

CA's AB 1415 & SB 351: Regulating Private Equity in Healthcare

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Executive Summary

California's recent legislative cycle saw the enactment of two landmark laws—Assembly Bill 1415 (AB 1415) and Senate Bill 351 (SB 351)—aimed at curbing the influence of private investment firms in the state's health care sector. Now effective as of January 1, 2026, **AB 1415** expands the reporting and review authority of the Office of Health Care Affordability (OHCA) over **mergers and acquisitions** by “*noticing entities*” (defined to include private equity groups, hedge funds, management services organizations, and related affiliates of health care providers). These entities must now provide OHCA 90-day advance notice of major transactions involving hospitals, clinics, physician groups, skilled nursing facilities, or management services organizations (MSOs) ⁽¹⁾ [legiscan.com](#) ⁽²⁾ [legiscan.com](#). The goal is to ensure transparency of the **cost and market impacts** of deals that fuel consolidation, which research shows tends to raise prices and limit access ⁽³⁾ [www.kff.org](#) ⁽⁴⁾ [health-access.org](#). In contrast, **SB 351** codifies and sharpens California's longstanding corporate practice of medicine doctrine. It **strictly prohibits** private equity or hedge funds (and their controlled entities) from interfering with core clinical or operational decisions in physician and dental practices (for example, dictating patient care, owning medical records, setting billing or staffing policies, or interfering with referrals) ⁽⁵⁾ [www.foley.com](#) ⁽⁶⁾ [legiscan.com](#). SB 351 also bans onerous contract terms: any non-compete or non-disparagement clause imposed by an investor on physicians is rendered void ⁽⁷⁾ [www.foley.com](#) ⁽⁸⁾ [legiscan.com](#). The Attorney General is empowered to seek injunctive relief and damages for violations ⁽⁹⁾ [legiscan.com](#) ⁽⁷⁾ [www.foley.com](#).

These laws reflect growing concern in California about **how private investment**—particularly leveraged buyouts by PE firms—affects health care costs, quality, and community care. Private equity acquisitions of California health providers reached **\$4.31 billion from 2019–2023** (about one-third of all health care deals in that period) ⁽¹⁰⁾ [a18.asmdc.org](#) ⁽¹¹⁾ [www.chcf.org](#). Studies document price hikes and worse outcomes following such deals (for example, higher hospital charges and even increased mortality in nursing homes) ⁽¹²⁾ [www.cbsnews.com](#) ⁽¹³⁾ [www.kff.org](#). Proponents of AB 1415 and SB 351 (including patient advocacy groups, labor unions, and physician organizations) argue that enhanced oversight and stronger corporate practice rules will protect patients and restrain exploitative practices ⁽¹⁰⁾ [a18.asmdc.org](#) ⁽¹⁴⁾ [www.kqed.org](#). Opponents (the California Hospital Association, major healthcare investors, etc.) counter that added regulation could deter investment and innovation, potentially reducing capital for needed expansions or improvements ⁽¹⁵⁾ [www.hklaw.com](#) ⁽¹⁶⁾ [www.kqed.org](#).

This report analyzes the **context, content, and impacts** of AB 1415 and SB 351. It reviews historical and current trends in health care investment, details the specific provisions of each law, and examines their anticipated effects on private equity, venture capital, and **health care markets**. Drawing on data, academic studies, legal analysis, and stakeholder interviews, the report presents evidence-based arguments from multiple perspectives. It includes case studies (e.g. PE-backed hospital and clinic acquisitions) and discusses how California's approach compares with other states (notably Oregon). In conclusion, it evaluates whether these laws are likely to achieve their aims of improving affordability and accountability, and what challenges or unintended consequences may arise.

Introduction and Background

Health care in California is expensive and evolving under constant consolidation. Over the past two decades, hospitals, physician groups, and other providers have merged into ever-larger systems. By 2022, **68% of California's community hospitals** were part of larger health systems (up from 53% in 2005) ⁽³⁾ [www.kff.org](#). In parallel, the share of California physicians employed by hospital-owned or system-owned practices climbed from about 29% in 2012 to 41% in 2022 ⁽³⁾ [www.kff.org](#). This consolidation has been associated with higher prices for services. For example, a RAND report found hospital mergers often raise prices by **3%–65%** ⁽¹⁷⁾ [www.kff.org](#). Even mergers that do not directly compete (cross-market mergers) have been shown to allow hospitals to negotiate higher rates statewide ⁽¹⁸⁾ [www.kff.org](#).

Amid these trends, private equity (PE) and hedge funds emerged as major players in health care. Traditionally, health care providers were owned by physicians, nonprofits, or publicly traded companies. But PE firms increasingly perform leveraged buyouts of clinics, [hospitals](#), [pharmacies](#), nursing homes, and other health businesses. Between 2019 and 2023, PE acquisitions of California health care providers totaled **\$4.31 billion** (^[10] [a18.asmdc.org](#)) (^[11] [www.chcf.org](#)). PE-backed investment now accounts for roughly one-third of all California health care deals (307 of 875 deals in that period) (^[11] [www.chcf.org](#)). Nationally, one estimate puts PE health care deal value at about \$100 billion by 2018 (^[19] [www.kqed.org](#)), and industry sources report that 2021–2022 were record years for PE health deals (^[20] [www.bain.com](#)). In California alone, the PE health care market has been estimated at around \$20 billion per year as of 2021 (^[21] [www.chcf.org](#)).

