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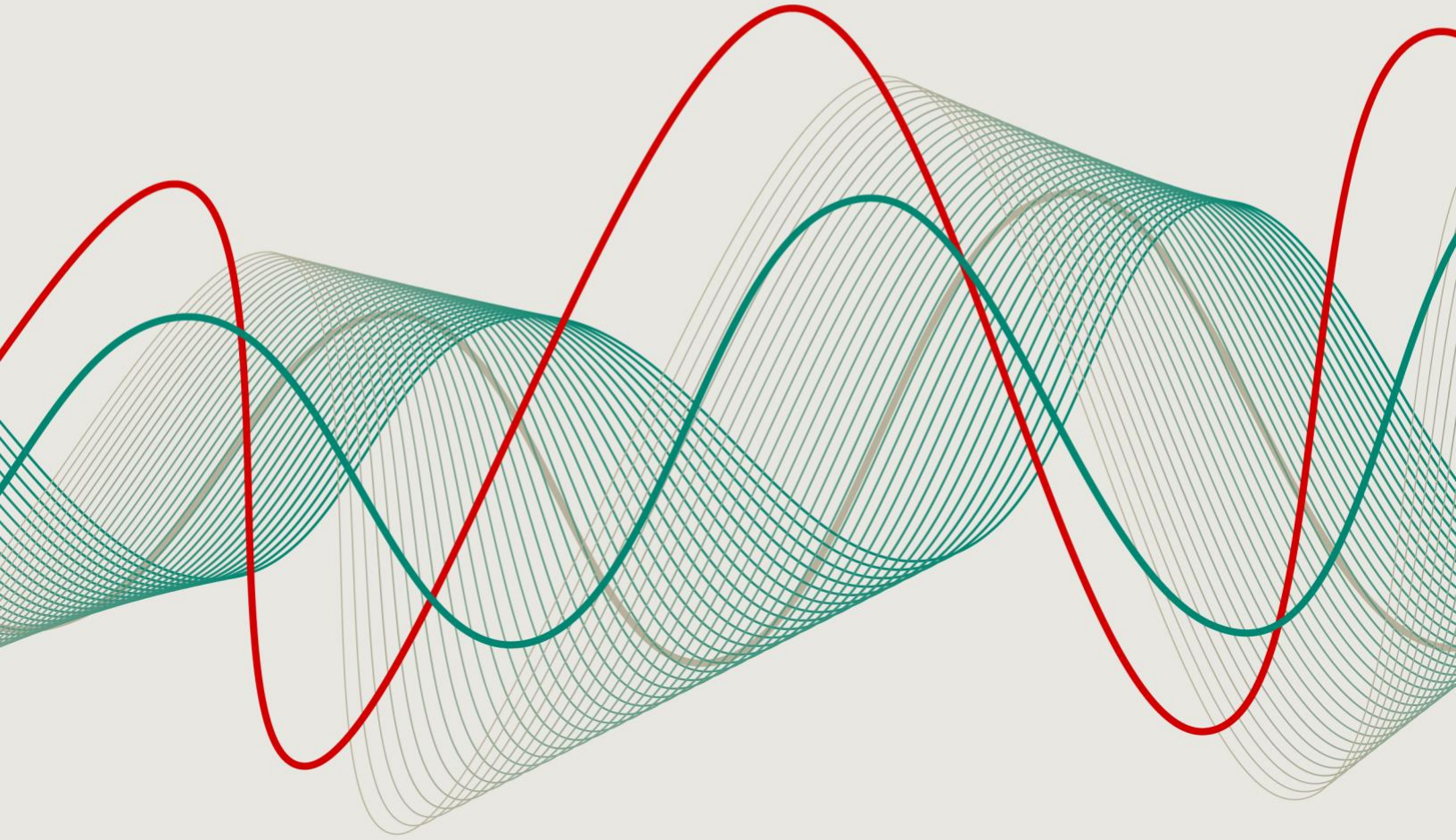

POLICY BRIEF

2026 State End of Session Recap

State Action on Healthcare Affordability and Consolidation

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For more information about CAHPR, visit cahpr.sph.brown.edu.

