CAHPR CENTER FOR ADVANCING HEALTH POLICY THROUGH RESEARCH

School of Public Health
BROWN UNIVERSITY

2025 State Legislative End-of-Session Recap

State Legislative Actions Related to Health Care Markets

Policy Brief

July 2025

Introduction

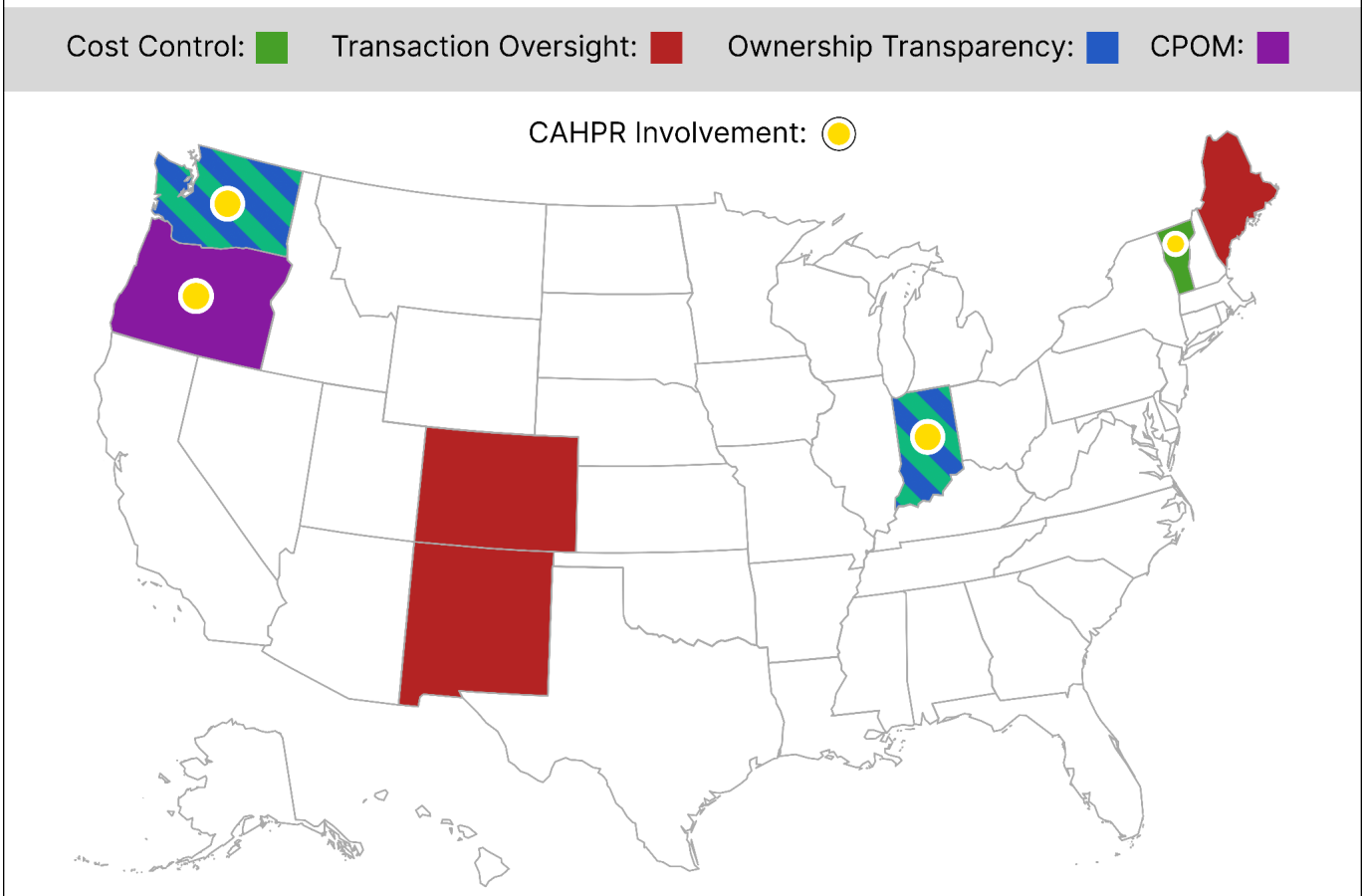
Over the first half of 2025, states have enacted numerous laws to strengthen their health care markets. These new laws address pressing policy issues including skyrocketing healthcare costs and consolidation in the healthcare sector. Economic analyses conducted by researchers at the Center for Advancing Health Policy through Research (CAHPR) at Brown University have identified high and variable prices as a key contributor to state health care spending and rising corporate ownership as an imminent challenge. Throughout the 2025 legislative session, CAHPR researchers received numerous requests to provide technical expertise to a number of states considering health care market reforms. This technical assistance has come in the form of legislative language recommendations, policy analyses, evaluations of economic impacts, and context regarding the national policy and research landscape.