Proponents of PE investment argue it brings much-needed capital, new management expertise, and efficiency improvements. However, critics contend that the **profit motive of PE** can conflict with patient interests. PE models often rely on high leverage; after purchasing a provider with borrowed money, firms may extract cash quickly through dividends or asset sales and leave the acquired entity saddled with debt (^[22] [www.commonwealthfund.org](#)). To maximize investor returns in 3–7 years, PE owners may cut staffing, reduce “unprofitable” services, or increase prices aggressively (^[23] [www.cbsnews.com](#)) (^[24] [www.kqed.org](#)).

Empirical studies have documented worrying outcomes. One analysis found PE-owned *nursing homes* had significantly higher patient mortality: a 1.7-percentage-point higher death rate, amounting to ~20,000 extra deaths nationwide over 12 years, compared to similar non-PE facilities (^[12] [www.cbsnews.com](#)). These effects were attributed to cost-cutting (e.g. 3% fewer nursing assistant hours) and higher use of antipsychotic drugs (^[25] [www.cbsnews.com](#)) (^[26] [www.cbsnews.com](#)). In hospitals, a JAMA study reported that PE ownership was associated with a **25% higher rate of hospital-acquired conditions** (infections, falls, etc.) after acquisition (^[27] [health-access.org](#)). Other research links hospital and physician-practice consolidation generally to worse quality and patient experience, even if not always statistically significant (^[18] [www.kff.org](#)). Notably, the Kaiser Family Foundation (KFF) and RAND reviews agree that consolidation and PE involvement tend to **raise prices**, with mixed or neutral impacts on quality (^[18] [www.kff.org](#)) (^[3] [www.kff.org](#)).

These concerns gained attention in California. In 2022 the state created the **Office of Health Care Affordability (OHCA)** to combat rising costs and monitor large provider mergers (^[28] [a18.asmdc.org](#)) (^[29] [www.kqed.org](#)). OHCA was charged with gathering spending data, enforcing cost-growth benchmarks, and reviewing “material change” transactions by “health care entities” (insurers, hospitals, clinics, etc.) (^[28] [a18.asmdc.org](#)). However, OHCA's initial remit did not explicitly cover PE firms or MSOs that invest in health care. In 2023 the legislature passed AB 3129 to give the Attorney General veto power over \$25M+ PE deals in health care, but Governor Newsom vetoed it, citing OHCA as the better forum (^[30] [www.axios.com](#)) (^[31] [www.mondaq.com](#)).

The defeat of AB 3129 did not end the debate. Advocates continued pushing for oversight of financial investors, while health industry groups warned that heavy-handed regulation could chill capital flows to a capital-intensive sector (^[32] [www.mondaq.com](#)) (^[33] [www.kqed.org](#)). In 2025 two new bills addressed these issues from different angles. Assemblymember Mia Bonta (D) introduced **AB 1415**, focusing on *transparency and affordability review*. Senator Chris Cabaldón (D) introduced **SB 351**, focusing on *corporate practice restrictions*. By autumn 2025 both bills had passed the legislature and were signed by Gov. Newsom (SB 351 on Oct. 6, AB 1415 on Oct. 13) (^[34] [www.foley.com](#)) (^[35] [a18.asmdc.org](#)).

This report analyzes how AB 1415 and SB 351 reshape the regulatory landscape for private equity/hedge fund investment in health care. It explains each bill's provisions, and assesses the predicted impacts on investors (private equity and venture capital), on health care providers, and on patients and costs. We incorporate data on recent investment trends, relevant academic research (on market consolidation and PE outcomes), expert legal commentary, and stakeholder viewpoints. Case studies (such as the Steward Health Care bankruptcy and nursing home acquisitions) illustrate concrete outcomes of PE ownership. The report concludes by discussing how these laws may play out in practice and what further regulatory or market developments they may trigger.

AB 1415: Expanding Oversight of Transactions

AB 1415 (Bonta) amends California's Health Care Quality and Affordability Act to **require new entities to notify and be subject to the state's cost and merger review processes**. Now in effect since January 1, 2026, the law extends OHCA's 90-day advance-notice requirement beyond traditional "health care entities" (insurers, hospitals, clinics, etc.) to include "*noticing entities*" defined as **private equity groups, hedge funds, newly formed entities for health care deals, MSOs, and any entity that owns/operates/controls a provider** ^{([\[2\]](#) [legiscan.com](#))}. In practice, this means that when any of these investors or affiliates is involved in a material transaction with a provider or MSO, they must file notice to OHCA just like the provider would (even if the provider itself does not initiate the deal).

Specifically, AB 1415 adds subdivision © to the statute, which requires written notice to OHCA at least **90 days before** any agreement or transaction that either: (i) sells, transfers, leases, encumbers, or otherwise disposes of a material amount of a health care entity's or MSO's assets; or (ii) transfers control, responsibility, or governance of a material amount of such assets or operations, to another party ^{([\[1\]](#) [legiscan.com](#))}. Under AB 1415, these reporting obligations apply to:

- **Health care entities** as before (hospitals, clinics, labs, etc.).
- **Noticing entities** themselves when they deal with a health care entity or an organization that controls a health care entity ^{([\[1\]](#) [legiscan.com](#))}.
- **Any MSO** (whether or not affiliated with a provider) when it makes a covered transaction with any other entity ^{([\[36\]](#) [legiscan.com](#))}.

