" by the transacting party.[107]

By enacting TRLs that assess anticompetitive behavior, states assert an independent interest that operates in conjunction with federal antitrust law.[108] Nevada's law states that anyone who files a notification with the Federal Trade Commission (FTC) or Department of Justice (DOJ) under the Hart-Scott-Rodino Antitrust Improvements Act of 1976 must also submit a copy to the

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[103] *Id.* § 9420(j).

[104] *See From Mergers to Market Power: 2025 Legislative Recap on Health Care Consolidation*, NAT'L CON. OF STATE LEGISLATURES (Jan. 21, 2026), https://www.ncsl.org/health/from-mergers-to-market-power-2025-legislative-recap-on-health-care-consolidation.

[105] *See* 740 ILL. COMP. STAT. ANN. 10/7.2a (West 2026); NEV. REV. STAT. §§ 598A.290– 430 (West 2026); IND. CODE. ANN. § 25-1-8.5-4 (West 2026).

[106] *See id.*

[107] 740 ILL. COMP. STAT. ANN. 10/3 (West 2026).

[108] *See* NEV. REV. STAT.§ 598A.400 (2025).

state AG's office.[109] Because healthcare transactions directly affect local communities, states are claiming authority by enacting TRLs that vest power in the AG to evaluate the transactions for anticompetitive elements.[110] Many states enacted TRLs that include oversight beyond federal antitrust law and capture transactions that would otherwise escape review.[111]

B.3 Increasing Transparency

Increasing transparency to the public has also been a focus of TRLs. Many TRLs contain public disclosure provisions to ensure that the public is informed about potential transactions.[112] Minnesota, for example, grants the Commissioner of Health the authority to issue public reports on the number and types of transactions, including information addressing the impact of transactions on health care cost, quality, and competition.[113] New York has a requirement that the Department of Health must post a summary of proposed transactions on its website and allow public comment.[114] The Oregon Health Authority (OHA) accepts public comments from individuals regarding any healthcare transaction that is under review.[115] By creating more

[109] *Id.*

[110] *See, e.g., id.* (requiring concurrent state review in Nevada).

[111] *See, e.g., id.*

[112] *See, e.g.,* MINN. STAT. § 145D.01, subd. 6(b) (2023); N.Y. PUB HEALTH LAW § 4552(2)(b) (2023).

[113] MINN. STAT. § 145D.01, subd. 6(b) (2023).

[114] N.Y. PUB HEALTH LAW § 4552(2)(b) (2023).

[115] *See* HCMO Transactions and Reviews, Oregon Health Authority, https://www.oregon.gov/oha/hpa/hp/pages/hcmo-transaction-notices-and-reviews.aspx (last visited Apr. 7, 2026).

transparency through public disclosure, state legislatures are fulfilling a key policy goal of informing the public and allowing public debate on major transactions that could affect public welfare.

C. *Rationale for TRLs Beyond Traditional Tools*

As mentioned, existing laws have focused on establishing minimum standards, setting out operational requirements, and ensuring consistency and quality in services to address the Underlying Health Policy Interests. TRLs are designed to do more. In a few circumstances, they have been used to replace existing laws.[116] TRLs are generally designed to take a 360-degree view of healthcare transactions by evaluating traditional issues such as patient access, quality, and the bona fides of the buyer, and to also address antitrust and competition, health equity, and the post-closing costs and affordability of the services provided.[117] Many of these issues are either not issues that have been historically part of a healthcare transaction review process or were not evaluated in the same way in a licensure or CON review.[118] In that respect, they are distinguishable from existing frameworks, and it is clear that they are creating an entirely new level of regulatory scrutiny of healthcare transactions.

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[116] Erin C. Fuse Brown, *To Oversee or Not to Oversee? Lessons from the Repeal of North Carolina's Certificate of Public Advantage Law*, Milbank Mem'l Fund (Jan. 2019), https://www.milbank.org/publications/to-oversee-or-not-to-oversee-lessons-from-the-repeal-of-north-carolinas-certificate-of-public-advantage-law/; Stacey Pogue & Kennah Watts, *State Spotlight: New Massachusetts Law Enhances Oversight of Private Equity in Health Care*, Geo. Univ. Ctr. on Health Ins. Reforms (Mar. 5, 2025); See *supra* note 58.

[117] *See supra* note 58.

[118] *See supra* note 58.

We provide examples and descriptions of how certain states have implemented TRLs below; however, in summary, TRLs typically require mandatory advance notice or pre-closing approval for certain "material transactions" or "material changes," with notice periods ranging from 30 to 180 days depending on the state and transaction type.[119] The scope of covered entities and transactions is broad and varies by jurisdiction, often including hospitals, physician groups, management service organizations, and health insurers, with some states applying specific financial thresholds.[120] The review processes often demand extensive disclosures, encompassing financial data, market analysis, community impact assessments, and ownership structures.

Regulators scrutinize factors such as market share, pricing, service availability, workforce effects, and the impact on at-risk, underserved, and government payer patient populations.[121] Many states also include public comment periods and hearings to enhance transparency.[122]

II. ELEMENTS AND FEATURES OF ENACTED TRLS

Although enacted TRLs vary in detail, they share recurring elements and features. Across jurisdictions, these laws tend to adopt similar frameworks to define the scope of covered transactions and entities and to establish the thresholds and triggers that give rise to regulatory review.[123] They also tend to include consistent categories of exclusions and exceptions, set notice

[119] *See infra* Appendix A.

[120] Jaromin, *supra* note 47.

[121] *See supra*, note 58.

[122] *Id.*

[123] *See e.g.*, COLO. REV. STAT. § 6-19-102(1) (West 2024); MINN. STAT. § 145D.01(1)(j), (k) (2025); N.Y. PUB. HEALTH LAW § 4550(4) (McKinney 2023) (demonstrating similarities in statutory frameworks across three jurisdictions).

and disclosure obligations, provide mechanisms for public participation and ensure transparency, and set out enforcement and oversight tools, even as specific requirements differ from state to state.[124]

A. *Scope of Covered Transactions and Review Triggers*

TRLs often define the scope of covered transactions by specifying the types of transactions subject to regulation, the covered entities, state-specific financial thresholds that trigger notice or review requirements, and, in some states, a series of related transactions occurring within a defined period.[125] Many rely on the concepts of material or materiality to determine which transactions are significant enough to warrant regulatory oversight.[126]

For example, Minnesota's law applies broadly to mergers and acquisitions, assets and ownership transfers, changes of control, revenue-sharing arrangements, and the formation of new healthcare entities, including hospitals, hospital systems, group practices, and related organizations such as medical foundations, occurring within a five-year period in whole or in part in Minnesota or involving a healthcare entity formed or licensed in Minnesota.[127] Other states, like Colorado, similarly treat a series of transactions occurring within five years as a single transaction requiring AG notice.[128]

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[124] *See* MINN. STAT. § 145D.01(1)(j), (k); N.Y. PUB. HEALTH LAW § 4550(4).

[125] MINN. STAT. § 145D.01(1)(e), (j), (k) (2025) (defining "health care entity" and "transaction" broadly to cover a wide range of related actions and the outer limits of those definitions).

[126] COLO. REV. STAT. § 6-19-102(1) (West 2024).

[127] MINN. STAT. § 145D.02(A)(1)–(2) (2025).

[128] COLO. REV. STAT. § 6-19-102(1) (West 2024).

For purposes of notice and review, Minnesota law also distinguishes transactions based on annual review bands, including transactions involving healthcare entities with average annual revenue between $10 million and $80 million, or transactions projected to result in an entity with average annual revenue within that range once operating at full capacity.[129]

Similarly, New York's law requires the disclosure of "material transactions," which are defined to include mergers with healthcare entities, acquisitions of one or more healthcare entities (including the assignment, sale, or other conveyance of assets, voting securities, membership, or partnership interest or the transfer of control), affiliation agreements, and the formation of partnerships, joint ventures, accountable care organizations, MSOs, or similar entities that contract with health plans, third-party administrators, pharmacy benefit managers, or healthcare providers.[130] These requirements apply to a broad range of healthcare entities, including physician practices, management services organizations, provider-sponsored organizations, and health insurance plans.[131]

New York law also includes a *de minimis* threshold that exempts transactions from the notice requirement that would result in a healthcare entity increasing its total gross in-state revenues by less than $25 million.[132] Financial thresholds like this play an important role in transaction review and will be explored further in the next section on exclusions and exceptions.[133]

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[129] MINN. STAT. § 145D.02(A)(1)–(2) (2025).

[130] N.Y. PUB. HEALTH LAW § 4550(4)(a).

