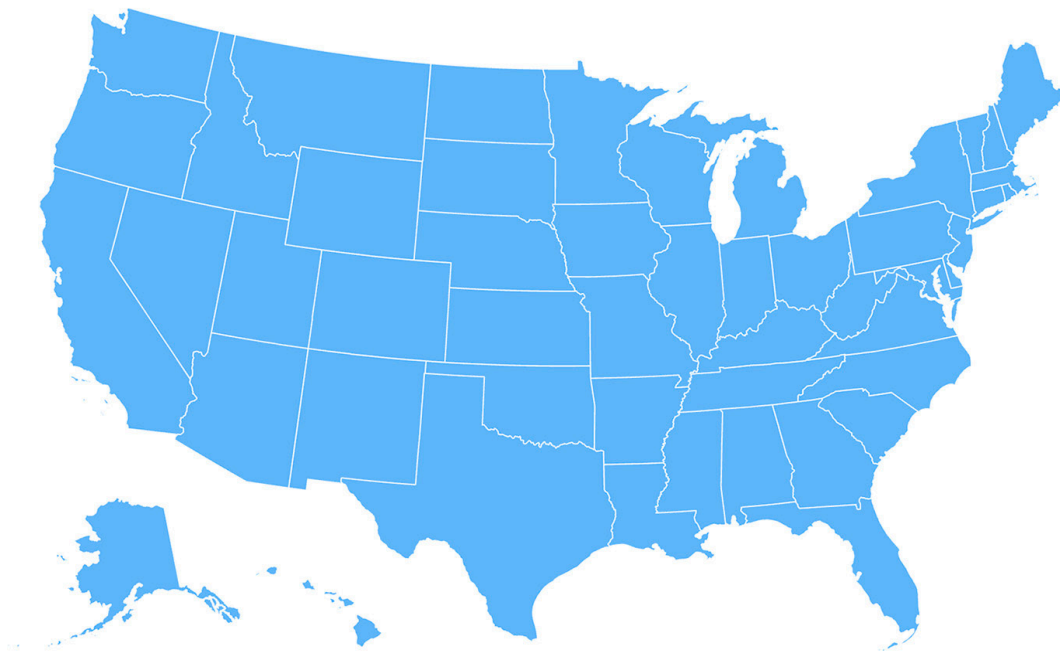


THE SOURCE

ON HEALTHCARE PRICE & COMPETITION

STATE LEGISLATIVE UPDATE



March 2026

THE SOURCE

ON HEALTHCARE PRICE & COMPETITION

MARCH 2026

The Source's State Update gives a snapshot of key legislation we are currently monitoring. Every item represents a proposed state action that we feel could potentially be relevant to healthcare price and competition. The Update is published four times a year, and items will carry over from previous Updates if they are still being considered. New items from the previous Update, and any changes with existing items, will be highlighted in **bold**.

Throughout the document the following acronyms may be used:

AG - Attorney General

ASC - Ambulatory Surgery Center

DOJ - Department of Justice

FTC - Federal Trade Commission

PBM - Pharmacy Benefit Manager

TPA - Third Party Administrator

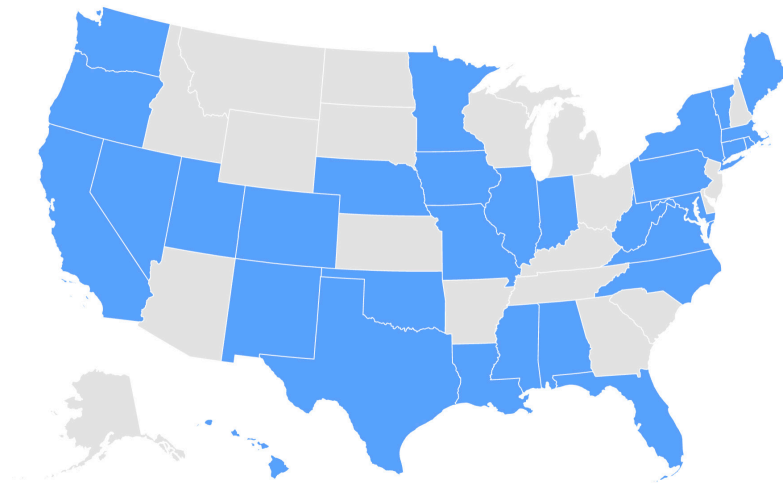
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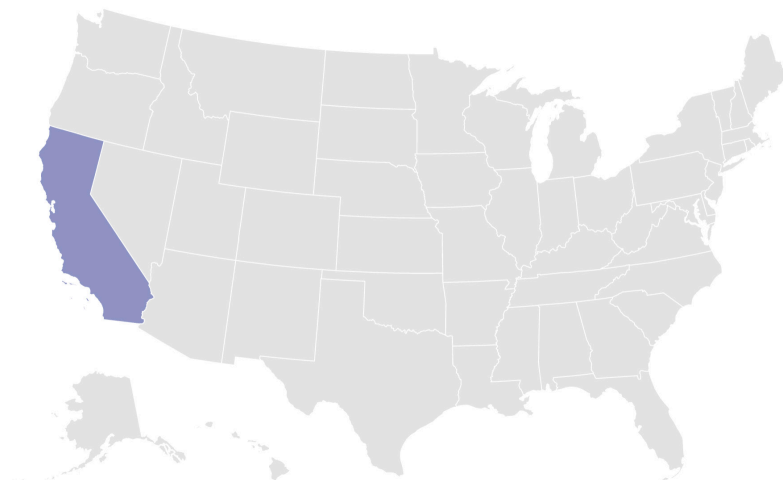
SECTION 1: ANTITRUST AND MERGER REVIEW

Below is a listing of legislation we are monitoring related to healthcare antitrust and merger review. Recent evidence demonstrates that provider and insurer markets in the United States have been highly concentrated for years and have led to increased healthcare prices and insurance premiums without a commensurate increase in quality. [Click here](#) for more information on this topic.