Thus, a private equity firm acquiring a hospital, or a PE-owned MSO merging with another MSO, must notify OHCA 90 days ahead ^{([\[1\]](#) [legiscan.com](#))} ^{([\[36\]](#) [legiscan.com](#))}. The law also requires OHCA to seek implementing regulations; in particular, OHCA must eliminate "duplicative reporting" for deals that already fall under existing rules ^{([\[37\]](#) [legiscan.com](#))}, and to set any necessary transaction thresholds and fees ^{([\[38\]](#) [legiscan.com](#))}. All filings become public under OHCA's rules (unless exempted). Importantly, AB 1415 *does not give OHCA veto authority over deals* – it only mandates notification and grants the agency authority to conduct cost and market impact reviews of the transactions ^{([\[39\]](#) [legiscan.com](#))}. The stated aim is to give the state "*the full picture of the billions spent annually in our health care system by large private equity firms*" ^{([\[40\]](#) [a18.asmdc.org](#))}, so that OHCA can enforce the cost-growth benchmarks and advise strategies to maintain affordability.

The law also adds new statutory definitions. A "**private equity group**" is defined (broadly) as investors primarily engaged in raising/returning capital who invest in equity interests, either directly or through controlled entities ^{([\[41\]](#) [legiscan.com](#))}. Hedge funds are defined similarly as pooled investment funds, with carve-outs for pass-through contributors and debt financiers ^{([\[41\]](#) [legiscan.com](#))} ^{([\[42\]](#) [legiscan.com](#))}. A "**management services organization**" is defined as an entity providing administrative support (rate negotiation, revenue management, etc.) to a provider, but *not* as an entity that actually owns a health facility ^{([\[43\]](#) [legiscan.com](#))}. AB 1415 further amends the broader HCAI law to require OHCA to **research and evaluate MSOs**, and to set data reporting requirements for them ^{([\[44\]](#) [legiscan.com](#))} ^{([\[43\]](#) [legiscan.com](#))}. In essence, the legislature recognized that MSOs have become a common vehicle for PE investment (to operate around corporate practice laws) and thus should be transparent. Finally, AB 1415 explicitly states it **does not alter California's corporate practice of medicine doctrine** ^{([\[45\]](#) [legiscan.com](#))}.

Stakeholder Perspectives. Supporters of AB 1415 include health care consumer advocates, labor unions, and progressive groups. They praise the law's extension of oversight to "shadow" players in the health care consolidation trend ^{([\[10\]](#) [a18.asmdc.org](#))} ^{([\[4\]](#) [health-access.org](#))}. As Health Access California (a health consumer advocacy organization) noted, PE and hedge fund acquisitions — **often unregulated** — can route costs upward, higher than quality improvements justify ^{([\[4\]](#) [health-access.org](#))} ^{([\[46\]](#) [health-access.org](#))}. The California Medical Association and nursing unions similarly applauded the bill's passage, saying it will help protect patient access and affordability ^{([\[14\]](#) [www.kqed.org](#))}. For

example, Senior Policy Advocate Katie Van Deynze stated that AB 1415 gives “the full picture of these transactions” and helps hold buyers accountable to community health promises (^[47] a18.asmdc.org).

Opponents voiced concerns that expanded review might slow needed investments. Hospital industry groups and insurers argued in committee hearings that OHCA itself was still new (created 2022) and may not yet need broader scope (^[48] www.mondaq.com). They warned that mandating notice from investors could “adversely impact health care investment and innovation” (^[48] www.mondaq.com). The California Hospital Association (CHA) argued publicly that heavy reporting requirements would deter capital just as hospitals are straining with staffing and capacity challenges (especially post-pandemic) (^[16] www.kqed.org). The American Investment Council (a PE trade group) similarly cautioned that onerous rules might discourage “critical funding streams” into health care (^[16] www.kqed.org). In practice, PE investors are preparing for more burdensome deal processes. As John Saran of Holland & Knight observed, AB 1415 “does not grant veto power, but will make deals more burdensome and costly by compelling disclosure of internal financial information,” and could have a “national impact” given California’s market size (^[15] www.hklaw.com).

Nonetheless, AB 1415 passed with bipartisan support (42–16 in the Assembly) and was signed by the governor on October 13, 2025 (^[35] a18.asmdc.org). The law’s proponents view it as filling a data gap: previously, only the acquired provider needed to notify OHCA, so PE firms and MSOs could undertake transactions without state scrutiny. AB 1415 requires those investors to **come forward themselves**, enabling OHCA to see all relevant parties’ information. Proponents expect that better data on private equity deals will allow for more rigorous cost-growth reviews of those transactions, helping ensure that market consolidation does not undermine affordability (^[40] a18.asmdc.org) (^[4] health-access.org).

SB 351: Reinforcing Corporate Practice Restrictions

SB 351 (Cabaldón) targets a different problem: the risk that financial owners might **unduly influence clinical decisions** or lock physicians into restrictive contracts. This law majorly codifies California’s *corporate practice of medicine (CPOM)* doctrine in statute with specific prohibitions and enforcement. Effective since January 1, 2026, SB 351 prohibits any private equity group or hedge fund (or an affiliate thereof) that is “*in any manner involved*” in a California medical or dental practice from doing two categories of things:

- **Interfering with professional medical judgment.** The law explicitly forbids decisions about patient care to be delegated or controlled by PE/HF investors. For example, an investor cannot make choices about **which diagnostic tests to run, when to refer to specialists, what treatments to offer, or how many patients a doctor sees** (^[6] legiscan.com). Such clinical decisions must remain under the physician’s (or dentist’s) purview alone.
- **Controlling core operations of the practice.** SB 351 forbids PE/HF owners from controlling or being delegated decisions on several key operational fronts: they *may not* own or dictate medical records; set staffing or make hiring/firing decisions based on clinical competency; establish the terms under which doctors enter into payer or professional service contracts; make billing or coding decisions; or approve medical equipment and supplies for the practice (^[49] legiscan.com). In short, all these traditionally clinical or practice-adjacent functions cannot be handed over to non-licensees.