[131] *Id.*

[132] N.Y. PUB. HEALTH LAW § 4550(4)(b).

[133] *See infra* Part II.B.

Other states, such as California, Illinois, Massachusetts, and Oregon, have adopted or proposed laws specifically targeting private-equity-backed healthcare transactions or ownership structures by imposing additional requirements, oversight, or restrictions when hedge funds, private equity firms, or similar investors are involved.[134] As mentioned in Part I.A.2, in California, Assembly Bill 1415 requires private equity groups, hedge funds, and MSOs to file pre-closing notices with the OHCA for major healthcare transactions involving hospitals, physician organizations, or other healthcare providers.[135] Likewise, Illinois introduced an amendment to its Antitrust Act to require AG approval, rather than merely a notice, before healthcare transactions financed by private equity or hedge funds could close.[136] Massachusetts also expanded its healthcare transaction review to include deals involving "significant equity investors,"[137] and Oregon prohibits MSOs and their agents, who are often private equity investors, from owning, controlling, or managing medical practices in ways that affect clinical or operational decisions.[138]

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[134] *See, e.g.*, CAL. ASSEMB. B. 1415, § 4, 2025–2026 Reg. Sess. (Cal. 2025) (amending CAL. HEALTH & SAFETY CODE § 127507(c)(2)(A), (h)); 740 ILL. COMP. STAT. 10/7.2a(d-1) (added by 2025 ILL. S.B. 1998, 104th Gen. Assemb.) (Il. 2025); MASS. GEN. LAWS ch. 6D, § 11 (as amended by 2025 MASS. H.B. 5159) (expanding healthcare transaction review to include deals involving "significant equity investors."); OR. REV. STAT. § 441.510(2)(a) (2023) (as amended by 2025 OR. S.B. 951, enrolled).

[135] CAL. ASSEMB. B. 1415, § 4, 2025–2026 Reg. Sess. (Cal. 2025).

[136] 740 ILL. COMP. STAT. 10/7.2a(d-1) (Il. 2025) (added by 2025 ILL. S.B. 1998, 104th Gen. Assemb.).

[137] MASS. GEN. LAWS ch. 6D, § 11 (2025) (as amended by 2025 MASS. H.B. 5159).

[138] OR. REV. STAT. § 441.510(2)(a) (2025) (as amended by 2025 OR. S.B. 951, enrolled).

Overall, these examples illustrate the states' intention to design their TRLs to capture a broad spectrum of healthcare transactions, specifically targeting what they perceive as high-risk, such as private equity investment, through the application of financial thresholds and "series of transactions rules" to ensure regulatory oversight.[139]

B. *Exclusions and Exceptions*

Despite a tendency towards capturing transactions that may not have historically been through a regulatory review, many TRLs include categories of transactions that are excluded from notice or review requirements if certain conditions are met.

As discussed in Part II.A above, with respect to New York, smaller transactions that fall below specified statutory financial thresholds are generally exempt in many TRLs.[140] For example, in California, OHCA notice is required only if a healthcare entity meets the specified "materiality thresholds": (i) the entity has annual revenue of at least $25 million or owns or controls California assets or at least $25 million; or (ii) the entity has annual revenue of at least $10 million or owner controls California assets of at least $10 million and is a party to, or subject of, a transaction with another entity that satisfies the $25 million threshold or owns or controls an entity that does.[141] Transactions not meeting the above thresholds are not subject to the notice requirement and

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[139] *Comprehensive Consolidation Model Addressing Transaction Oversight, Corporate Practice of Medicine and Transparency*, NAT'L ACAD. FOR STATE HEALTH POL'Y (updated July 26, 2024), https://nashp.org/a-model-act-for-state-oversight-of-proposed-health-care-mergers/

[140] *See, e.g.*, N.Y. PUB. HEALTH LAW § 4550(4)(b) (McKinney 2023) (applying the *de minimis* revenue exclusion).

[141] CAL. CODE REGS. tit. 22, § 97435(b)–(c) (2023).

therefore do not trigger OHCA review. [142]

Similarly, as also previously noted, Minnesota does not require notice for smaller transactions involving entities with annual revenue below $10 million.[143] Some states, like Connecticut, do not have specific thresholds and require notice to the AG only when a transaction results in a "material change" to the business or corporate structure of a group practice.[144] A "material change" can range from the merger, consolidation, or affiliation of a group practice with another practice or hospital system, to the acquisition of all or substantially all assets or equity of a group practice, the employment of all or substantially all of its physicians, or the acquisition of one or more insolvent group practices. [145] Any transaction not included in this definition will not trigger review and is therefore exempt.[146]

Routine provider contracts or internal restructuring that does not result in a change of control are typically excluded from scrutiny under many TRLs. For example, Minnesota expressly excludes corporate restructurings, mortgages or secured loans, affiliations for clinical trials or graduate medical education, employment offers, and contracts to provide clinical services from the definition of "transaction."[147] Thus, such arrangements generally do not trigger advance notice

[142] *Id.* § 97435(a).

[143] MINN. STAT. § 145D.02(4)(b) (2025).

[144] Notice of Material Change, CONN. OFF. HEALTH STRATEGY, https://portal.ct.gov/ohs/programs-and-initiatives/file-or-find-data/notice-of-material-change?language=en_US (last visited Dec. 16, 2025).

[145] *Id.*

[146] *Id.*

[147] MINN. STAT. § 145D.01(1)(k) (2025).

obligations when they do not constitute a change of control of the parties involved.[148] Similarly, Nevada excluded transactions involving business entities that are under common ownership or that have pre-existing contracting relationships established before the statute's effective date from triggering review, effectively carving out routine operations that do not constitute a substantive change in control from the legal definition of a "reportable health care or health carrier transaction."[149]

Certain practitioner-owned or in-state providers may also be exempted. For instance, Indiana law explicitly excludes from reporting obligations healthcare providers that are or will be majority-owned Indiana-licensed healthcare practitioners who routinely furnish healthcare services in the practitioner-owned practice.[150] This means that if the practitioners delivering care hold majority ownership (or will do so after the transaction), the provider is not subject to the 90-day notice requirement for mergers and acquisitions under the applicable statute.[151]

Finally, while non-profit status can sometimes provide relief under specific reporting or review regimes—as is the case in California under the AG's oversight of non-profit hospital mergers, where the agreement or transaction is in the usual and regular course of the non-profit

[148] *See id.* (excluding limited arrangements from the definition of "transaction"); *see also* MINN. STAT. § 145D.01(2) (requiring notice for transactions which meet statutory guidelines, including party control change).

[149] NEV. REV. STAT. § 598A.370(2) (2025).

[150] IND. CODE § 25-1-8.5-2(b) (2025), as amended by H.B. 1666, § 9 (2025); H.B. 1666, § 9 (2025).

[151] IND. CODE § 25-1-8.5-4(a) (West 2026).

activities or if the AG has given the corporation a written waiver—[152] this is not always the case. Non-profit-to-for-profit conversions and dispositions of all or substantially all assets of a non-profit are often captured, as is the case in New York and Massachusetts,[153] as are private-equity-backed transactions, as previously discussed with respect to California, Illinois, Massachusetts, and Oregon.[154]

C. *Notice and Pre-Closing Requirements*

States impose varying notice periods for healthcare transactions, typically ranging from 30 to 180 days.[155] For example, California requires at least a 90-day notice;[156] Connecticut and Oregon require at least 30 days and 180 days, respectively, provided the transaction results in a material change;[157] and Massachusetts sets a 60-day minimum notice period.[158] In Massachusetts, however, the HPC's review process can extend the effective review period well beyond that baseline if the HPC initiates a CMIR, potentially delaying the transaction's closing for up to

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[152] CAL. CORP. CODE § 5914(c) (West 2025).

[153] *See* N.Y. NOT-FOR-PROFIT CORP. LAW § 511-a (McKinney 2024) (demonstrating no exception for not-for-profit hospitals); MASS. GEN. LAWS ch. 180, § 8A(c) (2025) (demonstrating affirmative notice duty for charity hospitals).

[154] CAL. ASSEMB. B. 1415 2025-2026 Reg. Sess. (Ca. 2025) (amending CAL. HEALTH & SAFETY CODE § 127507(c)(2)(A), (h)); Ill. H.B 5000, 104th Gen. Assemb. (Il. 2025) (amending Illinois Antitrust Act 740 ILL. COMP. STAT. 10/7.2a(d-1)); *and* MASS. GEN. LAWS ch. 6D, § 11 (2025).

[155] *See supra* note 58.

[156] CAL. HEALTH & SAFETY CODE § 127507(c)(2)–(3) (West 2025).

