To:	**House Health Care Committee**
From:	**Jessa Barnard, Executive Director**
Date:	**January 27, 2026**
RE:	**H. 583, Health Care Financial Transactions and Clinical Decision Making**

The Vermont Medical Society is the largest physician membership organization in the state, representing over 3,100 physicians, physician assistants and medical students across specialties and geographic locations. The mission of the VMS is to optimize the health of all Vermonters and the health care environment in which Vermont physicians and PAs practice medicine.

At a high level, the Vermont Medical Society shares concerns regarding the impact of corporate investor partnerships or corporate entity relationships on the practice of medicine. However, we also believe that supporting practices in Vermont, especially smaller, independent practices that have less access to administrative support and capital, is crucial to supporting options in our State's health care system. We heard just last week from an independent practice that "While its intent is to stop large corporations from stripping assets from Vermont practices, it presents significant 'friendly fire' risks for independent groups."

As drafted, many of the approaches in H.583 are overly limiting and burdensome to health care practices. Some are not limited to practices involving private equity at all – for example, limiting taking on loans or mortgages. Others may limit practices working with existing Medicare-only accountable care organizations (ACOs) and independent practice associations (IPAs), threatening the existence of practices other state policies are seeking to support to encourage low cost, efficient sites of health care. We question how much of the language in the bill is workable and have substantial concern with the bill opening up practices for citizen lawsuits by allowing noncompliance to be enforced via the Consumer Protection Act.

VMS instead has submitted language that in some ways more targeted and in other ways more broadly directly addresses the "Corporate Practice of Medicine." Our suggested language includes definitions of a private equity group or hedge fund; and clear language stating that a private equity group or hedge fund involved in any manner with any health care facility doing business in Vermont not interfere with the judgment of health care professionals in making various enumerated health care decisions such as treatment options, scheduling, and determining clinical policies. A few important distinctions from H. 583: this language addresses all health care facility types without exception and it protects all health care professionals. This approach is based on language adopted in both California and Oregon. VMS is attaching a full language proposal for the Committee's review.

Our detailed comments on the bill language follow:

Section 9521 – Definitions

- (**5): Health care entity** – In the bill a "health care entity" means any health care provider, health care facility, provider organization, PBM or health insurer. This is relevant because all of these entities – including thousands of individual providers – would be required to report ownership information under Sections 9541 – 9542. In fact, as of 2024, the Attorney General's office lists 49,546 health care professionals with active Vermont licensees. Granted the majority of these individuals are likely employed by other health care facilities who could report on their behalf, but not the small, independent physician, mental health, dental, or other

providers. Is there a plan for outreach and education to these providers? What utility will this data to be to the State, the legislature or the public, especially if the Green Mountain Care Board is now requesting not to analyze this data?

- **(12)(A) "Material change transaction –** In the bill, any "material change transaction" needs to be reported to the Attorney General's office and Green Mountain Care Board – with penalties and threat of private litigation for failure to make reports, as addressed further below. We are concerned about the implications of the broad definition of material change transaction to include mergers, sales, real estate leases, closures of health care facilities and reduction in services – especially pared with the fact that these can occur over multiple transactions and apply to health care entities with a relatively low threshold of having $1,000,000 in assets.
- **(13) "Medical practice" –** More comments on this topic are below but we are unclear the intent behind the limitations on corporate practice of medicine for "medical practices" rather than all health care facilities.
- **(18) "Private equity fund" –** We echo the Vermont Health Care Association's comment that this definition should focus on entities whose primary purpose is to raise and return capital through taking an equity interest in health care entities rather than on any company that collects capital investments – this is a very broad definition that will capture a wide range of investment in the health care sector.