2026 States Considering Antitrust and Merger Review Legislation














2026 States Enacting Antitrust and Merger Review Legislation



Merger Review and Approval

In Process

-  **Colorado** - [SB041](#) allows the Attorney General to review mergers and acquisitions of health-care entities (including hospitals, urgent care facilities, ambulance services, pharmacies, and other licensed medical providers). These material change transactions require 60 days' notice to the AG, and prohibits transactions that could substantially reduce competition, create a monopoly, or harm consumer welfare. It also allows the AG to challenge transactions involving nonprofit hospitals if they would materially alter these missions or lead to the transfer of charitable assets out of state.
-  **Hawaii** - [SB3175](#) requires healthcare entities to provide 180 days' notice before mergers, acquisitions, or other consolidation, including information on market share, pricing, and impacts on access to care. The state would then review to see if the transaction is in the public interest. For vertical transactions, where entities at different levels of the healthcare supply chain merge, legislative approval would be required if the combined entity would control at least 25% of a market and would be expected to significantly increase prices or premiums.
-  **Illinois** - [SB1998](#) would require healthcare facilities or provider organizations to notify the AG at least 30 days before any mergers or new affiliations. The bill adds that the AG must provide written consent if a private equity group is providing financing for the transaction. The AG would be given power to investigate the transaction.
-  **Massachusetts** - [H1355](#) would expand the Health Policy Commission's authority to review and potentially block mergers, acquisitions, and expansions by healthcare organizations. Entities that have exceeded cost growth benchmarks would be required to file performance improvement plans. Previously approved material changes would be reviewed annually to determine if lower costs and improved quality have been achieved.
-  **North Carolina** - [S532](#) would establish the Preserving Competition in Healthcare Act. The bill would require notice to the State Auditor, AG, and State Treasurer before hospital entities could engage in any sale, transfer, or change of control of assets worth more than \$5 million. Proposed transactions would be jointly reviewed, which would include public hearings, and would be evaluated on patient access, community benefits, potential conflicts of interest, and potential effects on healthcare providers. Reviewing officials can file a legal action to block or modify any deals found to be objectionable. Additional scrutiny would be imposed on deals involving nonprofit or publicly owned hospital to ensure community benefits are protected.

-  **New York** - [A06056](#) would require healthcare providers looking to engage in mergers and acquisitions to be evaluated by the Public Health and Health Planning Council to determine if the transaction would improve access to medical care for underserved individuals, lower costs, and advance public health goals. For five years after the transaction, approved providers would be prevented from raising charges beyond the medical care consumer price index, and would have to submit annual reports showing how the merger has improved prices, outcomes, or efficiencies.
-  **Pennsylvania** - [SB708](#) would require healthcare facilities to notify the AG before entering into mergers, acquisitions or substantial asset transfers. The AG would be empowered to conduct public hearings, request additional information, and potentially enjoin transactions deemed against the public interest.
-  **Pennsylvania** - [HB1266](#) would require potential hospital acquirers to provide detailed information to the Department of Health, who would approve or deny acquisitions based on whether they will maintain accessible and affordable healthcare for local communities. The bill also requires monitoring of acquisitions for at least 10 years to ensure any commitments made during the approval process were upheld.
-  **Pennsylvania** - [HB1460/SB322](#) requires healthcare entities to obtain state approval before engaging in sales, transfers, leases, or changes in control of healthcare facilities. Proposed transactions would be evaluated to see if they reduce competition, increase costs, diminish care, or limit access. The AG would be allowed to block or impose conditions on transactions deemed against public interest, and can establish a monitoring period of up to five years to ensure compliance.
-  **Pennsylvania** - [HB2115](#) requires healthcare entities involved in material changes (including mergers, acquisitions, or affiliations) to notify the Attorney General at least 120 days in advance. The Attorney General will investigate transactions for potential anticompetitive conduct and consumer harm. The AG can potentially seek injunctions, divestiture of assets, and civil penalties.
-  **Washington** - [SB5704](#) would require parties to a healthcare material change transaction to submit detailed notices that assess potential impacts on community health services. Public hearings would be required, and the AG would have the ability to approve, modify, or disapprove transactions and to impose penalties for non-compliance. The bill would require ongoing monitoring for five years after the transaction.

Merger Notification

Enacted



California - [SB25](#) would require any business already required to submit a Hart-Scott-Rodino premerger notification with the federal government to also file a copy with the California AG, if the business has their principal place in business in the state, or annual net sales in California at 20% or more of the federal filing threshold.

In Process



Hawaii - [SB348](#) establishes a Uniform Antitrust Pre-Merger Notification Act, requiring businesses to file copies of their Hart-Scott-Rodino (HSR) pre-merger notification forms with the AG, if their principal place of business is in the state, or if they meet minimum in state sales requirements.



Indiana - [SB0219](#) enacts the Uniform Antitrust Pre-Merger Notification Act. This requires entities to file an electronic copy of their federal Hart-Scott-Rodino Act pre-merger notification forms with the Indiana Attorney General.



Massachusetts - [H3947](#) would create new requirements for healthcare insurance and service organization mergers. The bill would require specific conditions to be met before the state insurance commissioner can approve the merger, including that the merger agreement must be filed with the state 60 days prior, and a public hearing will be held if requested by various state agencies or at least 10 state taxpayers.















Vermont - [H0071](#) prevents corporations from interfering with the clinical judgement of medical professionals, and prevents non-medical entities from controlling medical practices. It also requires healthcare entities to inform the state before any material change transaction (mergers, acquisitions or partnerships) of over \$1 million or more. The bill would also require physicians to have majority ownership and control of medical practices, and would void any non-competition and non-disclosure agreements that could restrict rights.



West Virginia - [SB147](#) enacts the Uniform Antitrust Pre-Merger Notification Act, requiring entities to file an electronic copy of their federal Hart-Scott-Rodino Act pre-merger notification forms with the West Virginia Attorney General.








Certificate of Need

In Process





-  **Alabama** - [SB82](#) would remove the certificate of need requirement for new or expanded healthcare facilities and services located in rural areas.
-  **Florida** - [H0693](#) is a comprehensive health services bill, which, among other things, would repeal the state's Certificate of Need program.
-  **Hawaii** - [HB11](#) would eliminate the certificate of need requirement for most health facilities and services, with the exceptions of nursing homes, hospices, intermediate care facilities, and ambulance services.
-  **Iowa** - [HF224](#) would eliminate certificate of need requirements.
-  **Maryland** - [SB494/HB944](#) repeals an existing Certificate of Need exemption for certain mergers. Material change transactions would now require advance notice to the state, who would conduct a review to determine the impact on cost, quality, access, and equity of healthcare services.
-  **Missouri** - [HB1637](#) would repeal the existing Certificate of Need law.
-  **North Carolina** - [H455](#) would repeal the state's certificate of need laws.
-  **North Carolina** - [S370](#) would repeal the state's certificate of need laws.
-  **Nebraska** - [LB437](#) would repeal the Nebraska Health Care Certificate of Need Act.
-  **Rhode Island** - [H7143](#) repeals the states certificate of need process, meaning that providers won't need state approval to acquire new major medical equipment or offer new services.
-  **Virginia** - [SB239](#) will direct a Task Force to identify areas medical deserts in the state, and to propose criteria for when projects in these areas should get an expedited CON review.
-  **West Virginia** - [HB4917](#) would terminate the West Virginia Health Care Authority and its certificate of need program, meaning that after January 1, 2027, healthcare facilities would no longer need a certificate of need to operate. The Authority would also no longer review and approve collaborative agreements between healthcare providers.