This report highlights the laws that states have enacted so far in their 2025 legislative sessions related to health care markets. In addition, this document outlines instances when policymakers requested technical assistance from CAHPR during the drafting and consideration of these laws. This report is broken down into four sections, for four related policy issues:

1. Controlling health care costs;
2. Bolstering state oversight of major health care transactions;
3. Requiring public reporting on the ownership of health care entities; and
4. Strengthening the corporate practice of medicine doctrine (CPOM), to ensure that licensed medical providers maintain control over medical practices.

Health Policy Laws by State: 2025

Notable health care bills passed in the 2025 legislative session through June.



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

Cost Control

Vermont (S.126)

Summary

On June 12, 2025, Vermont Governor Phil Scott signed S.126, "An act relating to health care payment and delivery system reform." This bill establishes reference-based hospital price caps across the commercial market. It directs the Green Mountain Care Board (GMCB) to establish upper limits on the amounts that hospitals can accept as payment for providing health care services. These limits must be established as a percentage of the amount that Medicare would reimburse for the same or similar service. The GMCB is directed to establish such caps no later than hospital fiscal year 2027. To increase investment in underfunded healthcare services, the bill also permits the GMCB to establish reference-based payment floors for services provided in non-hospital settings, such as primary care services.

The bill also mandates that the GMCB monitor the implementation of these caps and ensure that any reductions in hospital payments are passed along as savings to ratepayers through lower insurance premiums. The bill even mandates that the board annually post information on the alignment between price decreases and premium decreases.

The reference-based pricing caps in the Vermont bill are only temporary, however; they serve as stepping stones toward the establishment of global hospital budgets. The bill tasks the GMCB with establishing global budgets for at least one hospital starting in hospital fiscal year 2028, and establishing global budgets across all hospitals by hospital fiscal year 2030. Global hospital budgets, established most notably in Maryland, involve setting a cap on the total patient revenue that an individual hospital can receive in a given year.

Background

The Vermont legislation is notable because it is the first time that a state has established reference-based hospital price caps across the commercial market. In 2017, Oregon established a reference-based hospital price cap for its state employee health plan, limiting reimbursements to 200% of Medicare rates for in-network hospitals and 185% of Medicare rates for out-of-network hospitals. Within the first 27 months of the policy's implementation, the policy yielded upwards of $107 million in savings for the state. As of this legislative session, Washington has become the second state to adopt an across-the-board reference-based hospital price cap for its state employee health plan.

However, no state has adopted such a cap for the entire commercial market—until now. With S.126, Vermont has established an across-the-board reference-based price cap for hospitals. This means that regardless of the payer, hospitals will only be able to charge for medical services below a cap that the Green Mountain Care Board has established as a percentage of Medicare rates.

CAHPR Involvement

Previous economic analysis work by CAHPR researchers identified rising hospital prices as a pressing issue for the state to address. In March 2025, Chris Whaley, Roz Murray, Erin Fuse Brown, Hayden Rooke-Ley, and Nathan Hostert were asked to provide technical assistance on this bill, which addresses the problems identified in previous CAHPR research. This included background information on the hospital price cap policies that have been established in other states, as well as legal analysis of the proposed legislation. In addition, Roz Murray performed an economic analysis of the expected effect of reference-based pricing on the state and estimated that "reference-based pricing for Vermont state employees and educators, set at a cap of 200% of Medicare payments, would save VSEA and VEHI approximately $89 million across the six short-term acute care hospitals in the state." Murray's analysis broke down savings estimates by each hospital in the state, and it also included estimates of how the policy would affect each hospital's commercial operating and overall operating margins. Finally, Chris Whaley testified virtually in front of the Vermont House Committee on Healthcare regarding the hospital price caps in April 2025.

Indiana (HB 1004)

Summary

On May 6, 2025, Indiana Governor Mike Braun signed HB 1004, a comprehensive health care bill that takes steps to control hospital price growth. The bill directs the state's Office of Management and Budget to establish a methodology for studying Indiana's statewide average inpatient and outpatient hospital prices. The bill requires that nonprofit hospitals must bring their aggregate average inpatient and outpatient hospital prices under those statewide average prices by June 2029. If a nonprofit hospital's prices exceed the statewide averages, then the hospital must forfeit its nonprofit status for at least one year, until the hospital can bring its prices below the statewide averages. In addition, by 2025, every nonprofit hospital system is required to begin offering a direct-to-employer healthcare arrangement in which the total cost of the system's facility prices is below 260% of the sum of Medicare rates for the same services. By 2026, hospitals that are unaffiliated with a nonprofit hospital system must offer a similarly compliant direct-to-employer healthcare arrangement.