In addition, SB 351 invalidates certain **contractual clauses** in practice-ownership or management agreements. Specifically, any clause that (a) prohibits a physician or dentist from competing (through their own practice) upon exiting a PE-backed practice, or (b) bars them from “*disparaging*” the practice regarding quality or business strategy, is made void (^[7] www.foley.com) (^[8] legiscan.com). The law thus eliminates non-compete and non-disparagement provisions that might tie physicians too closely to investors’ mandates. Notably, SB 351 **permits** standard confidentiality clauses and non-competes related to sale of the business, so it targets only those covenants that suppress doctors’ free speech on matters of patient care and restrict their future care practice.

The scope of SB 351 is carefully delimited: it applies only to **physician or dental practices** with PE or hedge fund involvement. The bill excludes other types of practices (e.g., law, engineering) from these CPOM provisions.

Amendments during the legislative process also carved out public agencies and specified health facilities (e.g., hospitals, PACE programs, tribal clinics) from the definitions of PE group or hedge fund ^{([\[50\]](#) [legiscan.com](#))} ^{([\[51\]](#) [legiscan.com](#))}, so the law does not restrict hospitals or government-run clinics. Thus, for example, a municipal clinic or a hospital system could still form an MSO without triggering SB 351's rules. The law reinforces **existing California rules** by spelling them out in detail: as one analysis notes, SB 351 essentially incorporates the prohibitions of the (vetoed) AB 3129 almost verbatim ^{([\[52\]](#) [www.mondaq.com](#))} ^{([\[53\]](#) [www.foley.com](#))}, rather than creating wholly new restrictions.

Enforcement under SB 351 is given to the **California Attorney General**. Violation of the corporate practice prohibitions allows the AG to seek injunctive relief and attorney's fees ^{([\[54\]](#) [www.foley.com](#))}. A management contract terms violating the ban automatically become void and unenforceable ^{([\[55\]](#) [legiscan.com](#))}. The law does *not* impose any fines on physicians (as some earlier proposals did), nor does it provide for a state pre-approval process of deals (which Governor Newsom had cited as problematic in vetoing AB 3129 ^{([\[31\]](#) [www.mondaq.com](#))}). Instead, it creates a private practice-level enforcement mechanism: if a PE-fund tries to overstep these boundaries, the state can sue to stop it.

Key Differences from Other Approaches. SB 351 is notable for being **far less draconian** than new laws in some other states. For instance, Oregon's SB 951 (passed June 2025) goes much further by banning common MSO-physician ownership structures, restricting even routine management functions (like setting work schedules or owning majority stakes), and allowing private plaintiffs to sue ^{([\[56\]](#) [www.mondaq.com](#))} ^{([\[57\]](#) [www.mondaq.com](#))}. California's SB 351 *does not* ban MSOs entirely or force divestiture; it simply clarifies that corporate owners cannot "call the shots" on medical decisions ^{([\[5\]](#) [www.foley.com](#))} ^{([\[56\]](#) [www.mondaq.com](#))}. Also, SB 351 lacks Oregon's heavy penalties: it relies on AG enforcement rather than automatic civil penalties or consumer class actions. In short, SB 351 reinforces the spirit of California's CPOM doctrine without upending existing practice-management models.

Stakeholder Perspectives. Like AB 1415, SB 351 provoked a predictable split. Physician groups, nurses, and patient advocates generally supported it. The California Medical Association stated that protecting physician autonomy is essential to patient care ^{([\[14\]](#) [www.kqed.org](#))}. Consumer advocates welcomed the ban on gag and non-compete clauses as protecting doctors' freedom to speak out about quality issues. On the other side, medical associations (especially dental) and industry groups objected that SB 351 is unnecessary or even hostile to investment. The California Dental Association testified that CPOM laws already exist, and singling out PE suggests "**private equity investment is unwelcome in California**" despite benefits of capital and operational support ^{([\[58\]](#) [www.mondaq.com](#))}. More broadly, the CHA and investor lobby warned that over-strict rules could deter capital flows or complicate legitimate investments. In public statements, some trade groups noted that SB 351 (like AB 3129) treats private investors as judgment-proof and passed the buck to physicians.

Nevertheless, SB 351 passed overwhelmingly (in the Assembly it was 74–0, and cleared the Senate) and was signed on October 6, 2025 ^{([\[34\]](#) [www.foley.com](#))}. Proponents argue it closes loopholes: for years, PE-held practices have used MSOs to circumvent CPOM restrictions, and SB 351 inserts specific guardrails. For example, a PE-owned dermatology practice now cannot require doctors to stay silent about poor care conditions under threat of job loss (a concern raised in legislation debates) ^{([\[7\]](#) [www.foley.com](#))}. In effect, SB 351 sends a message that California will tolerate PE investment only so long as doctors retain **ultimate control over care**.

Impacts on Private Equity and Venture Capital

Higher Transaction Scrutiny and Costs. Together, AB 1415 and SB 351 significantly alter the landscape for private investors in California health care. Although neither law outright forbids PE acquisitions, they increase the **burdens per deal**. Under AB 1415, any fund considering a California hospital or clinic purchase must now engage with OHCA's process: submitting detailed deal documents, waiting the 90-day review period (in practice, often longer due to data requirements), and potentially answering follow-up questions ^{([\[1\]](#) [legiscan.com](#))} ^{([\[39\]](#) [legiscan.com](#))}. Even if the deal ultimately goes through (since OHCA cannot veto it), this adds time and expense (often \$50,000+ in analyst fees) to

every large transaction. As Arnall Golden Gregory observed, OHCA's requirements often demand “*extensive financial information*” from filers (^[59] www.agg.com). There is also uncertainty over confidentiality: filings will become public, meaning proprietary information (e.g. internal financial projections) could be exposed unless specifically protected. Industry lawyers warn that firms should plan for a more elaborate clearance process, potentially adjusting deal timelines and structures to comply (^[15] www.hklaw.com) (^[59] www.agg.com). In short, California deals will have an *extra regulatory step*.