ABOUT CAHPR

The Center for Advancing Health Policy through Research (CAHPR) at the Brown University School of Public Health is an evidence-based, nonpartisan research and policy center that aims to make fundamental contributions toward understanding and developing policies that will lower spending growth, improve patient outcomes, and drive structural change in healthcare delivery in the US. Learn more at https://cahpr.sph.brown.edu/.

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If you have any questions about the policies in this brief, or if you would like to discuss how CAHPR can support evidence-backed policymaking in your state, please contact Nathan Hostert, Director for State Policy, at nathan_hostert@brown.edu.

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Overview

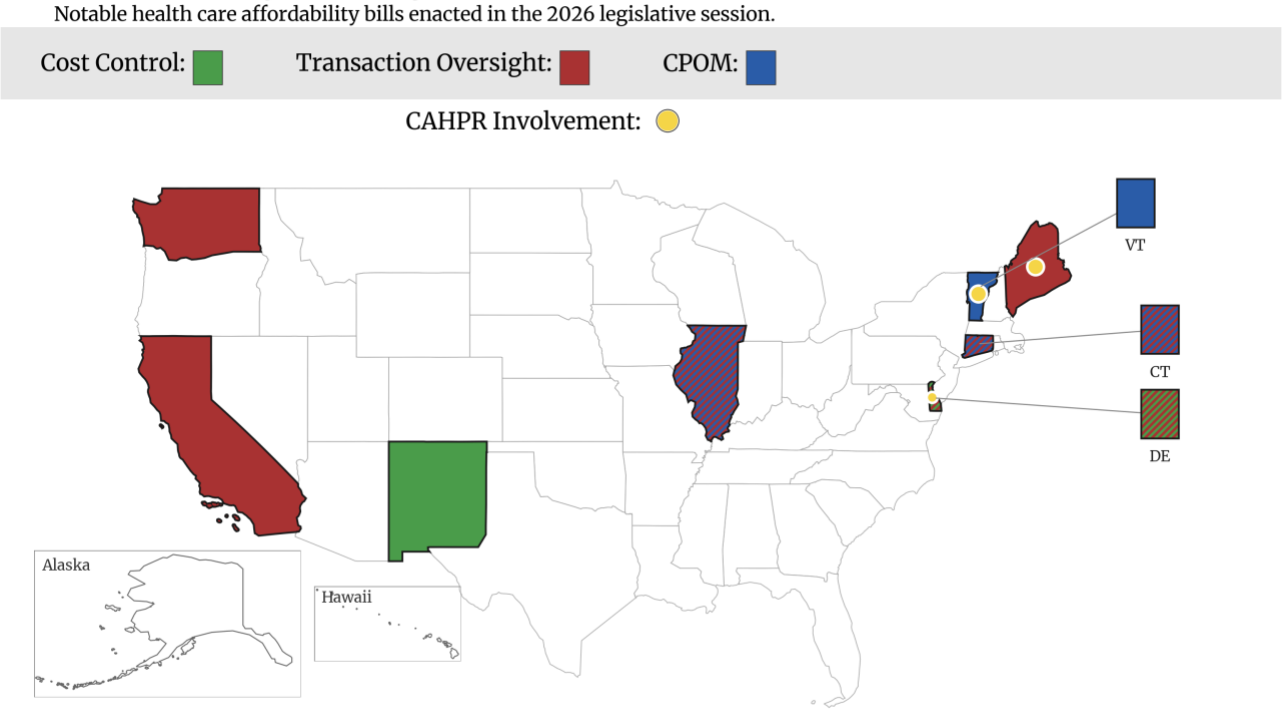
States have been weathering a perfect storm of health care challenges this year. As health care spending continues to rise, families are paying $27,000 for employer-sponsored insurance coverage every year, and annual premium increases exceed $1,400. The expiration of the enhanced premium tax credits at the end of 2025, coupled with administrative changes that have made it harder to maintain coverage, has led to a 12% drop nationally in coverage through the individual marketplace. And millions more are expected to lose insurance coverage as the One Big Beautiful Bill Act's (OBBBA) immigration restrictions and work requirements for Medicaid go into effect in October 2026 and January 2027, respectively.