[157] CONN. GEN. STAT. § 19a-486i(c) (2024); OR. ADMIN. R. 409-070-0030(2) (2025).

[158] MASS. GEN. LAWS ch. 6D, § 13(a) (2025).

approximately 215 days from the initial notice.[159]

States also differ as to whether pre-closing approval is required or whether a notice-only filing suffices. For example, New Mexico requires pre-closing approval with a 120-day review period, and Minnesota allows for a review period as long as 150 days during which the Attorney General may approve, disapprove, block, or unwind a transaction.[160]

In contrast, notice-only regimes, which do not require explicit approval before closing, exist in states such as New York, with a 30-day pre-closing notice period,[161] and Nevada, which requires a 30-day pre-closing notice for reportable healthcare or health carrier transactions and a separate 60- day post-closing notice for certain hospital and physician group practice

[159] *Material Change Notices and Cost and Market Impact Reviews*, MASS. HEALTH POL'Y COMM'N (2025), https://masshpc.gov/moat/mcn-cmir.

[160] *See* Health Care Consolidation Oversight Act, N.M. HEALTH CARE AUTH. (2025), https://www.hca.nm.gov/health-care-consolidation-oversight-act/ (showing that once a complete notice of a proposed health care transaction is filed, the Authority has a 120-day review deadline to act) and MINN. STAT. § 145D.01(2)(b)–(e), 5(a)–(c) (2025) (establishing a minimum 60-day notice period for material health care transactions, allowing the Attorney General to extend the review period by up to 90 days, and authorizing the Attorney General to seek injunctive or equitable relief, including modification or unwinding of a transaction that violates statutory requirements or threatens the public interest).

[161] N.Y. PUB. HEALTH LAW § 4552(1) (2023) (requiring notice to the Department of Health at least 30 days before closing of a material transaction and forwarding of the notice to the Attorney General).

transactions.[162] The latter means that the transaction may close first, with notice provided after the fact.[163]

D. *Disclosure Requirements*

Many TRLs impose far more in-depth disclosure requirements than existing licensure and CON laws. Before TRLs, existing law focused on pre-approval of certain transactions;[164] however, states recently have enacted laws that emphasize pre-closing transparency through monitoring and disclosure rather than solely focusing on transaction approval.[165] States that have implemented such disclosure requirements provide a comprehensive list of what must be disclosed prior to closing.[166] The required disclosures cover party identification, existing operations, the specifics of

[162] NEV. REV. STAT. § 598A.390 (2024); NEV. REV. STAT. § 439A.126 (2024).

[163] *See* NEV. REV. STAT. § 439A.126 (noting that notice shall be provided no later than 60 days after finalization of the transaction).

[164] *See, e.g.*, N.Y. PUB. HEALTH LAW § 2802-b (2023) (requiring pre-approval and an assessment to determine whether "a project will improve access to hospital services and health care, [or] health equity and reduction of health disparities.").

[165] Act of March 13, 2024, Pub. L. No. 95 (West 2024); N.Y. PUB. HEALTH LAW § 4552; NEV. REV. STAT. § 598A.390; ILL. H.B. 2222, 103d Gen. Assemb., Reg. Sess. (2023).

[166] New York, Nevada, and Illinois require notice 30- day pre-closing, while Indiana requires notice 90 days pre-closing (*see* N.Y. PUB. HEALTH LAW § 4552; NEV. REV. STAT. § 598A.390; ILL. H.B. 2222, 103d Gen. Assemb., Reg. Sess. (2023)).

the material transaction, and all related supporting materials.[167]

The identification disclosure requirements demand that parties provide detailed identifying information.[168] This information usually includes the names, addresses, and ownership interests of all relevant parties in the transaction; however, in some cases states require more detailed disclosures.[169] For example, Nevada requires "the names and specialties *of each practitioner* working for the group practice. . . subject to the transaction,"[170] while California requires parties to submit an organizational chart of the organization of all parties in the transaction.[171] In addition to party identification, many TRLs target disclosure of ownership interests by private equity investors. For example, Indiana, in its definition of "health care entity," includes "private equity partnerships . . . seeking to enter into a merger or acquisition with [another healthcare entity]."[172]

In addition to transaction party identifying information, the disclosure requirements often

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[167] *See, e.g.*, N.Y. PUB. HEALTH LAW § 4552 (requiring, for instance, "[c]opies of any definitive agreements governing the terms of the material transaction, including pre- and post-closing conditions").

[168] *Id.*

[169] *See, e.g.*, NEV. REV. STAT. § 598A.390(1)(c) (requiring detailed disclosures, such as "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….").

[170] *Id. (emphasis added)*.

[171] CAL. CODE REGS. tit. 22, § 97438(c)(6) (2024).

[172] IND. CODE § 25-1-8.5-2(a)(6) (2025).

request operational information.[173] This requirement usually centers on disclosure of the location of operating facilities[174] and the areas served.[175] However, some states will require financial and revenue data.[176] For example, in addition to common operational and location disclosures, New York and Minnesota require parties to share the revenue generated from each location.[177]

States also require parties to disclose transaction-specific information, including a description of the transaction,[178] the purpose of the transaction,[179] and the anticipated effects the transaction may have on health equity, quality, and accessibility.[180] As part of this disclosure requirement, certain states ask for additional information to be included. Illinois and New York

[173] *See infra*, notes 179-182 and accompanying text.

[174] *See* 20 ILL. COMP. STAT. 3960/8.5(a) (2024) (requiring public notice of location in newspapers and notification of local public officials).

[175] *See* NEV. REV. STAT. § 598A.390(1)(f) (mandating disclosure of the "primary service area" to the Attorney General).

[176] MINN. STAT. § 145D.01(2)(a); MINN. STAT. § 145D.02 (b)(3).

[177] N.Y. PUB HEALTH LAW § 4552(1)(c). Entities with a revenue between $10 million and $80 million only need to report revenue for the last three years. *See* MINN. STAT. § 145D.02(b)(3).

[178] *See, e.g.*, 2024 IND. S.B. 9, § 3(b)(4) (requiring notice which describes the nature of the transaction).

[179] ILL. COMP. STAT. 3960/8.5 (2025); NEV. REV. STAT. § 598A.390(1)(a).

[180] *See* N.Y. PUB HEALTH LAW § 4552(f)(i-ii) (requiring that the description of the transaction include "the anticipated impact of the material transaction on cost, quality, access, health equity, and competition in the impacted markets," and any commitments made by the health care entity to address such).

both require parties to submit copies of the agreements governing the transaction.[181] In addition, Illinois requires disclosure of any reports of financial and economic analysis that the party reviewed or relied upon during negotiations.[182]

The TRL disclosure requirements have evolved beyond the traditional CON and licensure requirements by requiring greater transparency on a broader range of information. This expanded scope includes identification and organizational structures, operational and financial information, as well as transaction-specific documentation.[183]

E. *Public Participation and Transparency*

With transparency as a central goal, many TRLs mandate or allow public disclosure of healthcare transactions. Public participation and disclosure often take the form of public comment periods, hearings, and post-closing reporting and monitoring.[184] Some TRLs authorize the reviewing authority to gather information from the public on the transaction.[185] For example, in Oregon, a review board may hold up to two public hearings before deciding on the proposed transaction.[186] Should the reviewing authority hold a public hearing, they must post information

[181] H.B. 2222, 103rd Gen. Assemb., 2023–2024 Sess., § 7.2(2) (Ill.); N.Y. PUB HEALTH LAW § 4552.

[182] H.B. 2222, 103rd Gen. Assemb., 2023–2024 Sess., § 7.2(2) (Ill.).

[183] N.Y. PUB HEALTH LAW § 4552.

[184] *See, e.g.*, OR. ADMIN. R. § 415.501(15) (2025) (providing hearings as a mechanism for public input).

[185] *Id.*

[186] *Id.*

about the hearing and the relevant transaction materials to their website at least 10 days in advance of the hearing.[187] Additionally, the OHA's webpage invites comments from the public on any healthcare transaction in the public health assessment process.[188]

In addition to public hearings and comments, some states publicly disclose information obtained during the review process. For example, Indiana has certain ownership information published annually by the Department of Health[189] and Nevada's Department of Health and Human Services is required to publish an annual report on market transactions.[190] The New York State Department of Health posts information received through the notice process 30 days prior to closing.[191] Such information includes details on the proposed transaction, information about the relevant services and individuals likely to be impacted, and details for individuals to submit comments.[192]

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[187] *Id.*

[188] *See HCMO Transactions and Reviews*, OR. HEALTH AUTH., https://www.oregon.gov/oha/HPA/HP/Pages/HCMO-transaction-notices-and-reviews.aspx (last visited Mar. 3, 2026).