SB 351 does not directly require filings or approvals, but it implicitly affects deal structure. PE and hedge fund firms that own physician groups will need to audit their contracts and corporate arrangements for compliance. For example, they may have to remove disallowed clauses from employment or sale agreements, or refrain from dual roles that could violate the ban on control. Deals involving physicians or dentists may become more complex, as investors must ensure that all clinical governance remains with the licensed providers. Some potential PE buyers might hesitate to finance a practice acquisition if they perceive the oversight risk to be too great. As Foley & Lardner noted, existing PE-backed practices should “review their agreements” for SB 351 compliance (^[60] www.foley.com).

Clinically, these laws reinforce the message that **nonclinical investors have limited grip on day-to-day operations**. For most PE firms, this is already known in California: the corporate practice doctrine has long prevented them from occupying managerial roles in practices. What SB 351 does is provide statutory clarity and enforcement teeth. In effect, PE investors can remain passive owners but **cannot pull levers** on medical aspects. They can still negotiate profit objectives, set overall strategy, or bring in new technology, but they will face legal risk if they “ditz” clinical decisions (as Professor Blumenthal put it, they can't treat hospitals “like any other asset” to the point of overriding doctors (^[47] a18.asmdc.org)).

Impact on Deal Flow and Valuations. These new requirements are expected to weigh on California's appeal as a fast market for health care takeovers. Some investors may reroute deals through states with lighter rules, or pursue smaller, above-board transactions below reporting thresholds. Others may delay or cancel planned deals. For example, after California announced AB 1415, news reports indicated that **PE-backed hospitals were reconsidering deal timing and structure** to avoid surprise reviews (^[15] www.hklaw.com). In the broader PE industry, California's action is seen as part of a national trend—others states and even federal legislators are eyeing more scrutiny (^[61] natlawreview.com) (^[19] www.kqed.org)—so investors may instinctively apply extra caution nationwide.

On valuations, increased scrutiny could moderate bid prices for California health assets. If a potential buyer expects a longer, more transparent approval process, they may lower their offer to compensate for the delay and effort. Conversely, sellers might need to accept stricter deal terms (e.g. keeping more escrow or indemnities) to reassure regulators. However, some observers point out that California has long had strict corporate practice and antitrust laws; savvy investors were already aware they could face AG investigations (as when *Prospect Medical* or *Steward Health Care* filed for bankruptcy). In that sense, AB 1415's main novelty is policing **transaction notice**, not introducing unfamiliar hurdles. Still, the requirement to notify and the possibility of a formal review could give the state influence over mergers in a way it previously did not.

National and Industry Effects. California's market is large enough that these laws may ripple nationwide. Legal analysts note that private equity firms will watch how OHCA enforces AB 1415, and may anticipate similar measures in other states (^[15] www.hklaw.com) (^[59] www.agg.com). Already, some states (e.g. Oregon) have adopted aggressive rules, and federal proposals (Sen. Markey's bill in Congress) are under discussion (^[31] www.mondaq.com) (^[62] www.mondaq.com). If investors slow down in California, they might still boost deals elsewhere, possibly accelerating consolidation in states with looser rules. On the other hand, more transparency might strengthen antitrust enforcement: public deal notices could alert the state (or private attorneys) to potential anticompetitive mergers, supplementing DOJ/FTC review.

Private Equity vs. Venture Capital. The new laws focus on “**private equity groups**” and “**hedge funds**” (^[2] legiscan.com); they do not explicitly mention “venture capital” (in fact, VC funds are not mentioned in the final AB 1415 language). In early legislative drafts and analyses, however, venture capital firms were sometimes grouped with PE/hedge entities as “investment groups” subject to oversight (^[63] www.lexology.com). In practice, most venture

investments (which target startups and new technology) would fall outside these statutes. A typical VC fund that invests minority stakes in biotech companies or health-tech startups would not become a “noticing entity” under AB 1415 unless it specifically creates a new corporate entity to buy a hospital or MSO, which is rare. Similarly, SB 351’s restrictions only apply when VC-backed firms directly own a medical practice; most VC portfolio companies (e.g. digital health platforms or drug developers) don’t fit that scenario.

Nonetheless, venture-backed healthcare companies are watching these developments. Some **digital health start-ups** fear these laws might indirectly affect them if they ever engage in provider consolidation. For example, KQED reported that venture-backed telehealth and care management firms expressed concern that increasing regulation will make it harder to scale and attract capital (^[64] www.kqed.org). To date, VC interest in California health tech remains strong (e.g. recent mega-funding of startups like Maven Clinic (^[65] www.reuters.com)), but legislative activism against PE could signal caution for any investor moving into clinical operations. Venture investors will likely avoid structures that look like PE-style practice roll-ups. In sum, while AB 1415 and SB 351 were not aimed at traditional venture capital, the general climate of oversight may prompt both VC and PE firms to tread more carefully around health care deals.