As states reckon with these immediate challenges, policymakers are also addressing the structural drivers of costs in their health care markets. Hospital systems continue to acquire physician practices, a practice that both strengthens hospitals' bargaining power and expands their ability to collect more through in-system referrals and facility fees. At the same time, a new wave of financial actors, including private equity firms, have been expanding their footprint in health care. These firms have been taking over health care providers through nontraditional means, such as management service organizations and real estate investment trusts, that largely evade traditional state antitrust laws.

In their 2026 legislative sessions, state policymakers considered a variety of bills to improve affordability and strengthen their health care markets. These included policies to put an upper limit on the amount that commercial insurers pay hospitals, policies that strengthen regulators' oversight of health care consolidation, and policies that set guardrails around how financial actors can engage in health care.

Health Policy Laws by State: 2026

Notable health care affordability bills enacted in the 2026 legislative session.



Source: Author review of state-level legislation. CAHPR involvement includes testimony, technical assistance, and analysis.

SUMMARY OF KEY LEGISLATION ENACTED BY STATES IN 2026

The table and figure below summarize the most significant state legislation enacted across all four policy areas covered in this brief.

STATE	BILL	POLICY AREA	LEGISLATION
Delaware	SB 1	Hospital Price Caps	Establishes reference-based price caps for the state's employee health plan, individual market, and fully-funded commercial market.
New Mexico	HB 306	Facility Fee Ban	Bans facility fees for preventive services, vaccinations, and telehealth services.
Maine	LD 2201	Transaction Review	Requires prior state approval for private equity-backed health care transactions.
Connecticut	SB 196	Transaction Review, Corporate Practice of Medicine	Prohibits hospitals from entering into sale-leaseback transactions. Requires hospitals to attest to independence from private equity influence.
Delaware	SB 313	Transaction Review	Establishes on one-year moratorium on transfers of hospitals to for-profit owners. Brings nonprofit hospital sale-

STATE	BILL	POLICY AREA	LEGISLATION
			leaseback agreements under the state's health care transaction notice process.
Illinois	HB 5000	Transaction Review	Ensures that health care transactions involving private equity firms are covered under the state's health care transaction notice process.
Washington	HB 2548	Transaction Review	Ensures that the state's health care transaction notice process captures all changes of control, including sale-leaseback transactions.
California	SB-25	Transaction Review	Requires the state filing of federal Hart-Scott-Rodino (HSR) premerger notification forms.
Vermont	H.583	Corporate Practice of Medicine	Prevents private equity firms from exerting control over health care facilities. Requires private equity-backed health care entities to report annually on ownership structures and financial information.

STATE	BILL	POLICY AREA	LEGISLATION
Illinois	SB0712	Corporate Practice of Medicine	Strengthens corporate practice of medicine (CPOM) restrictions for applied behavioral analysis providers.

Hospital Price Caps

Research has consistently shown that hospital prices are the largest driver of increases in commercial health care spending. Hospital markets are dominated by monopolies, which enable hospitals to charge higher prices without improving quality or outcomes. As states seek to tackle the drivers of health care spending, policymakers are increasingly looking for options to limit excessive hospital prices. Our research shows that capping the highest, most egregious prices charged by hospitals can meaningfully improve health care affordability, while still allowing hospitals to generate a healthy margin on patient care.

Last year was a landmark year for state hospital payment cap policies. Indiana and Vermont capped the prices that hospitals could be paid across commercial payers, and Washington and New Mexico capped hospital payments under their state employee health plans. Indiana and Vermont are still preparing to implement their hospital price cap policies. But Washington and New Mexico have already begun implementing their caps and are set to begin yielding state savings as a result. In 2026, Delaware joined the ranks of these states, passing bipartisan legislation to cap hospital prices for the state employee plan and the state-regulated insurance market[1]. In addition to Delaware, multiple other states considered legislation to limit hospital prices.

Signed into Law: Delaware SB 1

[1] The state-regulated insurance market includes the individual market, the small-group and large-group markets, and the state's employee health plan. Combined, these segments account for around 40.6% of the total commercial insurance market in Delaware. Due to the federal Employee Retirement Income Security Act (ERISA), states generally cannot regulate self-funded insurance plans.