[189] *See* H.B. 1666, 124th Gen. Assemb., Reg. Sess., § 35(a)(2) (Ind. 2025) (requiring, among other things, the publication of information on entities with at least a five percent ownership interest or, if the entity is a practitioner, any interest).

[190] NEV. REV. STAT. § 439A.126 (5)(b) (2025).

[191] N.Y. PUB. HEALTH LAW § 4552(2)(b).

[192] *Id*. § 4552(2)(b)(i)–(iv).

F. *Review and Enforcement*

F.1 Elements of Review

One component of the new TRLs is the grant of review authority to state agencies or the attorney general's office. These entities are given the authority to review proposed transactions prior to closing.[193] When reviewing such transactions, they typically consider a range of factors, including the potential impact on market competition,[194] the accessibility of services by underserved populations[195], and the effects on the healthcare workforce.[196] They may also assess how the transactions can affect beneficiaries of government programs like Medicaid and Medicare,[197] as well as monitoring nonprofit entities to ensure they continue to fulfill their

[193] *See* N.Y. PUB. HEALTH LAW § 4552(1) (exemplifying required notice to the office of the New York attorney general); *see also* H.B. 1460, 2025 Gen. Assemb., Reg. Sess. (Pa. 2025) (referred to Institutional Sustainability & Innovation, June 18, 2025) (providing for approval from the Department of Health and the Office of Attorney General before certain transactions within Pennsylvania).

[194] 740 ILL. COMP. STAT. 10/7.2a; NEV. REV. STAT. §§ 598A.390 et al.; *Material Change Notices and Cost and Market Impact Reviews*, MASS. HEALTH POL'Y COMM'N, https://masshpc.gov/moat/mcn-cmir**;** CAL. CODE REGS. tit. 22, § 97441(a)(1)(C), (H) (2024).

[195] CAL. CODE REGS. tit. 22, § 97441(a)(1)(B); OR. REV. STAT. § 415.501(6), (7)(b) (2023); N.M. STAT. § 59A-63-7(D)(2), (5) (2024) (repealed 2025).

[196] CAL. CODE REGS. tit. 22, § 97441(a)(1)(D); *See Material Change Notices and Cost and Market Impact Reviews*, MASS. HEALTH POL'Y COMM'N, https://masshpc.gov/moat/mcn-cmir; N.M. STAT. § 59A-63-7(D)(3) (2024); MINN. STAT. § 145D.01(5)(9)–(10).

[197] *See* MASS. GEN. LAWS ch. 6D § 13(d)(ix).

charitable purposes.[198]

In some states, a separate agency reviews healthcare transactions and forwards its findings to the AG for potential action, while in others, the AG's office has primary review authority from the outset. Massachusetts illustrates the first model by requiring the parties to a proposed transaction to provide the Health Policy Commission (HPC) with notice of a material change 60 days prior to the date of the transaction.[199] While the HPC does not have the authority to block a transaction, it can notify its findings to the Office of the AG for further action.[200] Alternatively, in Colorado, the statute authorizes the AG's office to review proposed transactions to ensure they do not harm the public.[201]

Some states conduct a CMIR to evaluate proposed material transactions. The review is often conducted by a state agency and assesses how the transaction can affect cost, competition, and public healthcare access.[202] The CMIR may require additional documentation and can

[198] MINN. STAT. § 145D.01(4)-(5).

[199] *Material Change Notices and Cost and Market Impact Reviews*, MASS. HEALTH POL'Y COMM'N, https://masshpc.gov/moat/mcn-cmir (last accessed June 23, 2026).

[200] *See* MASS. GEN. LAWS ch. 6D, § 13(h) (allowing the AG to, upon report referral by the commission, to investigate, report, and, if appropriate, act).

[201] *See* COLO. REV. STAT. § 6-19-403 (2024) (providing certification criteria to include "the transaction shall be in the public interest"); *see also id.* § 407 (giving the attorney general the power to review filings for compliance with § 6-19-403).

[202] *See* Jaromin, *supra* note 47 (identifying relevant agencies for CMIR review); *see also* Markenson et al., *supra* note 83 (identifying factors of CMIR assessment).

potentially delay closing.[203] In California, for instance, the OHCA has 90 days to conduct a CMIR and can extend the period by an additional 30 days if needed.[204] If the OHCA requests further documentation for its review, the timeline is paused until the parties provide the information.[205]

Often, TRLs authorize the reviewing authority or AG to take additional actions beyond mere review. In Illinois[206] and Indiana,[207] the AG's office may open an investigation to seek additional information on the transaction. Some states grant agencies or the attorney general's office the authority to block or condition transactions. In New Mexico, for example, the Office of the Superintendent of Insurance ("OSI") has 120 days after receiving a complete notice of the proposed transaction to either approve the transaction, approve it with conditions, or disapprove it.[208] Similar regimes exist in other states.[209]

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[203] Markenson et al., *supra* note 83.

[204] CAL. CODE REGS. tit. 22, § 97442(a)(1).

[205] *See id.* § 97442(a)(2) (providing an extension to the timeline tolling time periods of review where additional information is necessary for review).

[206] 740 ILL. COMP. STAT. 10/7.2a.

[207] IND. CODE § 25-1-8.5-4(e) (2024).

[208] N.M. CODE R. § 13.2.12.12(A) (LexisNexis 2024).

[209] Oregon's OHA has the authority to approve, approve with conditions, or disapprove a transaction. *Health Care Market Oversight 2024 Annual Report*, OR. HEALTH AUTH. (2025), https://www.oregon.gov/oha/HPA/HP/HCMOPageDocs/HCMO-2024-Annual-Report.pdf.

F.2 Enforcement Mechanisms

While reviewing authorities do not always have the authority to block or condition transactions, they are granted other enforcement mechanisms. Most commonly, state TRLs impose civil penalties and fines for noncompliance by transacting parties. For example, New York imposes a fine of up to $10,000 per day to parties who fail to comply with the notice requirements.[210] Rhode Island currently has a proposed rule which states that the penalty for failing to provide notification for proposed merger transactions is up to $200 per day, starting on the 59th day prior to the date of the transaction and $100,000 after the given date.[211]

In addition to fines, state authorities can conduct investigations when there is a concern about a proposed transaction. For example, if the Massachusetts Health Policy Commission (HPC) alerts the AG about a potential legal violation, the AG's office can investigate or bring a civil action under a consumer protection law (Chapter 93A).[212] Similarly, Nevada authorizes the AG to issue investigative demands when it suspects parties are violating anticompetitive and unlawful activities.[213]

Lastly, most state TRLs allow the AG to bring civil lawsuits to enforce compliance and seek remedies against unauthorized transactions. As mentioned in Part I.A, Minnesota grants the

[210] *See* N.Y. PUB. HEALTH LAW § 12(1)(a)–(c) (McKinney 2025) (providing that civil penalties generally do not exceed $2,000 per violation but allows for increased penalties of up to $5,000 for repeat violators and up to $10,000 when the violation results in serious physical harm to patients).

[211] R.I.C.R. § 110-30-00-5 (proposed), https://rules.sos.ri.gov/Promulgations/part/110-30-00-5.

[212] MASS. GEN. LAWS ch. 6D § 13(h).

[213] NEV. REV. STAT. §§ 598A.060, 598A.100.

AG the authority to bring an action in district court to enjoin, unwind, or seek relief on a transaction.[214] In Colorado, the AG can obtain a temporary restraining order or injunction against the parties for failing to comply with its TRL.[215] Most TRLs do not establish a private right of action and instead limit enforcement actions to government authorities.[216]

III. LEGAL CHALLENGE AND FAILED LEGISLATION

There have not been significant legal challenges or guidance from judicial interpretation related to TRLs. There have been failed legislative efforts in certain states.[217] While the enactment of TRLs in certain states may be a little more than a few years old, the implementation of them is still new.[218] There has been one notable case and certain failed legislative efforts that provide additional context to the landscape.[219] We also discuss what the future might hold for TRLs in Part

[214] MINN. STAT. § 145D.01(5)(a).

[215] COLO. REV. STAT. § 6-19-103(2) (2024).

[216] *See, e.g.*, NEV. REV. STAT. 598A.430 (affirming lack of right to private action).

[217] *See infra* Part III.B.

[218] *See, e.g.*, CAL. ASSEMB. B. 1415, 2025 Reg. Sess. (2025) (enacted); Pa. H.B. 2344, 2023–24 Leg., Reg. Sess. (2024) (engrossed as amended, Printer's No. 3726).