Other


In Process

-  **Florida** - [H1047/S1122](#) allows two or more special hospital districts to jointly create, participate in, and manage various ventures, partnerships, or collaborations, including business entities or service networks, protected from both state and federal antitrust laws. In Florida, special hospital districts are tax-payer funded entities authorized by the state government to provide healthcare services. The bill also states that providing quality and cost-efficient medical care is a public necessity.
-  **Massachusetts** - [S873](#) requires hospitals to provide 180-day advance notice before closing or discontinuing essential health services.
-  **Minnesota** - [SF2025](#) establishes the Fair Competition Act to address anti-competitive business practices by prohibiting the establishment or maintenance of monopoly or monopsony power that affects competition or controls prices. The bill broadens the scope of existing antitrust law by creating new legal standards for price fixing, market allocation, and collusive practices. The bill also creates a prohibition on unconscionably excessive prices (defined as prices 10% above recent market rates) and a ban on price discrimination that could potentially lessen competition or create monopolistic conditions.
-  **New York** - [A02015/S00335](#) would significantly expand existing New York anti-trust laws. The definition of monopolistic and anti-competitive practices would be amended to include unilateral actions by dominant firms that harm market competition. The bill also would make it easier to establish a company's dominant market position, including presumptions based on market share and allowing direct evidence of market dominance. The bill would also require notification to the AG when companies are involved in significant mergers.
-  **New York** - [A09225](#) prevents any entity from simultaneously owning or controlling both a health insurance company and a health care provider in the state.
-  **Oklahoma** - [HB1415](#) would expand who can bring an antitrust lawsuit by allowing for claims for injuries that are direct or indirect. The Attorney General would be empowered to bring civil actions on behalf of the state, governmental entities, or residents.
-  **Pennsylvania** - [HB1371](#) prohibits anticompetitive practices, creating antitrust regulations that allow the Attorney General to take action against entities engaged in activities that restrain trade, monopolize markets, or create anti-competitive mergers. Health care facilities, health care systems, and provider organizations would have to provide premerger notifica-

tions to the Attorney General. Others that suffer damages from anticompetitive practices can bring civil actions, and the law allows for class action lawsuits.

-  **Pennsylvania** - [SB754](#) establishes comprehensive requirements for hospitals planning to close all or a significant portion of their operations. Hospital authorities would be required to obtain approval from the Attorney General and either the state or local health department before closure, to ensure that patient care continuity and community health needs are adequately addressed.
-  **Pennsylvania** - [SB785](#) creates the “Pennsylvania Open Markets” comprehensive antitrust law. The law would prohibit contracts that restrain trade and require premerger notification for certain healthcare transactions. Both the AG and private parties could bring actions for antitrust violations, with remedies including damages and injunctions.
-  **Vermont** - [H0719/S0249](#) allows health systems to collaborate on cost containment, improving access to care, enhancing quality, or preserving rural hospitals, with immunity from antitrust lawsuits if the collaborations follow specific state oversight procedures. Sharing cost, utilization, workforce, and quality data among collaborating parties would not be considered a violation of antitrust law.
-  **Washington** - [HB2548/SB6208](#) requires hospital systems or provider organizations engaging in mergers, acquisitions, or contracting affiliations to notify the Attorney General at least sixty days prior. Additionally, the law would require the Secretary of State revoke the nonprofit status of a healthcare entity if it converts to a for-profit or unincorporated entity through a material change transaction.

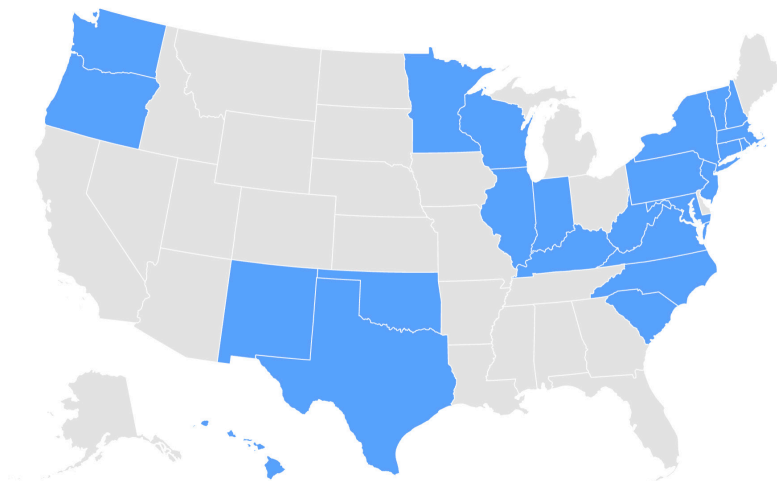
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-  **California** - [AB1345](#) expands the definition of anticompetitive practices under the Cartwright Act, making it unlawful for one or more persons to take actions that restrain trade, impede free competition, or attempt to monopolize or monopsonize trade or commerce.

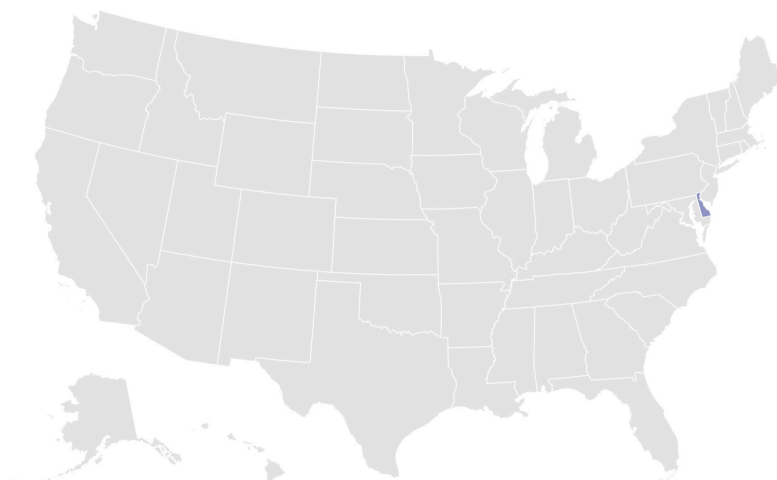
SECTION 2: RATE REGULATION AND COST CONTROL

Below is a listing of legislation we are monitoring related to rate regulation and cost control. Healthcare costs in the United States are significantly greater than in other countries because we pay higher prices for the healthcare services we receive, not because we use more services or have higher quality care. [Click here](#) for more information on this topic.