Section 9525 – Prohibited Transactions

We have many concerns with the impact of this section as drafted – many of the provisions are difficult to interpret and have the potential to ban many common financing and contracting mechanisms for health care practices. There is nothing limiting these transactions to those involving private equity or other concerning practices such as leveraged buyouts. In particular:

- **(1) a transaction that would give a party ownership…of an essential community provider** – This provision appears to bar any sale of any practice that serves predominantly low-income, medically underserved individuals - as "essential community provider" is defined in the referenced federal regulations. The intent of this is unclear and unworkable.
- **(2) a transaction that involves financing the acquisition of a health care entity through the use of debt –** This provision would appear to bar mortgages, bonds and other loans – making it nearly impossible to open or expand medical practices.
- **(4) a transaction that involves entering into any contract or other service or purchasing arrangement with an affiliated legal entity…except for… -** It is very difficult to interpret this paragraph and the intent is unclear – why prohibit purchasing arrangements with affiliated legal entities, especially if the intent of the arrangement is to reduce costs or improve efficiency in our health care system. This would appear to contradict our State's work on transformation and increased affordability of health care services.
- **(5) a transaction that would result in one or more health care entities that does not accept, or that places limitations on, patients covered by Medicaid, original Medicare, or Medicare Advantage**. Private practices make decisions regarding whether or not to accept new Medicaid, original Medicare or Medicare Advantage patients for any number of reasons, including payment rates, administrative burdens imposed by a payer and ease of contracting. Many Medicare Advantage plans, in particular, have high rates of prior authorization and denied payments. This would appear to place smaller, independent practices at a particular disadvantage in contracting negotiations and operating their businesses. As an example of the perhaps unintended consequences of this language – it could force a newly acquired pediatric practice to contract with Medicare Advantage plans, which typically don't serve children.

Sections 9531 - 9534 – Corporate Practice of Medicine

Section 9531 begins by stating that only professionals licensed as MDs or DOs can own a medical practice or employ other medical licensees in Vermont. VMS questions the efficacy and ability of Vermont at this juncture in our health care system's development to now bar the ownership of medical practices by non-physicians, as this section proposes. First, this approach is exclusionary of many other health care professional types who own medical practices in Vermont and could immediately upend existing ownership structures. Second, this approach has been found to be of limited utility in regulating the role of private equity in other states. A useful brief on this topic, The Corporate Practice of Medicine: Time for a Reevaluation? finds that "At present, prohibiting physician employment by lay entities has led to complicated and confusing corporate structures… The CPOM doctrine was developed to prevent the unlicensed practice of medicine, but views about how it has impacted physician markets have been mixed… While efforts by state legislatures to refine and strengthen CPOM restrictions may ward off some harmful private equity investments in physician practices, alternative policy interventions may be more effective at furthering the goal to decouple clinical decision-making and profit motives."

More specific drafting concerns with these sections include that they primarily regulate "medical practices" while excluding FQHCs, hospitals, ASCs and other practice types, with the result that the impact and burden of the proposed changes will predominately fall on independent practices. Further, the structure of these sections breaking out limitations regarding employment and control of medical decision-making separately between "medical practices" and other "employers" appears complicated for health care entities to interpret and implement. Finally, the prohibition on relinquishing control of medical practice in § 9533(f) is overly broad and would limit administrative arrangements that assist with running a medical practice but do not control medical decision making.

As stated above, VMS instead recommends the approach of prohibiting private equity groups or hedge funds from interfering with the judgment of health care professionals in making various enumerated health care decisions.

Sections 9533 & 9534 – Prohibition on Restrictive Covenants

VMS supports a broad ban on restrictive covenants or noncompete agreements in health care and extending this language to all licensed, certified or registered health care professionals as defined at 18 V.S.A. § 9402 (7). We do believe the language in H. 583 needs to be reworked and expanded to address issues that have arisen with noncompetes in other states.

The primary ethical and policy issues with noncompetes in health care are that they can restrict patients' access to care, disrupt care continuity by forcing providers to move or stop practicing, and limit clinician autonomy, potentially harming communities, especially in underserved areas. The **Federal Trade Commission (FTC)** and American Medical Association have both voiced concerns with the impact of noncompetes in health care. As recently as September 10, 2025 Federal Trade Commission Chairman Andrew N. Ferguson sent letters to several large healthcare employers and staffing firms urging them to conduct a comprehensive review of their employment agreements to ensure any noncompetes or other restrictive agreements are appropriately tailored and comply with the law. See the announcement here. The letters state that: "Noncompetes may have particularly harmful effects in healthcare markets where they can restrict patients' choices of who provides their medical care—including, critically, in rural areas where medical services are already stretched thin."