[219] *See Oregon Ass'n of Hosps. & Health Sys. v. Oregon*, No. 24-3770, 2025 WL 1833815, at *1 (9th Cir. July 3, 2025) ("Appellant alleged that Oregon's Health Care Market Oversight law (codified at Ore. Rev. Stat. §§ 415.500-.900 (2025)), is void for vagueness under the Due Process Clause of the Fourteenth Amendment and violates the non-delegation clause of the Oregon constitution."); S.B. 1998, 104th Gen. Assemb. (2025-26) (Ill.) (introduced but not enacted); S.B. 198, 75th Gen. Assemb., Reg. Sess. (Colo. 2025) (postponed indefinitely).

IV below.[220]

A. *Legal Challenge – Oregon Court Upholds OHA's Authority*

In mid-2025, the OHA faced a legal challenge asserting that its hospital merger oversight law was unconstitutionally vague and improperly delegated legislative power.[221] The Ninth Circuit Court of Appeals upheld the law.[222] The case is notable principally for affirming Oregon's authority to implement and enforce the law.[223]

B. *Failed Legislative Efforts*

There are also states that have tried but so far failed to implement a TRL.[224] The common reasons for failure to implement a TRL involve political opposition to increased regulation or some specific concern such as the targeting of private investment funds,[225] industry pushback in

[220] *See infra* Part IV.

[221] *Ass'n of Hospitals & Health Sys.*, 2025 WL 1833815, at *1.

[222] *Id.* at *2.

[223] *Id.*

[224] *See* i*nfra* Appendix A.

[225] *See* Alexandra D. Montague, et al., *Considerations for State-Imposed Conditions on Healthcare Provider Transactions*, FRONTIERS IN PUBLIC HEALTH, Aug. 16, 2023, at 13, https://pmc.ncbi.nlm.nih.gov/articles/PMC10466394/ (explaining conditions for less political opposition).

general,[226] and concerns about transaction delays or the economic impact on transactions.[227] These issues have taken hold in many legislative sessions and created barriers to the implementation of TRLs.

A few states have faced significant resistance when attempting to expand TRLs to expressly cover private equity, MSOs, REITs, or other financial sponsors. California provides a clear example of the consequences of granting overly broad pre-approval authority to the AG. In 2024, Assembly Bill 3129, which would have required private equity groups and hedge funds to provide notice to and obtain consent from the AG before consummating certain healthcare transactions—and would have empowered the AG to approve, deny, or condition such transactions—was vetoed.[228] Following the veto, California continued to regulate healthcare transactions through OHCA, which only required notice of "material change transactions" and

[226] *See id.* at 14 (describing general industry pushback of TRLs).

[227] *See* Ari J. Markenson & Emma Pons Claramunt, *Transaction Review Laws Expand Regulation of Healthcare M&A*, ABA Bus. L. Today (May 2026), https://businesslawtoday.org/2026/05/transaction-review-laws-expand-regulation-healthcare-ma/; *See supra* Note 59 and 230.

[228] CAL. ASSEMB. B. 3129, Reg. Sess. (2023–2024) (vetoed); Letter from Gavin Newsom, Governor of Cal., to Cal. State Assemb., *Veto Message on Assemb. B. 3129*, (Sep. 28, 2024) https://www.gov.ca.gov/wp-content/uploads/2024/09/AB-3129-Veto-Message.pdf (Governor Newsom's veto message for Assembly Bill 3129).

authorized review and referral, but without granting blocking authority to the AG.[229] Subsequent amendments expanded the scope of noticing entities to require filings from private equity groups, MSOs, and other financial sponsors, while preserving OHCA's non-approval role.[230] A similar dynamic took place in Illinois, where proposed legislation Senate Bill 1998 seeking to impose an AG consent requirement for healthcare transactions involving private equity or hedge fund financing was introduced, but failed to advance.[231]

Efforts to expand TRLs beyond private-equity-focused reforms also resulted in legislative failure. In Colorado, for example, Senate Bill 25-198—which ultimately failed and was postponed indefinitely—sought to repeal and reenact Colo. Rev. Stat. § 6-19 to expand its scope well beyond hospitals.[232] The bill also provided an expansive definition of "material transactions," authorized the AG to assess public interest impacts to flag transactions for review, imposed extensive notice requirements for transactions involving entities with more than $80 million in annual revenue, and required annual post-closing reporting for at least five years.[233] Similarly, Pennsylvania House Bill 2344, which ultimately stalled, would have prohibited a person from entering into a transaction with a health system or provider organization involving a material change deemed contrary to the

[229] *Id.*; CAL. HEALTH & SAFETY CODE §§ 127245–47 (West 2025); *Public overview of OHCA material change transaction notice regime,* https://hcai.ca.gov/affordability/ohca/assess-market-consolidation/material-change-transaction-notices-mcn-and-cost-and-market-impact-review-cmir/.

[230] CAL. ASSEMB. B. 1415, Reg. Sess. (2025) (enacted).

[231] *See* S.B. 1998, 104th Gen. Assemb. (2025–26) (Ill.) (introduced but not enacted).

[232] S.B. 25-198, 75th Gen. Assemb., Reg. Sess. (Colo. 2025) (postponed indefinitely).

[233] *Id.*

public interest, unless the required notification to the AG had occurred.[234]

Other states have pursued similar legislative efforts. Texas House Bill 2747 would have required healthcare entities to provide the AG with at least 90 days' advance written notice of any material change transaction, broadly defined to include mergers, acquisitions, control changes, joint ventures, or management services arrangements, and explicitly capturing MSOs and other nontraditional healthcare entities; the bill, however, did not advance past committee.[235] Washington Senate Bill 5241 proposed similar notice requirements, with a 120-day advance notification period, and included substantive standards requiring that transactions preserve accessible and affordable care.[236] Vermont House Bill 71 similarly aimed to subject private-equity-backed transactions to pre-transaction review and public-interest assessment by the AG.[237] Wisconsin Assembly Bill 50 would have imposed a 180-day pre-closing notice for material change transactions and granted the AG authority to evaluate their impact on competition, access, and affordability.[238]

Overall, efforts to expand or implement TRLs across states seem to frequently encounter similar legislative obstacles, particularly when proposals target private equity, MSOs, broadly redefine material transactions, or expand AG powers or pre-approval requirements. Thus, these

[234] H.B. 2344, 2023–24 Leg., Reg. Sess. (Pa. 2024) (Engrossed as Amended, Printer's No. 3503), § 802-C(a) (prohibiting agreements or transactions involving a material change that are against the public interest unless notification is complied with).

[235] H.B. 2747, 89th Leg., Reg. Sess. (Tex. 2025) (introduced; adjourned sine die).

[236] S.B. 5241, 68th Leg., Reg. Sess. (Wash. 2024) (introduced).

[237] H.B. 71, 2025–26 Leg., Reg. Sess. (Vt. 2025) (introduced).

[238] WIS. ASSEMB. B. 50, 105th Leg., Reg. Sess. (2025) (proposed).

proposals present challenges in protecting the public interest while maintaining a balanced approach to regulatory oversight.

THE FUTURE

The continued enactment by states of new TRLs, along with new TRL proposals, clearly indicates a trend in state health policy. States are moving aggressively toward stronger oversight and regulation. There is an expectation that an increasing number of states will adopt similar TRLs, expanding oversight beyond the existing regulatory framework. While industry may bristle at new and significant regulation, there is an overall trend pursued by consumers, consumer advocates, regulators, and health policy experts to address major issues in our healthcare system. These major issues include cost, access, health equity, and many others. TRLs are designed to address those issues at least in the context of healthcare transactions.

There is also a trend in incremental changes to TRLs by adding new requirements, changing the types of transactions covered, and revising review elements. As an example, Massachusetts has a current bill[239] designed to add elements to its existing TRL that would restrain private investment funds that own or control healthcare providers from causing them financial distress. The bill also targets certain business practices of MSOs and expands the definition of provider organizations to include MSOs and providers that are controlled by for-profit entities. Massachusetts is also considering a bill[240] relating to physician practices that requires filing registrations and additional disclosure information with a biennial renewal application requirement. Moreover, there is a notice requirement to the Massachusetts Department of Public Health at least 180-days prior to a sale,

[239] S.B. 868 (Mass. 2025).

[240] H.B. 2478 (Mass. 2025).

relocation, or closure of a registered practice.

The industry appears to expect that these initiatives will continue to advance. However, like approaches it has already pursued, states will see industry opposition to new regulation or certain types of TRL requirements that appear overly burdensome. The healthcare industry, and particularly investors, will want to ensure that the emerging regulatory landscape does not disrupt existing business models, especially among entities heavily reliant on private investment or complex ownership structures.