The biggest development in hospital payment policy in 2026 took place in Delaware, where lawmakers unanimously passed SB 1 to establish reference-based price caps for the state's employee health plan, individual market, and fully-funded commercial market. The new law extends through 2027 the state's existing policy of capping the annual growth of state-regulated insurance plans' nonprofessional fees at inflation plus 1%. Starting in 2028, the state will shift from a price growth cap to a price level cap. For 2028 and 2029, hospital prices will be limited to 275% of Medicare rates for outpatient services, and 310% of Medicare rates for inpatient and emergency department services. Those caps will phase down to 250% of Medicare rates for all hospital services by 2033. The new law provides exemptions for certain hospitals that meet defined criteria, but it is expected that at least three of the major hospitals in the state will be subject to the caps. (One of those is a children's hospital, which is bound by a separate, non-Medicare benchmark under the statute.) We estimated that the final version of the bill would save at least $137.9 million in annual health care costs by 2033.

Roz Murray, Nathan Hostert, and Erin Fuse Brown provided technical assistance on the bill to the Delaware Department of Insurance and Senate Majority Leader Bryan Townsend. Roz Murray testified on the bill before the Senate Health Committee. Written testimony for the committee can be found here.

Fell Short: Maine LD 2196

Notable legislation to cap hospital prices this year was filed in Maine, where it was approved out of the Standing Committee on Health and Human Services but did not make it to the floor of either legislative chamber. LD 2196 would have set both a price growth cap (benchmarked

to inflation) and a price level cap (set at 200% of Medicare rates) for hospital prices across the commercial market. The legislation also included restrictions on prior authorization and utilization review, and would have also established payment floors for primary care and behavioral health services. After a contentious committee hearing, the bill did not make it to a vote in either branch of the legislature. We estimated that the service-level price caps alone would have saved $1 billion annually in health care costs in the state.

Roz Murray, Erin Fuse Brown, Chris Whaley, and Nathan Hostert provided technical assistance on this bill to the Maine Office of Health Care Affordability. Roz Murray testified on the bill before the legislature's Health and Human Services Committee. Written testimony for the committee can be found here.

Other States

Bills to cap hospital prices for commercial payers were also filed this year in Massachusetts, New Jersey, and Oklahoma, but none made it out of their respective committees. In addition, Michigan's Speaker of the House filed legislation in June that would limit the prices of nonprofit hospitals. That bill would cap insurer-paid hospital prices at 200% of Medicare rates and limit cash-pay prices to 150% of Medicare rates. The bill would also establish an inflation-based cap on the growth of prices at nonprofit hospitals and create a board that would have to approve hospitals' proposed price increases. Nonprofit hospitals would also have to immediately lower their prices by 10% within 2 weeks of the bill's effective date. Hospitals that do not comply would be forced to pay back the full amount of tax exemptions that the hospital received from the state in the preceding year.

Legislation to limit reimbursements to hospitals under state employee health plans was filed this year in New Jersey and West Virginia. New Mexico, which last year passed legislation authorizing the state employee plan to establish reference-based price caps, considered but did not pass legislation this year to make those caps mandatory. .

Site-Neutral Policies and Facility Fee Bans

A key driver of rising health care prices is consolidation in health care systems, including through hospital acquisitions of physician practices. These acquisitions, which are a form of vertical integration, have been shown to increase hospital prices by 3-5%. This can be attributed to greater bargaining power, more intensive coding practices, and hospitals charging facility fees at what were previously independent physician practices but are now treated as "hospital outpatient departments." To prevent unwarranted price increases and to address one of the main financial incentives driving consolidation, states are increasingly considering facility fee bans or "site-neutral" policies that would cap prices for certain routine services that could be provided safely in an office setting.

Fell Short: New York Fair Pricing Act

The most high-profile site-neutral bill considered by a state legislature this year was the New York Fair Pricing Act (S705A/A2140A). This bill would have capped prices at 150% of Medicare non-hospital rates for services that the Medicare Payment Advisory Commission (MedPAC) has recommended should be paid on a site-neutral basis. We have estimated that the Fair Pricing Act would have saved New Yorkers $1.12 billion in 2022, with consumer savings ranging from $168.9 million to $213.4 million via lower out-of-pocket expenses. This year, both the House and

Senate versions of the Fair Pricing Act received favorable reports with minimal edits from their respective health committees. However, the Fair Pricing Act did not make it to the floor of either chamber.