2026 States Considering Rate Regulation and Cost Control Legislation



2026 States Enacting Rate Regulation and Cost Control Legislation



Benchmarks and Caps

Enacted



Delaware - [SB213](#) amends the state's Hospital Budget Review Act to allow hospitals with global budget agreements covering at least 50% of their patient volumes to be exempt from certain benchmark compliance processes. Hospitals exceeding the state's healthcare spending benchmark may be required to submit a compliance plan.

In Process



Maryland - [HB616/SB515](#) requires the Health Services Cost Review Commission to include costs associated with employing or contracting with physicians and other professional providers, in addition to hospital services, when reviewing costs and rates for hospital services.



Massachusetts - [H1376](#) would create a cost growth benchmark, setting a target for annual increases in healthcare spending. The total assessed amount for a variety of healthcare entities could not increase at a rate higher than the benchmark approved by the Health Policy Commission.



Massachusetts - [H1361](#) would allow the Health Policy Commission to implement performance improvement plans from healthcare entities that exceed spending benchmarks. The state would also perform an analysis of healthcare spending, referring entities with excessive spending to the Commission. The commissioner would also get authority to review rates, and have authority to approve, modify, or disapprove rates that appear excessive, inadequate, or unfairly discriminatory.



Massachusetts - [H1372/S905](#) creates the Weighted Average Payer Rate - a calculation that determines inpatient and outpatient revenue per discharge/visit for different types of payers. Requiring reporting on the index is intended to increase transparency, and the state's healthcare commission would be required to hold annual public hearings on healthcare expenditure growth, costs, payment systems, and delivery systems.














Massachusetts - [S2047](#) reforms the state's healthcare cost benchmark in Massachusetts by creating a new definition of "historical growth rate in gross state product" as the average annual growth rate of the gross state product measured over a ten-year period.



Massachusetts - [S904](#) modifying how the state's Health Policy Commission is able to address excessive healthcare spending. Entities that have been identified as exceeding the




cost growth benchmark may be required to develop a performance improvement plan to reduce spending. If the entity fails to implement the plan in good faith, civil penalties can be imposed.









-  **Massachusetts** - [H1384](#) creates a three-year benchmark cycle to monitor healthcare expenditure growth. Entities that exceed the benchmark would be required to develop performance improvement plans, with civil penalties for repeated violations.
-  **Massachusetts** - [H3196](#) changes the calculation of the healthcare cost growth benchmark, using a new standard that ties the benchmark to the historical growth rate of the gross state product.
-  **Minnesota** - [SF622](#) allows insurance carriers to offer reference-based pricing health plans, where the carrier sets a predetermined rate for services based on a percentage of Medicare rates, rather than negotiating separately with providers. Providers would decide if they wanted to accept the specified rate, and would not be required to participate in a reference-based plan.
-  **New Jersey** - [S3012](#) creates a new state entity to collect and analyze data on healthcare expenditures and prices and make the information publicly available. The bill would create a Health Care Cost Containment and Price Transparency Commission to set benchmarks for overall healthcare cost growth and hospital price growth. The Commission would identify entities that exceed these benchmarks, and could issue civil penalties.
-  **New York** - [A01915/S01634](#) requires health insurance plans to spend at least 12.5% of their total healthcare expenditures on primary care services, but spending shifts cannot result in higher premiums or increased cost-sharing. The legislation also contains guidelines for increasing primary care investments, including improving reimbursement rates, building provider capacity, upgrading technology, and implementing value-based payment arrangements.
-  **Oklahoma** - [SB787](#) limits payments for hospital services to either 200% of Medicare/Medicaid rates or the median amount paid by health benefit plans, whichever is less. Providers could not charge patients more than authorized cost-sharing amounts. Insurance rate filings would be reviewed for affordability, and the ability of lower-income individuals to pay for health insurance.
-  **South Carolina** - [H3302](#) prevents insurers from charging higher out-of-pocket rates for emergency services from out-of-network providers compared to in-network services and would require reimbursement of out-of-network providers at either the in-network rate, the usual and customary rate, or the Medicare reimbursement rate, whichever is greatest. The legislation would define surprise billing as an unfair trade practice.

-  **Vermont** - [H0245](#) expands the Green Mountain Care Board's existing hospital budget review powers to include optional review of budgets for health networks - systems comprising two or more affiliated hospitals with integrated financial and governance structures. The bill also requires budget reviews to consider factors like administrative costs, workforce development, and executive compensation.
-  **Vermont** - [S0055](#) directs the Green Mountain Care Board to develop a plan for implementing reference-based pricing for hospital services - where prices for medical services are based on a percentage of Medicare rates.
-  **Vermont** - [S0190](#) requires hospital and insurer contracts to express rates as a percentage of Medicare or some other approved benchmark. Additionally, hospitals would be required to use unique National Provider Identifiers for off-campus departments to improve billing accuracy. The bill would also bring outsourced clinical services under the Green Mountain Care Board's purview.
-  **Washington** - [HB2283/SB5953](#) requires health insurance plans to spend at least 90 percent of their premium revenues on direct medical care and quality improvement activities.
-  **West Virginia** - [HB5022](#) expands the the capitation rate review program to include the Aged and Disabled Waiver program, the Personal Care Services program, and the Traumatic Brain Injury Waiver program, studying the reimbursement rates for these programs.

Facility Fees and Site Neutrality









In Process

-  **Illinois** - [SB2182](#) creates the Facility Fee Transparency and Prevention Act. The Act would prohibit facility fees for preventive services and preventive care. For other services, patients would need to be informed in advance about specific facility fees.
-  **Illinois** - [HB4701](#) prohibits providers from charging facility fees for outpatient services, except for those provided on a hospital's campus, at a facility with a licensed hospital emergency department, or for emergency services at a freestanding emergency center
-  **Massachusetts** - [H1144/H4619](#) limits where providers can charge facility fees to services on hospital campuses or emergency departments. Clear written notice of facility fees would need to be provided to patients. Additionally, the bill would create requirements for notifying patients when services are out-of-network.