In 2024, the **American Medical Association (AMA**) adopted policy H-265.987, stating that the

AMA "opposes all restrictive covenants between employers and physician employees." In 2023, the AMA adopted policy to "support policies, regulations, and legislation that prohibits covenants not-to-compete for all physicians in clinical practice who hold employment contracts with for-profit or non-profit hospital, hospital system, or staffing company employers." The enforcement of noncompetes raises significant issues about the patient-physician relationship and the continuity of patient care. AMA Council on Ethical and Judicial Affairs Ethics Opinion 11.2.3.1 acknowledges this concern, stating in part that "Covenants-not-to-compete restrict competition, can disrupt continuity of care, and may limit access to care."

To address contracts that may have been entered with an out of state employer/staffing agency, VMS recommends adopting language like that adopted by New Mexico in Senate Bill 82 of 2017 specifying that the ban applies to health care services provided in this state and must be subject to the laws of this state and litigated in Vermont.

VMS also believes that over restrictive nonsolicitation agreements can prevent health care professionals from serving or communicating with patients in a way that limits continuity of necessary health care services. VMS does support continued use of "pay or stay" provisions as important tools for health care workforce recruitment and retention, with parameters regarding which "pay or stay" provisions are enforceable.

VMS Suggested Language for Noncompetes in Health Care

Section 1 - Prohibition of contracts that restrict health care practice
(1) A contract that creates or establishes the terms of employment, a partnership, or any other form of professional relationship with a health care provider as defined at 18 V.S.A. § 9402(7) who provides health care services in this state, may not restrict the right of the health care provider, after the termination of the employment, partnership, or other form of professional relationship, to:

(a) practice or provide services for which the provider is licensed, in any geographic area and for any period;

(b) treat, advise, consult with, or establish a provider-patient relationship with any current patient of the employer or with a patient affiliated with a partnership or other form of professional relationship; or

(c) solicit or seek to establish a provider-patient relationship with any current patient of the employer or with a patient affiliated with a partnership or other form of professional relationship.

(2) This section does not apply to a contract in connection with the sale and purchase of a practice or to a provision for repayment of all or a portion of money paid or advanced to health care provider that is subject to a payback provision that decreases over time, including but not limited to a bona fide loan, relocation cost, signing bonus, education expense, and tuition repayment expense.
(3) A provision in an agreement for clinical health care services to be rendered in this state is void, unenforceable and against public policy if the provision: (1) makes the agreement subject to the laws of another state; or (2) requires any litigation arising out of the agreement to be conducted in another state.

***Section 2. Effective date**. This act is effective January 1, 2027.*
***Section 3. Applicability**. This act applies to contracts made or renewed on or after January 1, 2027*

Sections 9541 – 9542 – Reporting of Ownership; Sharing Ownership Information

These sections require extensive reporting very two years by every "health care entity," and upon "material change transactions," including reporting of every individual with an ownership or investment interest in the health care entity, organizational charts and comprehensive financial statements, including audited financial statements. Section 9452(a) states that all of this information is public and not confidential. As defined, this reporting requirement applies to every independent

health care practitioner in the State – only excluding practices of two or fewer physicians. Not only does this pose a significant regulatory burden on every small practitioner in the state but it means that every private practice's financial statements would now be publicly available, a potential antitrust concern with little clear benefit to the state.

Section 9547 – Enforcement

VMS opposes enforcement of these provisions via the Consumer Protection Act, which opens up small practices to the threat of litigation, as the Consumer Protection Act allows private consumers to sue for violations – see 9 V.S.A. § 2461 (b). It is unclear why this is necessary or appropriate.

Thank you for your consideration of our concerns. We look forward to further work on developing a way to address the role of private equity in health care that does not create unnecessary barriers and burdens for smaller health care practitioners and practices.