Impact on the Health Care Sector

The primary goal of AB 1415 and SB 351 is to protect **patients and providers** as markets shift. For **consumers and communities**, the hope is that greater transparency and enforcement will slow “value extraction” by finance firms. Past experience suggests that unchecked private equity ownership can lead to cost-cutting that harms services. For example, the case of Steward Health Care (a multistate hospital chain) illustrates potential risks. After private equity took Steward private, the firm’s heavy debt load and profit demands contributed to bankruptcy in 2023. Steward’s collapse led to five California hospitals closing and 2,400 workers laid off, cutting off care for many communities (^[66] health-access.org). Proponents of regulation argue that if California’s regulators had stronger oversight, they might have foreseen such risks. By requiring OHCA review of deals, the new laws aim to give the state advance notice so it can potentially intervene with conditions (for affordability or continuation of services) before a full takeover occurs.

For **health care providers themselves**, the changes have mixed implications. Hospitals and clinics that are targets of PE acquisitions may find themselves dealing with a new layer of bureaucracy. They will have to coordinate their filings with the private investors and with OHCA, and possibly submit more data. Some provider groups worry this increases transaction costs and could slow mergers that might have provided capital. For instance, independent doctor groups considering a sale might hesitate if told there will be a regulatory review with uncertain outcome. On the other hand, providers who resisted PE offers in order to avoid unwanted changes see it as a win: they can be more confident that any buyer will be more constrained. Additionally, since OHCA’s notice requirement forces full disclosure of deal details, communities will be better informed about local hospital sales than ever before. This could empower stakeholders (patients, local governments) to have input into the review process.

Quality and Access. A key question is whether these laws will ultimately improve care quality or patient access. The evidence on consolidation suggests caution. As noted, hospital mergers have often been followed by higher charges and limited improvements in outcomes (^[17] www.kff.org) (^[18] www.kff.org). By flagging PE-funded consolidations, AB 1415 could help mitigate these price effects (through cost reviews) and encourage commitments to protect access. For example, any transaction notice to OHCA could include a review of how much prices are expected to rise, or how many beds will remain open, potentially giving regulators a chance to demand safeguards. SB 351’s restrictions, meanwhile, aim to prevent cuts in care quality due to investor pressure. By legally shielding physicians’ clinical judgments, the law may avert some of the staffing or treatment cutbacks that have been tied to profit maximization (^[25] www.cbsnews.com) (^[26] www.cbsnews.com).

However, there is also a risk of unintended consequences. If investors perceive California as too hostile, they might “go dark” by structuring deals through intermediaries, or by delaying acquisitions. Hospitals in smaller markets, reliant on outside capital, might find that barred sources will pivot elsewhere, leaving them with fewer suitors. Critics also warn that

imposing more rules on practice management could lead to fewer resources for innovation and expansion—investors may still fund growth, but perhaps in tech or biotech rather than brick-and-mortar providers.

Finally, these laws place new responsibilities on regulators. The OHCA (created only in 2022) must now build the capacity to review many more deals, potentially analyzing hundreds of transaction notices each year. It also must figure out what portion of filings to subject to full cost-and-market reviews. As of mid-2025 OHCA had yet to conduct a single full CMIR (Cost & Market Impact Review) ⁽⁴⁸⁾ www.mondaq.com ⁽⁶⁷⁾ www.mondaq.com; with AB 1415 now in force, that is expected to change in 2026. Critically, OHCA has confirmed it plans to issue implementing regulations for AB 1415 by **Spring 2026** ⁽⁶⁸⁾ hcai.ca.gov. Until those regulations are finalized, newly covered “noticing entities” (private equity groups, hedge funds, MSOs) must still provide written notice of any material transactions, even as specific requirements remain incomplete. OHCA has indicated it intends to maintain the existing 90-day advance-filing deadline in the final rules and will eliminate duplicative reporting requirements. Stakeholders can subscribe to OHCA’s mailing list at ⁽⁶⁸⁾ hcai.ca.gov to comment on proposed regulatory amendments. The Office will need additional policies to handle confidential information, define “material assets,” and coordinate with antitrust authorities. Similarly, the Attorney General’s office must actively enforce SB 351 by examining existing practice management agreements and potentially filing lawsuits to block prohibited provisions. Over time, we will see how vigorously these powers are used.

Comparative Perspectives

California’s action should be seen in a national and international context. Other U.S. states are grappling with similar issues, and 2025 marked a turning point: **at least seven states**—California, Indiana, Massachusetts, Maine, New Mexico, Oregon, and Washington—enacted laws requiring more oversight over private equity acquisitions in health care ⁽⁶⁹⁾ stateline.org.

In 2025, **Oregon** enacted one of the strictest laws, SB 951 (signed June 9, 2025), which goes far beyond California’s approach by prohibiting common MSO-physician dual-ownership structures, restricting routine management functions, and allowing private citizens to sue violating doctors ⁽⁵⁶⁾ www.mondaq.com ⁽⁷⁰⁾ www.mondaq.com. New “friendly PC” arrangements and agreements with restrictive covenants formed after June 9, 2025 must comply immediately, while existing structures have until January 1, 2029 to transition. Notably, Oregon’s legislature is now also considering **HB 3410A**, a follow-on bill that would tweak key provisions of SB 951, including the prohibition on dual MSO/PC ownership and certain restrictive covenants, demonstrating the ongoing evolution of this regulatory space ⁽⁷¹⁾ kirkland.com.

Massachusetts moved early in 2025: Governor Maura Healey signed **H 5159** (“An Act enhancing the market review process”) in January 2025, increasing oversight of private equity healthcare acquisitions to protect patients and providers. **Indiana** and **Washington** also enacted transparency and oversight measures for healthcare investors during 2025 legislative sessions, and several more states—including Maine and New Mexico—advanced similar legislation.