For transacting parties, these laws introduce significant practical implications, leading to longer and more uncertain transaction timelines, increased costs, and new levels of transparency through public disclosure of sensitive information. The patchwork of state-specific requirements creates multi-jurisdictional complexity, necessitating careful coordination and potentially impacting deal structure and strategic decision-making.

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The authors would also like to acknowledge the editing contributions of Gabrielle Danziesen, J.D., Associate at Venable LLP, to the matrix of TRLs found in Appendix A.

APPENDIX A

MATRIX OF STATE TRLS, OPEN LEGISLATION, AND FAILED BILLS

State	Statutory and Regulatory Citations	Agency	Notice or Pre-Closing Approval	Triggers for Review	Exceptions/ Exclusions
California (Enacted)	Cal. Health & Safety Code § 127500 et seq.; Cal. Corp. Code § 14700; 22 Cal. Code Regs. § 97431 et seq.	Office of Health Care Affordability (OHCA); California Attorney General (AG)	Health care transactions: 90-day pre-closing notice; OHCA may waive or conduct CMIR within 45–60 days respectively, which may extend the process for several months Retail grocery/drug acquisitions: 180-day pre-closing notice to California AG; California AG may temporarily enjoin transaction.	Healthcare entities proposing "material change transactions." Retail grocery or drug firm acquisitions that are reportable under the Hart-Scott-Rodino Act or involve the acquisition of more than 20 retail grocery or retail drug firm locations. Covered health care entities meeting applicable revenue or asset thresholds, including transactions involving transfers of control or governance, formation of new entities, affiliations, or a series of related transactions treated as a single transaction. Thresholds: (i) annual revenue ≥ $25 million or owns or controls California assets ≥ $25 million; or (ii) annual revenue ≥ $10 million, or owns or controls California assets ≥ $10 million, and is party to, or the subject of, a transaction with another entity that meets the $25 million threshold or owns or controls an entity that does.	Transactions involving entities already under common control, including internal corporate restructurings or transactions in the usual and regular course of business. Entities or transactions that do not meet the applicable revenue or thresholds.
California (Enacted)	2025 Cal. Stat. ch. 641 (enacted by A.B. 1415 (effective Jan. 1, 2026)).	OHCA; California AG	Expands OHCA review to transactions involving private equity groups, hedge funds, MSOs, and other entities that own, control or	Pre-closing notice required for most sales, acquisitions, and other transactions involving health care entities or MSOs, including transactions involving financial	Notice requirement does not apply to transactions already subject to regulatory review or oversight, including healthcare service plans reviewed by DMHC

State	Statutory and Regulatory Citations	Agency	Notice or Pre-Closing Approval	Triggers for Review	Exceptions/ Exclusions
			operate healthcare providers. Pre-closing notice required for most sales, acquisitions and other transactions. California AG may exercise enforcement authority, including seeking injunctive relief, as provided by applicable law.	sponsors, private equity, hedge funds, or newly formed entities created to transact with such entities.	under the Knox-Keene Act, health insurers reviewed by the Insurance Commissioner, county acquisitions to maintain local access, and nonprofit corporations reviewed by the California AG.
Colorado (Enacted)	Colo. Rev. Stat. § 6-19-101 et seq. (2024).	Colorado AG	Notice of a covered hospital transaction must be filed at least 60 days prior to closing.	Transactions involving hospitals, including: Disposition of ≥50% of hospital assets (or assets of a parent/holding company). Series of related transactions within 5 years. Transactions from nonprofit to nonprofit (subject to charitable purpose requirements). Transactions between for-profit entities. Transfer of assets from nonprofit hospitals to for-profit entities (that require additional certifications.	Transactions that do not meet the definition of a covered transaction, such as smaller transactions below the 50% asset/control threshold, routine provider contracts, or transfers that do not involve hospital assets.
Connecticut (Enacted)	Conn. Gen. Stat. § 19a-486i (2024).	Connecticut AG; Commissioner of Health Strategy	30-day pre-closing notice required for material change transactions. Connecticut AG or Commissioner may open a deeper inquiry or seek to postpone closing.	Transactions involving: Group practice mergers, consolidations, or other affiliations. Group practice and hospital or hospital system mergers, consolidations, or other affiliations.	Transactions that fall below the statutory thresholds or otherwise do not meet the definition of a material change transaction—such as smaller transactions.

State	Statutory and Regulatory Citations	Agency	Notice or Pre-Closing Approval	Triggers for Review	Exceptions/ Exclusions
			Reviews may extend up to or beyond 200 days.	Acquisition of substantially all assets or capital stock of a group practice or hospital. Employment or acquisition of substantially all physicians (>8) of a group practice. Acquisition of insolvent group practices.	
Illinois (Enacted)	740 Ill. Comp. Stat. 10/7.2a; Pub. Act No. 103-0526 (Ill. 2023) (effective Jan. 1, 2024, repealed Jan. 1, 2027).	Illinois A G Health Facilities and Services Review Board	30-day pre-closing notice. Illinois AG may request additional information and investigate potential anti-competitive effects.	Mergers, acquisitions, and contracting affiliations between healthcare facilities or provider organizations, including out-of-state entities with significant revenue in Illinois.	Not explicitly stated. Smaller transactions that do not meet the statutory definition are implicitly outside the requirement.
Illinois (Enacted)	20 Ill. Comp. Stat. 3960/8.5; Pub. Act No. 103-0526 (Ill. 2023).	Health Facilities and Services Review Board	Require submission to the Health Facilities and Services Review Board with a signed certification (including charity care commitments) and must be publicly noticed. A 90-day post-closing certification confirming the transaction must also be submitted.	Change of ownership of hospitals.	Not explicitly stated. All hospitals undergoing a change of ownership are covered.
Indiana (Enacted)	Ind. Code §§ 25-1-8.5-1 to -4; 2025 Ind. Laws Pub. L. 239; 2024 Ind. Pub. L. 95; H.B. 1666, 129th Gen. Assemb., Reg. Sess. (Ind. 2025)	Indiana A G; Indiana Department of Health	90-day pre-closing notice. AG may analyze antitrust concerns in writing or issue civil investigative demands.	Mergers or acquisitions of healthcare entities of total assets ≥ $10 million, including medical/dental providers, insurers, administrators, and private equity partnerships.	Excludes healthcare providers majority-owned by licensed Indiana practitioners who routinely provide services in-state.

State	Statutory and Regulatory Citations	Agency	Notice or Pre-Closing Approval	Triggers for Review	Exceptions/ Exclusions
Massachusetts (Enacted)	Mass. Gen. Laws ch. 6D, § 13; 958 Mass. Code Regs. § 7.00; Mass. H. 5159, 193rd Gen. Court (2024), ch. 343.	Massachusetts AG; Center for Health Information and Analysis; Health Policy Commission (HPC)	60-day pre-closing notice. HPC may initiate CMIR, potentially delaying closing up to 215 days. Massachusetts AG may collect information from private equity investors and investigate institutional providers.	Healthcare service providers and organizations with >$25 million annual revenue; material change transactions; transactions involving private equity firms, REITs, private equity-backed MSOs; change of ownership or control; significant asset acquisitions/sales including real estate; and nonprofit-to-profit conversions. The above includes any transaction where a Significant equity investor" acquires or controls a material interest in a provider or organization, giving the ability to influence governance, management, or strategic direction. *See definition of "Significant equity investor" at Mass. Gen. Laws ch. 6D, § 11	Not explicitly stated.
Minnesota (Enacted)	Minn. Stat. §§ 145D.01 –.11, 145D.32; see also Minn. Dep't of Health & Minn. Att'y Gen. guidance.	Minnesota Department of Health (MDH); Minnesota AG	Large entities (≥ $80 million avg revenue): 60 days' notice to Minnesota AG & MDH; Minnesota AG can block, enjoin, or unwind transactions. Mid-size entities ($10 million – $80 million): 30-day notice to MDH only, or within 10 business days if closing is anticipated sooner than 30 days. Entities <$10 million avg	Transactions involving: Mergers, transfers of ownership, or creation of new healthcare entities that result in a "material change" Change in control of governance. Management or revenue-sharing arrangements. Applies if any party is formed/licensed in Minnesota or part of transaction occurs in Minnesota	Entities under $10M avg revenue. Minnesota AG may waive notice/waiting period. Internal restructurings that do not involve a change in control or ownership may be excluded. Routine provider contracts or small practice integrations are generally excluded.