Enacted: New Mexico HB 306

While slightly different than site-neutral policies, facility fee bans tackle a similar policy goal: preventing the charging of facility fees for health care services that could be delivered in an office setting. This session, New Mexico banned facility fees for preventive services, vaccinations, and telehealth services.

Other States

In addition to New York, bills that would establish site-neutral caps at 150% of Medicare rates for certain services were filed in both Pennsylvania and Virginia. A pared-back version of the Virginia bill was enacted, but it does not establish a site-neutral cap. Instead, the new law directs the state's Department of Health to study how the state's All-Payer Claims Database could support evidence-based health policy reforms in the state. In particular, the state is directed to propose ideas for how the database could be used to inform "cost containment strategies, including site-neutral payment policies." In a similar move, Rhode Island Governor Dan McKee this year issued an executive order directing the state's health insurance commissioner to "evaluate opportunities to promote or implement site-neutral reimbursement and transparency across commercial and Medicaid markets" by October 2026.

Elsewhere, Vermont lawmakers considered two bills related to site-neutral payments. Both chambers enacted a bill that at one point included a requirement for the state's Green Mountain Care Board to

study site-of-service payment differentials; however, this provision was removed from the bill before it was enacted. In addition, the Vermont House passed a bill that would mandate site-neutral payments for physical therapy, occupational therapy, and athletic training. The Senate did not take up the bill.

Bills to ban facility fees for certain services were also filed in California (where the bill passed the House), Illinois, Massachusetts, Michigan, Minnesota, New Jersey, New York, North Carolina (where the bill passed the Senate), Pennsylvania, Rhode Island, Vermont, and West Virginia.

Transaction Review

Recognizing the role of consolidation in driving health care costs, a number of states acted in 2026 to strengthen state authority over major health care transactions. In particular, states prioritized legislation that targeted transactions involving private equity (PE) firms. These laws span the spectrum of state options for cracking down on consolidation in their health care systems. Connecticut enacted an outright ban on hospital sale-leaseback transactions that are often used by PE firms to take over health care facilities. Maine created a new prior approval process for all transactions involving PE firms. Delaware, Illinois, and Washington established notice requirements for transactions involving PE firms. And California required state disclosure of transactions that fall within federal antitrust reporting thresholds.

Signed into Law: Maine LD 2201

On April 13, 2026, Maine Governor Janet Mills signed LD 2201, which gives the state new authority to approve private equity-backed health care transactions. The bill requires health care entities to notify the state

of a major transaction involving a PE firm, hedge fund, or management service organization (MSO) at least 180 days before the transaction. The state is required to review the transaction and subsequently approve, conditionally approve, or disapprove it. The health care entities subject to this statute include facilities such as hospitals and outpatient clinics, as well as provider organizations employing more than 6 individual providers. The bill also establishes new reporting requirements for health care entities, directing them to submit a one-time report on their organizational structure (including all affiliated providers and subsidiaries), and to update that report upon completion of a material change transaction.

Erin Fuse Brown, Chris Whaley, and Nathan Hostert provided technical assistance on this bill to the Maine Office of Health Care Affordability.

Signed into Law: Connecticut SB 196

On May 27, 2026, Connecticut Governor Ned Lamont signed SB 196, which prohibits hospitals from entering into sale-leaseback transactions. Starting in July 2027, hospitals will be barred from entering into a transaction in which property that encompasses the main campus of a hospital is sold and then leased back from a separate entity. With this law, Connecticut follows Massachusetts to become the second state to prohibit future hospital sale-leaseback agreements. Massachusetts banned these arrangements through its 2025 health care market reform law.