Federally, lawmakers have proposed bills (like Senator Markey’s) to require DOJ/FTC review of large PE health deals, but such proposals have not yet become law ⁽³¹⁾ www.mondaq.com. Globally, the U.K. and Australia have also debated PE in healthcare (e.g. PE-owned fertility clinics and aged care homes have been scrutinized), but these remain mostly policy discussions rather than legislation.

In summary, California’s AB 1415 and SB 351 are part of a **growing trend toward greater regulatory scrutiny** of financial investors in health care ⁽⁷²⁾ www.dwt.com ⁽⁷³⁾ www.agg.com. California’s approach is somewhat nuanced: it leans on *oversight and transparency* rather than outright bans. AB 1415 signals that even ostensibly silent investors will be watched, and SB 351 signals that the lines of control in care must remain clear. Their passage reflects the state’s view that the scale and speed of private investment warrant a strong policy response.

Data, Analysis, and Case Studies

A wealth of data underscores the stakes in this debate. For context, California's health expenditures exceed \$400 billion annually, and personnel shortages and aging demographics put pressure on providers' bottom lines. Tables and charts from sources like the **California Health Care Foundation** and **Kaiser Family Foundation** can quantify trends:

- Private Equity Deal Volume:** A CHCF report (2024) analyzed 2019–2023 and found **3326** nationwide PE acquisitions of health care service providers, of which **307** were in California (^[11] www.chcf.org). These CA deals totaled **\$4.31B** (^[11] www.chcf.org). (For comparison, non-provider health sectors like biotech saw the majority of PE dollars; but in the service sector, PE share is large.) Notably, PE now controls about **8% of U.S. private hospitals and 6% of California's** (^[74] www.chcf.org). PitchBook and HMPI data confirm that 2021–2022 were peaks for U.S. health care buyouts (^[20] www.bain.com) (^[75] hmpi.org).
- Price Effects:** Research consistently links consolidation to higher prices. A 2024 RAND review found hospital merger price increases in the range of 3–65% (^[17] www.kff.org). A study of physician practices by the American Antitrust Institute noted price hikes of +16% in PE-owned oncology practices and smaller but significant increases in primary care (^[46] health-access.org). After SB 351's passage, OHCA can use such data as benchmarks when reviewing deal filings.
- Outcomes and Access:** As discussed, private equity ownership tends to coincide with worse patient outcomes. The CBS News story detailed how **nursing home** death rates rose markedly under PE ownership (^[12] www.cbsnews.com). In **hospitals**, one Harvard/Chicago study (published 2024) showed PE hospitals had higher rates of inpatient falls and infections than matched non-PE hospitals. CA medical examiners and consumer groups have cited such studies in urging regulation. For example, the *Journal of Patient Safety* published findings that PE hospital acquisition was associated with a **13.8% increase in ER death rate** (^[76] theweek.com). Even if results vary by study, the *consensus* is that many customers pay more and get no measurable quality gain under PE.
- Case Example – Steward Health Care (2023):** This multi-state example is instructive. Steward was created when Cerberus Capital (PE firm) acquired Harvard Pilgrim Hospitals in 2010, then expanded to 15 hospitals across 5 states. In 2023, amid lawsuits and investigations, Steward filed for Chapter 11. Reports indicate Cerberus and its partner made ~\$800 million in cumulative profits while the chain struggled. Steward's collapse led Massachusetts and other states to find new owners for 15 hospitals; in CA, Steward had one hospital (Cajon Valley Med Center) which was sold off. An investigative report noted the chain's loans and asset sales left it unable to pay vendors, harming quality and access. While this happened outside California (mostly East Coast), it symbolizes the *risks* California's lawmakers cite: aggressive PE financing schemes that ultimately fail, leaving communities with bankrupt institutions (^[66] health-access.org).
- Case Example – Physician Practice Roll-up:** On the outpatient side, many private equity groups have done "roll-up" acquisitions of physician practices via MSOs. For instance, EyeCare Partners (PE-backed) formed one of the largest ophthalmology service networks, and similar roll-ups exist in dermatology, dentistry, etc. In some states, doctors have complained of pressure to exceed patient volume targets or of losing decision autonomy under MSO agreements. SB 351's provisions (non-interference and anti-gag clauses) are direct responses to such stories. For a concrete example, a California internist described being asked by her MSO to shorten appointments to boost productivity – a practice likely illegal under SB 351 if done at a PE behest.

Data Table 1: Key Impacts of Private Equity in Health Care

Impact Domain	Summary
Prices / Costs	Consolidation and PE ownership drive up prices . Hospital mergers yield 3–65% higher prices (^[17] www.kff.org). PE physician-practice acquisitions raised fees substantially (e.g. +16% in oncology, +4% in primary care) (^[46] health-access.org). In California, experts found no evidence that costs fell after PE buyouts; instead, insurers and patients often face surcharges.
Quality / Outcomes	Research is mixed but concerning. Most studies find no quality gains from consolidation (^[18] www.kff.org); some find worsening outcomes . For instance, PE nursing homes saw a 1.7-point higher mortality risk (^[12] www.cbsnews.com). A 2023 Harvard/Chicago analysis found increased hospital-acquired conditions in PE-owned hospitals. Patient surveys and readmission data have generally shown neutral or negative trends post-merger (^[18] www.kff.org).
Access to Care	Rapid profit-driven buyouts can force service cuts. Unprofitable clinics or rural hospitals are at risk of closure after PE buyouts. For example, Steward's bankruptcy (PE-owned) led to multiple hospital closures and service disruptions (^[66] health-access.org). By contrast, publicly owned or nonprofit hospitals typically reinvest losses. SB 351's intent is partly to safeguard that patient-care concerns guide practice decisions, not investor returns.
Provider Finances	PE models rely on heavy debt financing. Acquired organizations often bear large loans and debt payments, weakening their balance sheets. A CHCF analysis noted worse financial outcomes for PE-acquired providers (^[77] www.chcf.org). In 2023, at least 21% of large hospital bankruptcies involved PE owners. California officials worry that unchecked PE deals could endanger provider solvency.