State	Statutory and Regulatory Citations	Agency	Notice or Pre-Closing Approval	Triggers for Review	Exceptions/ Exclusions
			revenue: no notice requirement.	Expands the state's longstanding AG oversight of nonprofit hospital conversions to also cover for-profit and investor-backed entities.	
Nevada (Enacted)	Nev. Rev. Stat. §§ 598A.06 0, 598A.100, 598A.390 et seq.; Nev. Rev. Stat. § 439A.126.	Nevada A G; Nevada Department of Health and Human Services (DHHS)	Nevada AG (AB 47): Notice at least 30 days prior to consummation of "reportable health care or health carrier transactions." DHHS (SB 329): Notice within 60 days after the transaction or execution of the management agreement for certain hospital or "significant" physician group practice transactions. No state approval authority: AG and DHHS may investigate violations or monitor compliance but cannot block or approve transactions.	Covered transactions include: Any transaction that materially changes the business or corporate structure of a group practice or health carrier. Transactions that result in the group practice or health carrier providing ≥50% of a healthcare service (or health carrier service) within a defined geographic market. Mergers, acquisitions, joint ventures, management contracts, or acquisition of physician group practice or its assets. Employment of all or substantially all physicians in a group practice for "significant physician group practices." A "significant physician group practice" is defined as ≥20% of physicians of a specialty in a primary service area, or the largest of involved practices in the transaction.	Transactions involving business entities under common ownership. Contracting relationships established prior to October 1, 2021. Hart-Scott-Rodino (HSR) filings may satisfy the Nevada AG notice requirement.
New Mexico (Enacted)	N.M. Stat. Ann. §§ 24A-9-1 to -24 (Health Care Consolidation Oversight Act).	New Mexico Health Care Authority (HCA)	Pre-closing notice required. Notice must be submitted to HCA prior to	Transactions involving: Transfers of control of hospitals.	No statutory exemptions are explicitly provided.

State	Statutory and Regulatory Citations	Agency	Notice or Pre-Closing Approval	Triggers for Review	Exceptions/ Exclusions
			consummation of the transaction. Upon receiving a complete notice, HCA must approve, approve with conditions, or disapprove the transaction within 120 days.	Acquisition of an independent healthcare practice by a provider organization (e.g., physician organization or provider network) that is owned or affiliated with a health insurer.	
New York (Enacted)	N.Y. Pub. Health Law § 4550 et seq., art. 45-A; N.Y. Not-For-Profit Corp. Law § 511-a (McKinney 2024) -non-profit to profit conversions.	New York State Department of Health (DOH); New York AG; other relevant bureaus (health care, charities, antitrust)	30-day pre-closing notice required for transactions resulting in $25 million+ increase in gross in-state revenue; no statutory pre-closing approval is required	Transactions by healthcare entities including: Physician practices, physician groups, MSOs. Transfers of assets, equity, or change in control. In-state revenues ≥ $25 million.	Smaller transactions below thresholds; internal reorganizations with no change in control; routine provider contracts.
Oregon (Enacted)	Or. Rev. Stat. §§ 415.500 et seq.; OAR 409-070-0000 to -0085.	Oregon Health Authority (OHA)	At least 180-day pre-closing notice required. Review: OHA conducts a 30-day preliminary review after a complete filing and may approve, approve with conditions, or initiate a comprehensive review (up to 180 days).	Material health care transactions affecting cost, equity, access, or quality of care. Includes large provider organizations, hospitals, and health systems. Applies if one party had average annual revenue of ≥ $25 million over the preceding three fiscal years and another party had average annual revenue of ≥ $10 million over the preceding three fiscal years (or, if newly organized, is projected to have ≥ $10 million in its first full year of revenue).	Material change review under Oregon's Health Care Market Oversight Program does not apply to certain excluded transactions—such as clinical affiliations for research/education, specified medical services contracts, affiliations that do not alter governance or control, limited-service contracts where operational control remains with the provider, certain health center arrangements, and changes that do not affect ultimate ownership. Market-share thresholds may limit review for out-of-state entities with

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					minimal Oregon presence.
Vermont (Enacted)	18 Vt. Stat. Ann. §§ 9405c, 9420 (2026).	Green Mountain Care Board; Vermont AG	Pre-closing approval required for nonprofit hospital conversions; notice required for hospital acquisitions of medical practices (≥ 90 days prior or as soon as practicable).	Conversion of a "qualifying amount" of nonprofit hospital assets or operations (≥ $1 million and ≥ 40 % of value, or that vests control). Hospital acquisition of a medical practice by which the hospital will own or control the practice.	Ordinary course transactions, including management, vendor, or physician contracts; and conversions to another nonprofit corporation (do not require § 9420 approval, though notice to or waiver from the Vermont AG may still apply).
Washing ton (Enacted)	Wash. Rev. Code §§ 19.390.030, 19.390.060 (2026)	Washington State AG	Notice required at least 60 days prior to closing for hospitals, hospital systems, and provider organizations. Filing a copy of any federal HSR form with the Washinton State AG satisfies the notice requirement.	Material transactions involving in-state entities or out-of-state entities that generate $10 million or more in health care services revenue from patients residing in Washington state.	Transactions conducted in the ordinary course of business, or minor affiliations that do not constitute a material change. 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.
Massachusetts (Proposed)	S.D. 1910, 194th Gen. Ct. (Mass. 2025-2026) (pending). H.D. 3147, 194th Gen. Ct. (Mass. 2025-2026) (pending). H.D. 4028, 194th Gen. Ct. (Mass. 2025-2026)	Massachusetts HPC; Massachusetts AG; Department of Public Health (DPH)	180-day notice to DPH and 90-day notice to patients for clinic or large physician practice sale/closure. DPH may hold public hearing. 60-day notice for transactions that	Proposed expansions to material change review: new clinic/ambulatory surgery center license applications, satellite facilities, private equity acquisitions, MSO transactions, and large physician practice sales or relocations.	MSO restrictions: cannot interfere with clinical decisions or restrict stock transfers.

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	(pending).		constitute a material change. HPC may conduct CMIR and refer report to Massachusetts AG.		
Pennsylvania (Proposed)	S.B. 708, 2025-2026 Reg. Sess. (Pa. 2025) (pending).	Pennsylvania AG	Pre-closing notice required. 45-day waiting period. Pennsylvania AG may request information, hold public hearings, or determine transaction is against public interest, and enjoin.	Transactions involving a health system, provider organization, or healthcare facility.	Does not apply to physician or psychiatric practices; exceptions where closure or loss of services is unavoidable.
Pennsylvania (Proposed)	HB 1371, 2025-2026 Reg. Sess. (Pa. 2025) (pending).	Pennsylvania AG	Pre-merger notice (waiting period not explicitly specified). Pennsylvania AG may investigate antitrust concerns.	Transactions involving two or more healthcare facilities, health systems, or provider organizations.	N/A
Pennsylvania (Proposed)	S.B. 322, 2025-2026 Reg. Sess. (Pa. 2025) (pending).	Pennsylvania AG	Pre-closing notice. 90-day waiting period (extendable 30 days). Pennsylvania AG may request information, hold hearings, or enjoin.	Transactions involving a healthcare entity and a for-profit or private equity entity seeking control.	N/A
Pennsylvania (Proposed)	H.B. 1460, 2025-2026 Reg. Sess. (Pa. 2025) (pending).	Pennsylvania AG	Pre-closing notice. 60-day waiting period (extendable 30 days). Pennsylvania AG may request information, hold hearings, or enjoin.	Transactions involving a healthcare entity controlling one or more facilities and a for-profit or private equity entity.	N/A