-  **Minnesota** - [HF1312/SF1503](#) would prevent providers from charging facility fees for specific types of services at provider-based clinics. Providers would not be allowed to charge facility fees for outpatient evaluation and management services.
-  **North Carolina** - [S316](#) would require hospitals and ASCs to disclose detailed cost information for common medical procedures and inpatient admissions, and require that patients be informed about potential out-of-network providers. The bill would also place limits on facility fees, and require reporting of facility fee practices.
-  **New York** - [A05342/S08039](#) would prohibit providers from charging facility fees that aren't covered by the patient's insurer by removing existing statutory language that allowed facility fees with advanced notice.
-  **New York** - [A02140](#) would create site-neutral payment policies for certain healthcare services. The bill would require providers participating in health benefit plans to accept rates that do not exceed 150% of Medicare rates for enumerated services.
-  **Oklahoma** - [HB3808](#) would create the "Oklahoma Hospital Facility Fees Reform Act of 2026". The current text of the bill lacks detail on what this might mean.
-  **Virginia** - [HB184](#) creates site-neutral payment policies for certain outpatient or ambulatory healthcare services, so that providers must accept payment that does not exceed 150% of Medicare. The State Corporation Commission and the Department of Health would be required to produce an annual report detailing payment trends for these services.
-  **Vermont** - [H0585](#) would enact health insurance reforms, including a requirement for "site-neutral billing" policies requiring certain healthcare services to be reimbursed at a standardized rate regardless of whether they are performed in a hospital or a non-hospital setting. The bill also restricts the exemption from prior authorization requirements for primary care providers to only those practicing independently.
-  **Vermont** - [H0848](#) prohibits facility fees for outpatient hospital services that use standard evaluation and management codes, or for any healthcare services provided through telehealth.

Transparency

In Process

-  **Hawaii** - [SB2277](#) requires hospitals to comply with federal hospital price transparency requirements, and allows patients to challenge debt collection actions by hospitals.
-  **Kentucky** - [HB59](#) would require healthcare providers to provide patients with statements for services that clearly explain each service, its cost, its price classification, and whether a claim has been or will be filed with an insurance company. Providers could not charge for the statements.
-  **New Hampshire** - [SB476](#) requires hospitals to maintain public pricing files and patient-friendly service estimators. Insurers would be required to allow consumers to obtain free, member-specific price estimates online. The legislation would also create a consumer portal as part of the All-Payer Claims Database that displays de-identified price benchmarks and links to carrier pricing tools.
-  **New Hampshire** - [HB297](#) requires insurers and third-party administrators to annually inform employers about the option to submit data to the state's all-payer claims database.
-  **Oklahoma** - [HB3647](#) intends to create a comprehensive database of health care information in the state by requiring health insurers and benefit plans with at least 2,000 covered individuals to submit claims data, unique identifiers, and demographic information to a state-designated entity. The data would be used to assess healthcare utilization, expenditures, and performance, and for improving health care quality and costs.
-  **Oklahoma** - [HB4453](#) creates an Oklahoma Health Care Cost Transparency Board to oversee an All-Payer Claims Database, which will collect and analyze health care costs, utilization, and spending data from insurers. The Board will publish an annual report on cost trends, primary care spending, and policy recommendations. The bill includes a mandate that commercial health insurers dedicate at least 11% of their total medical spending to primary care.
-  **Pennsylvania** - [HB1739](#) creates an All-Payer Claims Database that requires insurers, providers, and facilities to submit detailed claims data. Public reports and interactive tools will be developed using the data to help consumers understand healthcare costs.
-  **Virginia** - [HB618](#) requires the state to create and publicly share an inventory of all mandated health benefits and providers. Health insurers would be required to report on providers

they terminate from their networks and any they later reinstate, and consolidates reporting related to balance billing.



Virginia - [HB1209](#) requires hospitals to give patients a detailed, itemized statement of charges for any non-emergent medical procedure, test, or service they receive to increase transparency in hospital billing.

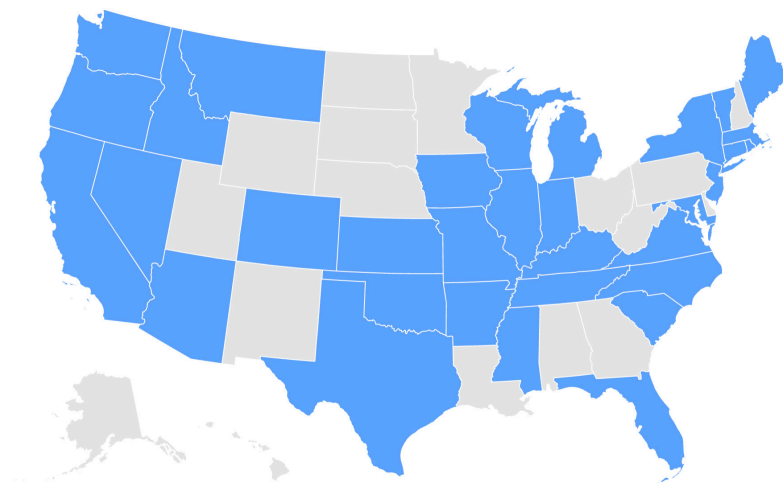


Wisconsin - [AB353/SB383](#) requires hospitals to publicly disclose detailed pricing information in both machine-readable and consumer-friendly formats, and make them easily accessible online. The bill also limits debt collection against patients for non-compliant hospitals.

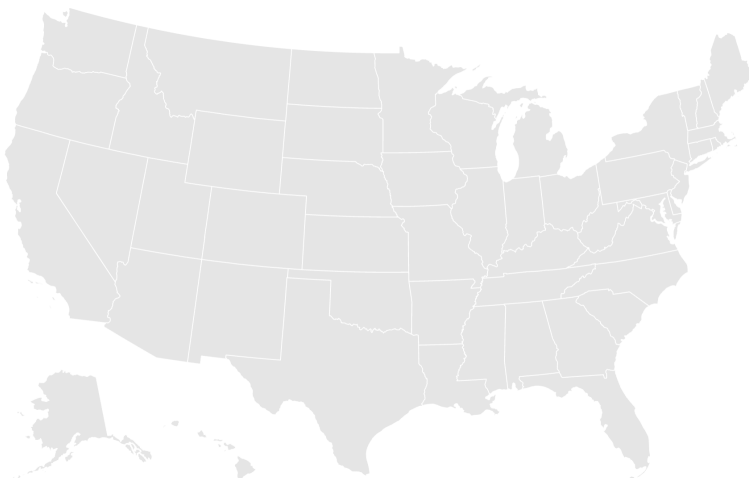
SECTION 3: PROVIDER CONTRACTING AND NONCOMPETE CLAUSES

Below is a listing of legislation we are monitoring related to provider contracting and noncompete clauses. In consolidated markets, dominant firms may be able to negotiate anticompetitive contract terms to obtain prices above the competitive level and reduce competition from existing firms and potential entrants. [Click here](#) for more information on this topic.