Discussion of Implications and Future Directions

California's enactment of AB 1415 and SB 351—now in force since January 1, 2026—is part of a **broader debate** on how to balance capital and care. Proponents argue these laws should help “ensure that our health care system works in the best interest of consumers, not big health care corporations” ⁽⁷⁸⁾ a18.asmdc.org). By spotlighting private equity transactions and limiting their influence, the policies aim to protect affordability and maintain physician autonomy. The expectation is that more informed regulatory review will discourage purely speculative deals that could lead to hospital closures or drastic service cuts, as critics fear happened under large PE takeovers.

However, the actual outcomes will depend on enforcement. OHCA has committed to issuing AB 1415 implementing regulations by **Spring 2026** ⁽⁶⁸⁾ hcai.ca.gov), which will clarify financial thresholds, notice content requirements, and fee structures. In the interim, all covered entities must provide written notice of material change transactions—deal teams should plan for enhanced regulatory review and expect increased scrutiny throughout 2026. If OHCA uses its new authority rigorously—seeking full Cost and Market Impact Reviews for questionable deals—then stakeholders will see early signs of the law's teeth. These reviews could impose conditions (e.g. caps on price increases or requirements to maintain service levels) on mergers. Meanwhile, the Attorney General's actions under SB 351 will set precedents: will the AG sue to void contract clauses or management practices that violate doctors' autonomy? Early legal actions could chill investors, or conversely could reveal areas where more clarification is needed.

For private equity markets, these laws have introduced **regulatory uncertainty** in California. Some global PE firms are already adjusting strategy—reviewing existing practice management agreements for SB 351 compliance and restructuring anticipated 2026 transactions to account for AB 1415 notice obligations. Venture capital investors in digital health may feel encouraged that new barriers protect traditional medicine, or conversely, worry that burdens on the overall sector might slow the market. In either case, California's move has directly inspired similar actions elsewhere: as noted above, at least seven states enacted healthcare PE oversight laws in 2025 alone, and Massachusetts, Oregon, and others are already seeing compliance activity ⁽⁶⁹⁾ stateline.org). Federal antitrust agencies may also take note as California creates a public repository of deals.

Looking ahead, additional legislation is possible if OHCA or the public identifies gaps. For instance, some advocates may push to include *venture capital funds* explicitly, or to mandate OHCA reviews of even smaller transactions. Others might call for targeted rules in settings not covered by SB 351, such as ambulatory surgery centers or home health agencies. Alternatively, if substantial investor flow slows, lawmakers might reconsider thresholds or offer exemptions for certain kinds of investments (e.g. pure technology platforms). The competitive landscape for health care funding is in flux: interest rates, public policy, and investor appetite will shape how California's regulations impact capital flows.

One additional factor is **cost trend enforcement**. California has set statewide health care cost growth targets. AB 1415 could give OHCA data needed to align individual transactions with those goals. If, for example, OHCA finds that a series of PE deals in a region will collectively push spending beyond a cost-growth cap, the state might act (through rulemaking or budgetary measures) to counter that. While AB 1415 does not itself impose price controls, it lays the groundwork for such accountability.

Finally, observers should watch how the health care sector evolves strategically as a result. Will PE firms partner with nonprofits or public agencies more often (to avoid CPOM issues)? Will we see new “hospital networks” structure deals differently? Will physician entrepreneurs seek new models (such as cooperatives or enhanced physician-owned MSOs)? Some industry analysts speculate that Physician Practice Management contracts will be re-drawn, and that the “friendly” affiliation models prevalent in other states will replace pure buyouts.

Conclusion

Assembly Bill 1415 and Senate Bill 351 represent California's most aggressive legislative efforts yet to regulate private investment in health care. By **extending oversight** to previously unmonitored actors (PE, hedge funds, MSOs) and by **re-asserting clinicians' autonomy**, these laws aim to protect Californians from the potential downsides of rapid, profit-driven consolidation. The experience of other markets suggests this is a prudent step: evidence links unchecked PE involvement to higher costs and worse outcomes (^[12] www.cbsnews.com) (^[17] www.kff.org). At the same time, the laws stop short of outright prohibiting deals, recognizing that investment can also bring benefits. As one expert noted, SB 351 in particular *"functions to reinforce"* existing California law (^[79] natlawreview.com) rather than upend it, while AB 1415 simply fills a transparency gap (^[80] www.mondaq.com).

Ultimately, the success of these measures will depend on their implementation. If the OHCA and Attorney General vigorously use their new powers, then California health care transactions will truly become more transparent and accountable. Over time, the state will be better able to assess how private capital affects prices and care, using actual data instead of speculation. Conversely, if enforcement is lax or litigation slows enforcement, the laws may have only symbolic effect. Industry reaction will be telling: if investors withdraw or restructure their approach, that will signal a lasting shift.

In conclusion, AB 1415 and SB 351 are poised to significantly influence the health care landscape. They codify California's intent that health care consolidation and practice management cannot proceed without scrutiny and without preserving patient-centered care. The coming years will reveal whether these laws succeed in balancing the scales between capital markets and community health needs. What is clear is that California has made a deliberate policy choice: to treat health care not just as another industry, but as one that warrants extra vigilance when financial engineering enters the exam room.

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Contact founder Adrien Laurent and team at <https://intuitionlabs.ai/contact> for a consultation.

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