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New York (Proposed)	A. 9042, 2025-2026 Legis. (N.Y. 2025) (pending).	New York Department of Agriculture and Markets; New York AG	Pre-closing notice within 14 days for sales, mergers, or acquisitions ≥ $200,000; New York AG has 90 days to review and may block transaction.	Material transactions involving veterinary clinics.	N/A
Rhode Island (Proposed Rule)	110-RICR-30-00-5 (Proposed 2025) – Pre-Merger Notification Rule for Medical-Practice Groups	Rhode Island AG	Proposed pre-merger notice required to the AG; AG may review the transaction prior to closing	Mergers, acquisitions, or ownership/control changes of medical-practice groups in Rhode Island.	Not specified in proposed rule.
California (Failed)	AB 3129, 2023-2024 Legis. (Cal. 2024) (vetoed Sept. 28, 2024). AB 1091, 2023-2024 Legis. (Cal. 2023) (failed Feb. 1, 2024).	OHCA; California AG	AB 3129: 90-day pre-closing notice and AG consent for change of control/acquisition of healthcare facilities or provider groups. AB 1091: pre-closing notice and AG approval for transactions ≥ $15 million.	AB 3129: private equity/hedge fund acquisitions of providers. AB 1091: material change transactions ≥ $15 million.	AB 3129: restrictions on control/interference with physician, psychiatric, and dental practices.
Colorado (Failed)	SB 25-198, 75th Gen. Assemb. (Colo. 2025) (postponed indefinitely Apr. 17, 2025).	Colorado AG	Proposed 60-day pre-closing notice for broad array of healthcare transactions. Colorado AG could assess public interest, flag transactions for review, and required annual post-closing reporting for 5 years.	Would have applied to healthcare entities (hospitals, medical/dental professional service corporations, provider networks), long-term care entities, and veterinary care entities.	N/A
Connecticut (Failed)	H.B. 5319; S.B. 261; S.B. 567; S.B. 469; S.B. 837; H.B. 6570; H.B. 6873; S.B. 1507;	Office of Health Strategies; Connecticut AG	Would have required notice (30– 60 days) or, would have granted AG authority to	Proposed expansions to cover: Private equity ownership of hospitals, group practices, radiology groups, rehab	N/A

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	S.B. 1480 (2024–25 sessions).		condition transactions.	facilities, nursing homes. MSOs, ACOs, PBMs, insurers. REITs. Disclosure requirements on ownership structures.	
Illinois (Failed)	SB 1998, 103rd Gen. Assemb. (Ill. 2023-24) (failed Jan. 7, 2025).	Illinois AG	Proposed requirement for AG consent for transactions involving private equity or hedge fund financing.	Proposed amendments to cover private equity or hedge fund-backed transactions.	N/A
Texas (Failed)	H.B. 2747, 89th Leg., Reg. Sess. (Tex. 2025) (failed to enact).	Texas AG	**90-day pre-closing notice** proposed. No AG "approval" required; only notice.	"Material change transactions" by healthcare facilities, provider organizations, and MSOs/DSOs with ≥ $5 million gross annual revenue.	N/A
Texas (Failed)	S.B. 1595, 89th Leg., Reg. Sess. (Tex. 2025) (failed to enact).	Texas Secretary of State	Proposed annual + transactional reporting, not pre-closing approval.	Health care entities with ≥ $10 million assets or revenue executing "material change transactions."	N/A
Florida (Failed)	H.B. 1219, 2021 Reg. Sess. (Fla. 2021) (failed to enact); S.B. 1064, 2021 Reg. Sess. (Fla. 2021) (failed to enact).	State AG's Office (would have been the receiving agency)	Proposed **90-day pre-closing notice** for health care entities undergoing "material change" transactions.	Transactions involving healthcare entities (facilities, providers, etc.) experiencing "merger, acquisition, or other material change.	N/A
Maine (Failed)	H.B. 1316, 131st Leg., 1st Reg. Sess. (Me. 2023) (failed to enact). H.B. 894, 131st Leg., 1st Reg. Sess. (Me. 2023) (failed to enact).	Maine Department of Health and Human Services; Office of Affordable Health Care; Maine AG	Proposed 180-day pre-closing notice for covered material change transactions; Department would have 60 days to approve, approve with conditions, or initiate comprehensive review.	Material change transactions involving healthcare providers, provider organizations, or facilities with > $10 million in total assets or annual revenue.	Smaller entities below $10 million excluded under proposal; some exemptions likely for non-facility providers.

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Minnesota (Failed)	S.F. 2939, 94th Leg. (Minn. 2025-2026) (failed to enact). S.F. 2972, 94th Leg. (Minn. 2025-2026) (failed to enact). S.F. 3354, 94th Leg. (Minn. 2025-2026) (failed to enact). H.F. 4206, 94th Leg. (Minn. 2025-2026) (failed to enact). H.F. 2771, 94th Leg. (Minn. 2025-2026) (failed to enact).	MDH; Minnesota AG	Proposed 120-day pre-closing notice for transactions involving a for-profit entity's acquisition of a nonprofit nursing home or assisted living facility. Proposed pre-closing notice and approval for private equity acquisitions.	Acquisitions/control changes in nonprofit nursing homes, assisted living, clinics, hospitals, ambulatory surgical centers, dental orgs, physician orgs; PE/REIT acquisitions or increases in ownership/operational/ financial control; reporting by health care facilities/providers/ insurers/PBMs.	Smaller transactions not explicitly covered. Exemptions for transactions already reported under current law.
New Mexico (Failed)	S.B. 14, 57th Leg., Reg. Sess. (N.M. 2025) (failed to enact).	New Mexico Office of Superintendent of Insurance	Proposed 60-day pre-closing notice; preliminary review within 60 days; potential comprehensive review with approval, conditional approval, or disapproval.	Hospitals, healthcare providers, and provider organizations.	N/A
New York (Failed)	FY 2026 N.Y. Exec. Budget, HMH Article VII Legis., Part S (2025).	New York Department of Health	Proposed 60-day pre-closing notice; preliminary review; optional 180-day cost and market impact review.	All health care transactions currently subject to notice-only requirement.	N/A
North Carolina (Failed)	S.B. 16, 2023 Gen. Assemb. (N.C. 2023) (failed to enact). H.B. 737, 2023 Gen. Assemb. (N.C. 2023) (failed to enact).	North Carolina Department of Health and Human Services; AG's Office for certain transactions	Proposed notice required prior to closing; law allows for possible pre-closing review with waiting period.	Transactions involving hospitals, providers, or other healthcare entities meeting thresholds for revenue, assets, or impact; includes mergers, affiliations, change of control.	Smaller entities/de minimis transactions; parties may be exempt if below thresholds.
Pennsylvania (Failed)	H.B. 2344, 2023-2024 Reg. Sess. (Pa. 2023) (failed to enact).	Pennsylvania AG	Proposed 45-day pre-closing notice.	Transactions causing material change to health care facility agreements; prohibited	N/A

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			AG may extend review.	unless notice to AG occurred.	
Pennsylvania (Failed)	H.B. 2012, 2023-2024 Reg. Sess. (Pa. 2023) (failed to enact).	Pennsylvania AG	Proposed 120-day pre-closing notice. AG may extend review.	Mergers, acquisitions, or contracting affiliations between Pennsylvania entities and out-of-state entities generating ≥ $10 million revenue in Pennsylvania.	N/A
Pennsylvania (Failed)	S.B. 548, 2023-2024 Reg. Sess. (Pa. 2023) (failed to enact).	Pennsylvania AG	Proposed 90-day pre-closing notice (extendable 30 days).	Provider organizations and for-profit entities owning/operating hospitals, hospice agencies, or nursing homes.	N/A
Vermont (Failed)	Proposed H.71 (2025) — Health Care Transaction Review Law (did not pass)	Green Mountain Care Board; Vermont AG	Proposed 180-day pre-closing notice to Board and AG; Board in consultation with AG could approve, conditionally approve, or commence comprehensive review.	Material change transactions involving healthcare entities. Comprehensive review would have been required for transactions resulting in transfer of assets >$1 million.	Not enacted, so exemptions never codified. Draft legislation included reporting requirements for private equity ownership and restrictions on friendly physician/MSO arrangements.
Washing ton (Failed)	S.B. 5241, 68th Leg., Reg. Sess. (Wash. 2023-2024) (failed to enact). H.B. 1072, 69th Leg., Reg. Sess. (Wash. 2025-2026) (failed to enact). H.B. 1881, 69th Leg., Reg. Sess. (Wash. 2025-2026) (failed to enact). S.B. 5704, 69th Leg., Reg. Sess. (Wash. 2024-2026) (failed to enact).	Washington State AG; Washington Department of Health (H.B. 1072)	Proposed 60–120-day pre-closing notice depending on bill; preliminary and comprehensive review; expedited review; confidentiality requests	Expanded material transactions to hospitals, providers, provider organizations, health care service contractors, HMOs, issuers, insurance holding company systems, or any entity controlling/parenting a healthcare provider; included "protected health services" for H.B. 1072.	Not enacted; proposed rules on expanded entities, protected health services, and notice length never became law.

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Wisconsin (Failed)	A.B. 50, 2025-2026 Leg., Reg. Sess. (Wis. 2025) (failed to enact).	Wisconsin Department of Health Services (DHS)	Proposed 180-day pre-closing notice to DHS; DHS would have 30 days for preliminary review, after which it could approve, approve with conditions, or initiate a comprehensive review.	Material change transactions involving healthcare entities. Comprehensive review would have been automatic for transactions resulting in transfer of assets >$20 million.	Not enacted; draft legislation contemplated thresholds for smaller entities and additional reporting carve-outs.