2026 States Considering Provider Contracting and Noncompete Clause Legislation














2026 States Enacting Provider Contracting and Noncompete Clause Legislation



Insurer Imposed Conditions







In Process









-  **Massachusetts** - [S851](#) states that a healthcare provider can't refuse to negotiate in good faith with payors, then subsequently charge extremely high rates for non-contracted services (defined as more than 200% of the payor's average contracted reimbursement rate for that same service).
-  **Massachusetts** - [H4954/H4955](#) among other things, prevents insurers from restricting provider participation or forcing all members of a provider group into the same cost-sharing tier or requiring their inclusion in a select network plan on an all-or-nothing basis.
-  **Missouri** - [HB3088](#) prohibits anti-steering clauses, anti-tiering clauses, gag clauses, and most-favored-nation clauses.
-  **Mississippi** - [SB2752](#) an any willing provider bill that prevents health insurers from discriminating against any licensed healthcare provider within the plan's service area who is willing to accept the insurer's terms and conditions.
-  **New Jersey** - [S504](#) requires that insurance companies must accept any licensed healthcare provider or facility that applies to join their network, and must reimburse these providers at a rate no less than 200% of the Medicare rate for similar services
-  **New York** - [S05527](#) forbids contracts where reimbursement is based on the lowest rate a provider has charged elsewhere, preventing payers from taking advantage of pricing disparities. The bill also prevents insurers from restricting patient referrals based on a provider's participation in a particular insurance product.
-  **New York** - [A05106/S07577](#) would prevent insurers from being required to include all members of a provider group in their network, place all group members in the same network tier, or include all group members in all of their insurance products. Contracts couldn't prohibit insurers from encouraging patients to seek care from higher-value providers using benefit design, and from including most-favored-nation clauses.
-  **Oklahoma** - [HB3259](#) would prohibit certain restrictive clauses between healthcare providers and anyone directly contracting with a provider for healthcare services. This includes a ban on "all-or-nothing clauses", "anti-steering clauses", "gag clauses", and "most favored nation clauses". Any such clauses in existing or future provider contracts would be void and unenforceable.

-  **Oklahoma** - [SB1626](#) would ban “all-or nothing” clauses, “anti-steering/anti-tiering” clauses, “gag” clauses, and “most-favored-nation” clauses from contracts between health insurance companies, health plan administrators, and providers. Terms would be considered unfair or deceptive acts enforceable by the Attorney General. Parties could get a waiver if they can demonstrate the term is necessary for a consumer welfare improvement that could not be achieved by less restrictive means.
-  **Washington** - [HB1589/SB5588](#) would require carriers to give providers a meaningful change to engage in good faith negotiations. The bill would also prohibit “all-or-nothing” contract clauses.
-  **Washington** - [HB2106](#) requires health insurers to provide notice to healthcare providers and facilities before making any significant contract modifications, which include any change that affects provider payments, reimbursement methodologies, service delivery requirements, administrative processes, or provider expenses.




Health System Imposed Conditions

In Process


-  **Arizona** - [HB2361](#) would prohibit employers from requiring current or prospective employees to agree to a noncompete clause as a condition of employment.
-  **Iowa** - [HF2254](#) would prevent the University of Iowa Hospitals and Clinics from using non-compete clauses in contracts with physicians.
-  **Massachusetts** - [S1336](#) would ban noncompete agreements, making them void and unenforceable.
-  **Michigan** - [HB4514](#) would change the Michigan Antitrust Reform Act to add a new prohibition against noncompete agreements specifically for physicians.
-  **Michigan** - [HB4040](#) intends to restrict noncompete agreements prohibiting businesses from enforcing them, with exceptions that include when a worker is selling their ownership stake. Businesses are still allowed to protecting legitimate interests, such as trade secrets.
-  **Missouri** - [HB2821](#) declares that any noncompete clause in an employment contract between a healthcare employer and a physician is void and unenforceable.

-  **North Carolina** - [S673](#) prevents employment contracts from containing noncompete clauses for healthcare professionals employed by hospitals, or terms that prevent professionals from providing practice information on patient request. The bill also adds whistleblower protections for healthcare professionals, and restricts nondisclosure agreements so professionals can report concerns with safety, ethics, and illegal activities.
-  **New Jersey** - [S1407](#) prevents employers from using non-compete clauses. Non-compete clauses for high-level employees earning at least \$151,164 annually with policy-making authority entered into before the bill's enactment may remain valid if they meet strict requirements. "No-poach agreements" (deals between employers to avoid hiring each other's employees) would also be banned.
-  **New York** - [S04641](#) would prohibit noncompete agreements for most workers, declaring them null and void. There would be exceptions for workers earning over \$500,000 annually, and for protecting trade secrets, confidential information, client solicitation, and in specific business sale scenarios. The bill also prevents employers from using alternative legal strategies, such as choosing a different venue, to circumvent its protections.
-  **New York** - [A10023](#) prohibits employers from using noncompete clauses with exceptions for individuals earning over \$500,000 annually, and in specific business sale scenarios.
-  **Rhode Island** - [S2160](#) generally prohibits noncompetition agreements, with an exception between a seller and buyer of a business. The bill would allow employers to sue employees who violate agreements addressing trade secrets.
-  **South Carolina** - [S0046](#) would prohibit contract terms that limit healthcare professionals' ability to treat patients, practice in certain geographic areas, or maintain patient relationships after leaving employment. Exceptions include repayment of relocation or recruitment expenses, and protection of legitimate business interests like trade secrets. The prohibition would apply to contracts entered into or renewed after its effective date.
-  **South Carolina** - [H4767](#) would prohibit noncompete terms that preventing physicians from practicing medicine in a geographic area after leaving employment, continuing to treat current patients, establishing new patient relationships, or notifying patients about their departure. The bill would allow employers to require repayment of expenses like relocation or signing bonuses and would still be allowed to protect trade secrets and confidential business information.
-  **Tennessee** - [HB1034/SB0995](#) would broadly prohibit non-compete agreements, rendering restrictions on the right to practice professionally after terminating employment void and unenforceable. The bill specifically removes existing language that allowed noncompetes re-

lated to healthcare. The bill would apply to contracts entered into (or amended) on or after July 1, 2025.

-  **Vermont** - [H0334](#) would restrict noncompete agreements and stay-or-pay provisions. Most noncompete agreements would be void, with exceptions for sale of a business, partnership dissolution, or limited liability company termination. Stay-or-pay provisions (which require employees to repay certain costs if they leave their job) would be generally unlawful, but with exceptions for specific, limited, conditions.
-  **Virginia** - [HB627/SB128](#) expands protections against non-compete agreements to include healthcare professionals, similar to existing state prohibitions for low-wage employees.
-  **Washington** - [HB1155/SB5437](#) prohibits noncompetition agreements, rendering them void and unenforceable regardless of when they were originally signed. Nonsolicitation agreements would still be permitted, but must be narrowly construed.