These sale-leaseback agreements, which often involve health care facilities selling their land to a PE-backed real estate investment trust (REIT) and then leasing that land back, have significantly expanded. As of 2021, 8% of all US health care real estate and 3% of hospital real estate

was owned by REITs. REIT transactions with health care entities can impose ongoing and growing rent obligations on providers, which can undermine the financial stability of the entity and transfer the value of health care real estate assets from the community to investors. One recent study found that hospitals owned by REITs were more likely to close or file for bankruptcy: 25% of REIT-acquired hospitals closed or went bankrupt, compared to 4% of hospitals not affiliated with REITs.

In addition to banning hospital sale-leasebacks, the new law requires hospitals to report annually to the state with: (1) an attestation that no PE entity has a controlling interest in the hospital or "ultimate governance control or authority over any asset or activity of the main campus of a hospital;" and (2) an attestation that no PE firm can direct a hospital to adopt a policy or procedure that would interfere with clinical decisions.

Signed into Law: Delaware SB 313

On July 20, 2026, Delaware Governor Matt Meyer signed SB 313, which puts a one-year moratorium on transfers of hospitals to for-profit owners such as private equity firms. This moratorium follows in the footsteps of Maine, which last year enacted a one-year moratorium on any PE firm or real estate investment trust acquiring or increasing ownership interest or control over a hospital. In addition, Delaware's new law also brings nonprofit hospital sale-leaseback agreements under the state's existing health care transaction notice process.

Hayden Rooke-Ley and Nathan Hostert provided technical assistance to the Delaware Governor's Office on this bill.

Signed into Law: Illinois HB 5000

On May 28, 2026, the Illinois legislature passed HB 5000, which ensures that health care transactions involving private equity are covered under the state's health care transaction notice process. The new law specifies that transactions are subject to the notice process even if the parties are not themselves health care entities, but the parties own or control, directly or indirectly, at least one of the entities involved in the transaction. In doing so, the bill ensures that all parties to a covered transaction, not just health care facilities or provider organizations, can be held accountable if they fail to comply with notice requirements.

Signed into Law: Washington HB 2548

On March 25, 2026, Washington Governor Bob Ferguson signed HB 2548, which expands the health care transactions that must be reported to the state under the state's transaction notice process. The new law ensures that this process captures a broader list of transactions involving a change of control, including sale-leaseback transactions. If the attorney general requests more information about a proposed transaction, the new law prevents the transaction from moving forward until 30 days after the parties have complied with the request. In addition, the law requires the attorney general to maintain a public list of pending and completed transactions that are subject to this statute.

Signed into Law: California SB-25 and Maine LD 2202

On February 10, 2026, California Governor Gavin Newsom signed SB-25, which requires entities that are already to file federal premerger notification forms under the Hart-Scott-Rodino (HSR) Act to also file those forms (along with additional documentary material) with the California Attorney General. And on April 13, 2026, Maine Governor Janet

Mills signed LD 2202, which establishes the same requirement for health care entities in the state.

California and Maine are following in the footsteps of Colorado, which enacted a similar law last year, as well as Oregon, which in 2019 required health care entities to file HSR disclosures with the state. Indiana's Senate also passed legislation this session to require state filings of HSR disclosures. While this policy provides the state with more transparency into health care mergers, it only applies to the largest health care transactions. As of 2026, the HSR reporting threshold is $133.8 million, which is far too high to capture most physician group transactions.

Fell Short: Louisiana HB 1118

On April 28, 2026, the Louisiana House passed HB 1118 by a vote of 97-1. While the Senate did not take up the bill, the bill would have required any hospital in the state that is involved in a sale-leaseback agreement with a REIT to disclose that arrangement with the state, along with a copy of the associated lease agreement. In addition, the bill would have required the state to maintain a public list of every hospital that is affiliated with a REIT.

Erin Fuse Brown, Nathan Hostert, and Hayden Rooke-Ley provided technical assistance on legislative language for HB 1118. In addition, Erin Fuse Brown provided written testimony on the bill for the Louisiana House Committee on Health and Welfare.

Other States

States across the country considered legislation to bolster state oversight of health care transactions in 2026. Bills to require prior notice, review, and/or approval of health care transactions were filed this session in

Colorado, Connecticut, Hawaii, Maryland, Michigan, New Hampshire, North Carolina, Pennsylvania (where legislation passed the House), Rhode Island, and Washington. Notably, two other states in addition to Maine considered bills that would have specifically required the prior approval of health care transactions involving private equity: Iowa and Illinois. Minnesota also considered legislation requiring annual ownership reporting by health care entities.