CAHPR Involvement

Previous economic analysis work by CAHPR researchers identified rising hospital prices as a pressing issue for the state to address. Throughout the winter and spring of 2025, CAHPR researchers were requested to provide technical assistance on how this bill could address the issues identified in that research. Chris Whaley, Roz Murray, Erin Fuse Brown, Hayden Rooke-Ley, and Nathan Hostert all provided feedback on this bill. This technical assistance involved assisting

with the drafting of potential legislative language, providing research and policy background on the policies at play, and participating in working group meetings regarding the bill.

Washington (SB 5083)

Summary

On May 20, 2025, Washington Governor Bob Ferguson signed SB 5083, which establishes a reference-based cap on the amount that the state employee health plan can reimburse hospitals for services provided to its members. The bill limits reimbursements to 200% of Medicare rates for in-network hospitals, and 185% of Medicare rates for out-of-network hospitals. The bill also sets a reimbursement floor for primary care and behavioral health services, mandating that these services are reimbursed at no less than 150% of Medicare rates.

The bill exempts critical access hospitals and some selected other hospitals from the price cap, and it even sets a reimbursement floor of 101% of Medicare allowable costs for services delivered at critical access hospitals. The bill establishes separate reimbursement caps for children's hospitals that are based on Medicaid rates and that vary depending on the location of the hospital and the hospital's network participation status. Finally, the bill mandates that expected cost savings resulting from the reimbursement caps are passed along to consumers via lower premiums.

On a separate note, the bill also adds a new requirement that nonprofit hospital systems annually submit to the state audited financial statements for the hospital's two preceding fiscal years.

CAHPR Involvement

Erin Fuse Brown and Hayden Rooke-Ley received a request to provide technical assistance on this bill, including potential legislative language and insight from other states. Roz Murray provided written testimony to the state legislature's House Appropriations Committee, citing her work evaluating the policy as implemented in Oregon. Roz noted that the bill "is likely to similarly reduce spending without compromising care or restricting access for enrollees, while also likely improving access to primary care and behavioral health services."

Transaction Oversight

New Mexico (HB 586)

Summary

New Mexico is so far the only state to enact a law this year requiring prior approval from a state entity for a major health care transaction. On April 7, 2025, New Mexico Governor Michelle Lujan Grisham signed HB 586. The bill, which applies to hospital mergers, changes of hospital control, and acquisitions of health care practices by provider organizations affiliated with a health insurer, requires entities to notify the state's health care authority of any such proposed transaction. Once a notice is received, the authority must publish and disseminate a statement describing the proposed transaction and inviting public comments.

The health care authority has 120 days following receipt of a notice to either approve the transaction, approve the transaction with conditions, or disapprove the transaction. The law lists several considerations that the authority must weigh when considering a proposed transaction, including the likely effects of the transaction on essential services, patient costs, the healthcare workforce, and market competitiveness. The authority may only approve a transaction if the parties demonstrate that the transaction: will benefit the public; will improve health outcomes; will not significantly harm the availability, accessibility, affordability, or quality of health care; and will not have anticompetitive effects that outweigh the transaction's benefits.

Following the approval of a transaction, the acquiring entity must submit annual reports to the authority for three years following the transaction. These reports must demonstrate compliance with any conditions imposed by the state, include descriptions of any service changes at the hospital, and provide analyses of the cost trends and cost growth trends of the hospital.

Context

This new law repeals and replaces temporary legislation that the Governor had signed in March 2024, requiring prior approval for significant health care transactions. That law was set to expire in July 2025. With the new permanent law, New Mexico becomes the fifth state to have some form of prior approval requirement for health care transactions. Hawaii, Oregon, Rhode Island, and Vermont currently have prior approval requirements in place. These laws vary in terms of the transactions they cover and the governmental body tasked with providing approval. New Mexico's law also follows Part I of the National Academy for State Health Policy's model legislation for market oversight in health care, which provides a roadmap for how states can "address the issues of corporate and private equity entry into health care markets, health care consolidation, and closures of key service lines or facilities."

Oregon has the most expansive of all state transaction review laws (Or. Rev. Stat. §§ 415.500–415.501). Oregon's law covers transactions involving any "health care entity" (defined broadly to include hospitals, insurers, and health care service providers), so long as one entity has over $25 million in annual revenue and the other entity has, or is expected to have, $10 million in annual revenue. The Oregon health authority is the entity designated to lead the review process. The authority is charged with analyzing and reporting on the effects of an approved transaction (including the cost trends and cost growth trends of the parties, as well as the impact of the transaction on the state's health care cost growth target) one year, two years, and five years following completion of an approved transaction.