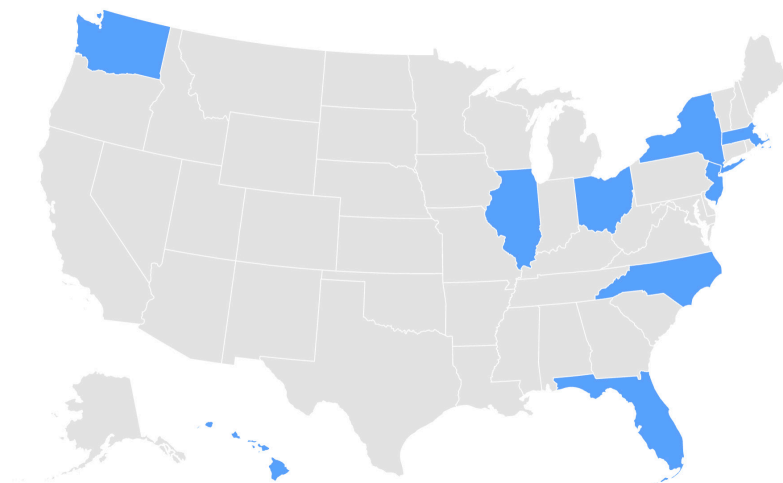
Dead

-  **Mississippi** - [HB500](#) declares that any contract term that restricts the ability of a healthcare provider to practice their profession in any geographic area or for any period of time after the relationship ends void and unenforceable.

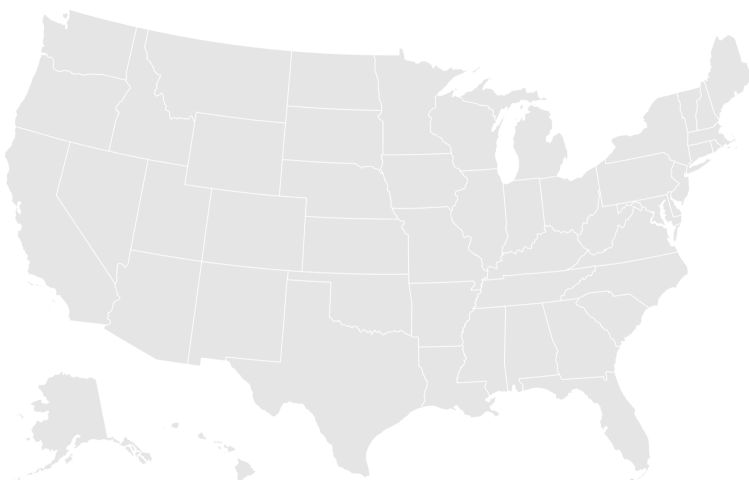
SECTION 4: HEALTHCARE SYSTEM REFORM

Below is a listing of legislation we are monitoring related to healthcare system reform.











2026 States Considering Healthcare System Reform Legislation














2026 States Enacting Healthcare System Reform Legislation



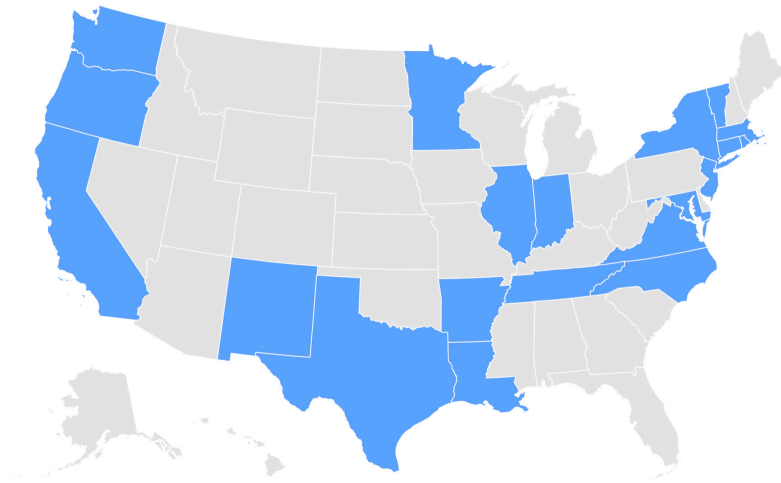
In Process

-  **Florida** - [S0348](#) would create a task force to design a single-payer healthcare system and submit recommendations back to the state legislature.
-  **Florida** - [H1489/S0740](#) would create the “Healthy Florida Act,” a state-managed health care system providing universal health coverage for all Florida residents, regardless of immigration status.
-  **Hawaii** - [HB1490/SB1179](#) establishes a universal, single-payer health care system to provide comprehensive health coverage for all residents of Hawaii. The system would allow residents to maintain supplemental health insurance if desired.
-  **Hawaii** - [HB2143/SB3305](#) establishes “Hawaii Care,” a universal, single-payer healthcare system intended to replace existing health insurance plans.
-  **Hawaii** - [HB1789/SB3243](#) establishes a “Health Care for All Hawaii Board” to develop a publicly funded, universal healthcare system.
-  **Illinois** - [SB2873](#) would provide universal health insurance coverage for all Illinois residents through a new state-administered program called the Illinois Health Services Program.
-  **Illinois** - [HB3287](#) would create the Illinois Medicare for All Health Care Act, providing comprehensive health coverage to all state residents. Funding would come from a progressive contribution model, supplemented by federal healthcare funds, grants, and other designated revenues. Only non-profit healthcare providers would be able to participate, and private insurers would be prohibited from offering duplicate coverage.
-  **Illinois** - [HB3568](#) establishes the Health Care for All Illinois Act, a comprehensive universal healthcare program to provide health insurance to all state residents. Funding would come from a progressive contribution model, supplemented by federal healthcare funds, grants, and other designated revenues. Only non-profit healthcare providers would be able to participate, and private insurers would be prohibited from offering duplicate coverage.
-  **Illinois** - [HB3780](#) creates the Illinois Universal Health Care Act, establishing a comprehensive, state-wide health insurance program to cover all state residents, funded through government appropriations, progressive income contributions, and federal healthcare funds. Only non-profit healthcare providers would be able to participate, and private insurers would be prohibited from offering duplicate coverage.
-  **Massachusetts** - [S849](#) explores the possibility of a single-payer healthcare system in Massachusetts by establishing a comprehensive benchmark and evaluation process.