Also, this year, there were some notable state regulatory developments related to transaction review in health care. Massachusetts finalized regulations, and California released proposed regulations, to enforce each state's 2025 law strengthening health care transaction review. In addition, Rhode Island's Attorney General promulgated regulations establishing prior notice requirements for transactions involving physician groups.

Corporate Practice of Medicine (CPOM)

To ensure physicians maintain autonomy from corporate investors, states are strengthening their existing restrictions on the corporate practice of medicine (CPOM). Corporate entities commonly use management services organizations (MSOs) to obtain de facto control of medical practices without formally owning them. To maintain the autonomy of health care providers, states are taking action to prevent MSOs from controlling medical decision-making.

Last year, Oregon enacted SB 951, a landmark bill to restrict corporate control of medical practices. Oregon's law is the first in the nation to target the widely used "friendly physician" loophole, in which a corporation contracts with a doctor to oversee a medical practice while masking the corporation's de facto control. The law also prohibits

noncompete, nondisclosure, and non-disparagement clauses for physicians, which restrict physicians' ability to raise concerns or leave a practice. This year, Oregon's law was put to the test when the nonprofit health system PeaceHealth announced its plans to drop its contract with the local physician group and instead contract with the Atlanta-based company Apollo MD to staff emergency departments in three hospitals. After public outrage, a lawsuit, and a judge saying that it was "quite clear" that PeaceHealth was violating the new law, PeaceHealth ended up reversing course and announcing that it would seek to renegotiate a contract with the local physicians.

Following in the footsteps of Oregon and California, which also enacted legislation last year to strengthen the state's CPOM doctrine, multiple states took action to strengthen their CPOM doctrines this year.

Signed into Law: Vermont H.583

On June 15, 2026, Vermont Governor Phil Scott signed H.583, which prevents PE firms and hedge funds from exerting control over health care facilities in which they have ownership or investment interest. The bill also requires health care entities to disclose if they have PE or hedge fund investment, and to report detailed ownership information if they do. Entities with PE or hedge fund investment will be required to report information on all individuals with ownership or investment interest in the entity, all affiliated MSOs, an organizational chart, and the entity's most recent annual profit & loss statement and balance sheet. Health care entities will also be required to file an updated report any time there is a change in their PE or hedge fund ownership interest.

As initially filed, the bill would have effectively barred any private equity-backed health care transaction in the state. However, the bill was

pared back over the legislative process to significantly restrict how PE firms can affect the provision of care.

Erin Fuse Brown, Nathan Hostert, Hayden Rooke-Ley, and Yashaswini Singh provided technical assistance on bill drafting to the Vermont Office of the Health Care Advocate. Erin Fuse Brown and Yashaswini Singh both testified on the bill before the House Committee on Health Care. Yashaswini Singh discussed the bill and private equity in Vermont's health care system during a broadcast of Vermont Public's Vermont Edition radio show.

Other States

In addition to Vermont, legislators across the country considered bills to regulate CPOM. Illinois enacted a bill that strengthens CPOM restrictions for applied behavioral analysis providers. Bills to expand CPOM restrictions were also filed in Massachusetts, Minnesota, New Hampshire, New York, North Carolina, Rhode Island, South Carolina, and Washington.

Looking Ahead

In 2027, states will be grappling with the real challenge of maintaining insurance coverage for their residents as Medicaid work requirements go into effect and premiums continue to rise. States will continue to explore options for financing their Medicaid programs as they prepare for OBBBA's restrictions on provider taxes and state-directed payments to go into effect in 2028.

State policymakers will likely continue exploring the affordability strategies covered in this report as they are weighing policies to save money for both states' and families' budgets. Some states may even seek

out innovative policy solutions that address commercial insurance affordability while also supporting state Medicaid programs. As states consider their options for 2027, policy developments from 2026 reflect the variety of options that states have for addressing affordability and consolidation in their health care markets.