The other three states with preexisting prior approval statutes restrict state jurisdiction to hospital transactions. Hawaii's law (Haw. Rev. Stat. §§ 323D-71–323D-82) pertains to the acquisition of hospitals, mandating that an acquiring entity receive prior approval from both the state's health planning and development agency and the attorney general. Rhode Island's law (23 R.I. Gen. Laws § 17.14) is restricted to transfers of hospital ownership (including through mergers), and it also requires the approval of both the state's Department of Health and the attorney general. Vermont's law (8 V.S.A. § 9420) applies to transfers of nonprofit hospital control to for-profit entities, and it requires approval from the Green Mountain Care Board and either the attorney general or the state superior court.

Maine (LD 985)

In June, Maine established an across-the-board ban on the expansion of private equity involvement in health care, at least for the short term. The new legislation, LD 985, establishes a one-year moratorium on any private equity company or real estate investment trust acquiring or increasing ownership interest, operational control, or financial control in any hospital in Maine.

Colorado (SB25-126)

While less intensive than prior approval requirements, Colorado has enacted a statute establishing notice requirements for significant health care transactions. On June 4, 2025, Governor Jared Polis signed SB25-126, dubbed the "Uniform Antitrust Pre-Merger Notification Act." This act requires Colorado-based businesses that are already required to file pre-merger notifications with the federal government to also file such notifications with the state.

Ownership Transparency

Indiana (HB 1666)

Summary

On May 6, 2025, Indiana Governor Mike Braun signed HB 1666, which effectively establishes a health care provider registry for the state. The bill bolsters the annual reporting requirements for entities that provide health care services, to include significantly more information on the ownership and financial status of the providers. In their regular reports to the state, these entities must now include the names, business addresses, business websites, and identification numbers of all persons or entities that have at least 5% ownership interest, a controlling interest, or an interest as a private equity partner in the entity. In addition, the entities must also describe the ownership stake of each person or entity identified. Hospitals must report on this information annually, while all other health care entities must report on this information biennially. The bill also establishes identical reporting requirements for health insurers, third party administrators, and pharmacy benefit managers—all of which must report this information on an annual basis to the state's department of insurance. Finally, the state department must now report annually on all of the new information collected under this law.

CAHPR Involvement

Erin Fuse Brown, Chris Whaley, and Hayden Rooke-Ley provided technical assistance on this bill to the Indiana Secretary of Health. This technical assistance included recommendations on what information should be collected by the state, as well as background information on similar policies adopted in other states.

Washington (HB 1686)

Summary

HB 1686, which was signed by Washington Governor Bob Ferguson on April 22, 2025, directs the state's department of health to develop a plan and provide legislative recommendations on how to create a "complete and interactive registry of the health care landscape in Washington." In particular, the department is tasked with considering "strategies to fully understand and monitor the business structure, funding, and contractual relationships of health care entities," including ownership status and affiliations between health care entities and other organizations, such as private equity firms. The department must provide a progress update to the legislature on this project by the end of 2027, and a final report must be submitted by November 2028.

The original bill would have established annual reporting requirements for all health care entities in the state and created a publicly accessible provider registry portal. However, the bill was pared back over the legislative process. Regardless, the bill is a significant step forward for health care

transparency in the state of Washington.

CAHPR Involvement

Erin Fuse Brown and Hayden Rooke-Ley both provided technical assistance on the bill at various points in the legislative process. In particular, this technical assistance involved recommendations on what information should be collected by the state, as well as language recommendations for the bill itself.

Corporate Practice of Medicine

Oregon (SB 951)

Summary

On June 9, 2025, Governor Tina Kotek signed SB 951, which restricts corporations' ability to own medical practices by strengthening the state's corporate practice of medicine (CPOM) doctrine. As the CAHPR team has written in this issue brief, corporate entities commonly use management services organizations (MSOs) to obtain *de facto* control of medical practices without formally owning them. The bill places several restrictions on MSOs and their contracting agreements with medical practices. In addition, the bill prohibits noncompetition and non-disparagement for physicians and other medical licensees. The bill does not apply to hospital-owned medical clinics or MSOs.

Background

The Oregon legislature came close to enacting similar legislation in the previous legislative session. In 2024, the state's House of Representatives passed the legislation, but the legislation never made it to the floor of the Senate. The bill was consequently refiled in the 2025 legislative session, when it was able to successfully make it across the finish line.

CAHPR Involvement

Hayden Rooke-Ley and Erin Fuse Brown received requests to provide extensive technical assistance on this bill in the current legislative session, as well as in the previous legislative session. This technical assistance included legal analysis, potential bill language, and policy context on the CPOM doctrine in other states. Hayden and Erin both testified in front of the Oregon House Committee on Behavioral Health and Health Care regarding the legislation in April 2025. In May 2024, Hayden and Erin had also coauthored a *Health Affairs Forefront* article on lessons learned from Oregon's 2024 effort to strengthen its corporate practice of medicine doctrine.