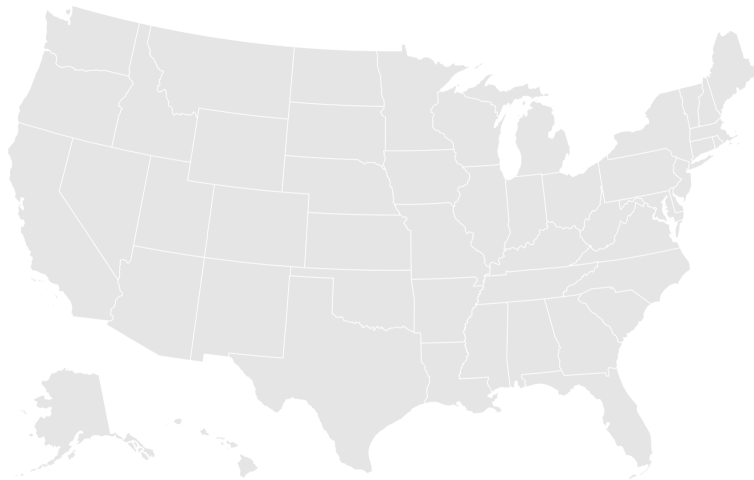
-  **Massachusetts** - [S860](#) would establish a single-payer healthcare system to provide universal healthcare coverage.
-  **North Carolina** - [H714](#) would create a state-run universal healthcare benefit plan to provide affordable health insurance to state residents whose incomes are too high to qualify for Medicaid but who may not be able to obtain private coverage.
-  **New Jersey** - [S426](#) would expand Medicare to cover all residents of New Jersey, regardless of their age, health, or disability status. The bill would eventually prohibit private health insurance companies from offering comparable plans to ensure that everyone participates in the Medicare program.
-  **New York** - [A06273](#) establishes the New York State Public Health Care Option Program to offer competitive, affordable health insurance with access to quality providers, and will be available through the state's health insurance Marketplace. The program would be funded through member premiums, potential federal payments, and other state funds.
-  **New York** - [S03425](#) would create the New York Health program to provide universal health coverage for all New York state residents without premiums, deductibles, or co-pays funded through payroll and non-payroll income taxes.
-  **New York** - [S08614](#) creates a buy-in option for the Basic Health Program allowing individuals and small groups to purchase health coverage even if they don't meet the traditional eligibility requirements.
-  **New York** - [A01466](#) creates the New York Health program, a comprehensive single-payer health insurance system.
-  **Ohio** - [SB78](#) would create a single, comprehensive universal healthcare system for all residents in Ohio, funded through federal funding, payroll taxes, and other new taxes.
-  **Washington** - [HB1445/SB5233](#) would create the Washington Health Trust to provide universal health coverage to all state residents via a comprehensive healthcare system. Funding would come from new capital gains taxes and employer contributions, guaranteeing coverage without premiums, deductibles or copayments.
-  **Washington** - [SB5947](#) creates the Washington Health Care Board to design and implement a universal healthcare plan to provide state-based healthcare for all residents.
-  **Washington** - [SB5948](#) creates a universal health care commission to develop a detailed plan for a unified health care financing system that provides universal coverage for all state residents.

SECTION 5: MISCELLANEOUS

2026 States Considering Other Relevant Legislation










2026 States Enacting Other Relevant Legislation




Private Equity/Corporate Practice of Medicine

In Process

-  **Massachusetts** - [S1628](#) prohibits entities from interfering with the professional judgment of any clinician, including restrictions on controlling patient care decisions.
-  **Minnesota** - [SF3354](#) would prevent private equity companies from acquiring (or increasing) their ownership or control over healthcare providers. Exceptions allow for routine replacement of employees or directors as part of normal business.
-  **North Carolina** - [S570](#) requires that medical corporations can only have licensed medical professionals as shareholders. The bill also mandates that physicians maintain full control over patient care decisions without interference from non-physicians or out-of-state medical professionals.
-  **New York** - [A09012/S08442](#) requires that licensed physicians hold the majority of voting shares, constitute a majority of the board of directors, and serve as most corporate officers in medical professional corporations.
-  **Vermont** - [H0583](#) would prevent corporations from practicing medicine or interfering with the professional judgement of healthcare providers.
-  **Washington** - [HB1675](#) would prevent organizations and people without a medical license from interfering with providers' professional decisions, such as treatments, coding and referrals. Any professional service corporation running a practice must have a majority of voting shares and directors be licensed providers.
-  **Washington** - [SB5387](#) would prohibit anyone (including corporations) without a healthcare license from owning a healthcare practice and employing licensed providers. Any professional service corporation running a practice must have a majority of voting shares and directors be licensed providers. Non-licensed providers would be prevented from interfering in clinical decision-making in many settings. There are exemptions to these rules.





Fiduciary Duties/Third Party Administrators

In Process

-  **Maryland** - [HB277/SB139](#) expands reasons why the Maryland Insurance Commissioner can deny, refuse to renew, suspend, or revoke the registration of a third-party administrator to include violations of any part of the entire Insurance Article or another state law related to insurance, or if they knowingly fail to follow a regulation or order from the Commissioner.


Artificial Intelligence







In Process

-  **Illinois** - [SB3027](#) prohibits hospitals from using artificial intelligence in setting healthcare pricing or billing.
-  **Rhode Island** - [S2010](#) requires insurers to report to the state how they use AI, including the types of AI models, their role in decision-making, training data, performance metrics, and risk management policies.
-  **Tennessee** - [SB2010/HB1866](#) prevents health insurers from denying, delaying, or modifying healthcare services based on AI or algorithms, unless the decision is reviewed by a competent licensed healthcare professional.
-  **Virginia** - [SB586](#) requires insurers to disclose their use of AI to manage claims and coverage, and cannot rely exclusively on AI for adverse determinations, and requires an external review process for appealing such AI decisions.

Other

In Process

-  **New Jersey** - [S1386](#) allows healthcare providers to engage in joint negotiations with carriers on the terms and conditions of contracts.

-  **New Jersey - [S952](#)** allows independent physicians to jointly negotiate with hospitals and commercial health insurers over non-fee-related matters impacting patient care. Negotiating jointly over fee-related matters can occur only if the Attorney General has determined that the health carrier has substantial market power and that the terms being negotiated threaten patient care quality and availability.
-  **New Jersey - [S3212](#)** requires PBMs to pass on rebates and discounts, prohibits spread pricing in certain circumstances, and would require PBMs to reimburse pharmacies at rates at least equal to the National Average Drug Acquisition Cost with a dispensing fee. The bill would also prevent PBMs from steering patients to pharmacies they own.
-  **New York - [A06775](#)** would allow physicians and dentists to collectively negotiate with health benefit plans under certain conditions.
-  **Vermont - [S0197](#)** creates a program where participating primary care providers would receive a monthly payment from a patient's insurer that covers routine primary care services without any out-of-pocket costs for the patient.
-  **Virginia - [SB593](#)** extends existing balance billing prohibitions by prohibiting out-of-network insurance providers from balance billing for emergency medical services transportation.
-  **Virginia - [HB1332](#)** allows hospitals to form compacts to collaborate on workforce development by pooling resources and sharing workforce data.