Cooley

California's New Laws: What Private Equity Needs to Know About Healthcare Investment Restrictions

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On October 6 and 11, 2025, California enacted two new statutes (SB 351 and AB 1415), as detailed in this November 17 client alert. These laws, effective January 1, 2026, are specifically designed to limit the influence of nonclinical entities, including private equity groups (the focus of this alert), hedge funds and management services organizations (MSOs), on physician and dental practices. For private equity clients, these changes fundamentally alter the landscape for investment in the state's healthcare sector, presenting both immediate compliance challenges and long-term strategic considerations.

Who is affected: Private equity and healthcare investments

SB 351 applies to any private equity group or hedge fund involved in any capacity with a physician or dental practice operating in California (a "Practice"), whether as an investor, owner or through management contracts.[1] The law's reach is broad, covering direct and indirect control, and applies regardless of a Practice's legal structure. Notably, entities even partially controlled by private equity or hedge funds are subject to these new requirements.

AB 1415 sets reporting requirements for a "noticing entity," which it defines as including all of the following:

- A private equity group or hedge fund.
- A newly created business entity created for the purpose of entering into agreements or transactions with a healthcare entity.
- An MSO.
- An entity that owns, operates or controls a provider, regardless of whether the provider is currently operating, providing healthcare services or has a pending or suspended license. [2]

Key restrictions and business implications for private equity

Quick recaps of the key restrictions imposed by these new California laws are below, followed by our practical insights as to how these will affect private equity investment in the healthcare industry. For detailed requirements, including notable limitations and exceptions, please see our alert, California's New Laws Targeting Nonclinical Influence on Healthcare.

SB 351's prohibitions on clinical control

- Private equity groups cannot interfere with the professional judgment of physicians or dentists in making healthcare decisions (e.g., determining appropriateness of diagnostic tests).3
- Private equity groups also generally cannot exercise control over, or be delegated the power to perform, specified healthcare activities (e.g., competency-based clinical staffing decisions).[4]

As a result of these prohibitions, private equity groups are now expressly prohibited from exercising direct or indirect control over clinical decision-making. This limits the scope of management rights and may require a fundamental rethinking of operational oversight and governance models.

SB 351's contractual limitations

- Contracts between a Practice and a private equity group – or an entity controlled directly, in whole or in part, by a private equity group – cannot enable violations of the above clinical control prohibitions.[5]
- A management contract between a Practice and a private equity group – or any entity controlled directly or indirectly, in whole or in part, by a private equity group – cannot include noncompete and nondisparagement clauses.[6]

These changes remove key protections that private equity investors have traditionally relied on to safeguard investments and manage risk during and after a transaction.

AB 1415's mandatory reporting requirements

- AB 1415 requires a "noticing entity," as defined above, to provide written notice to California's Office of Health Care Affordability (OHCA) of certain material agreements or transactions it enters into with a healthcare entity, MSO or entity that owns or controls a healthcare entity or MSO. [7]
- An MSO is additionally subject to reporting obligations for any such agreement/transaction it has with "**any other** entity" and is subject to ongoing research and evaluation by the OHCA.[8]

This new layer of regulatory scrutiny may introduce delays, increase deal costs and require enhanced diligence and documentation.

Practical scenarios: How the laws affect private equity strategies

For private equity clients, these laws have far-reaching implications for common investment strategies:

- **Roll-up and add-on acquisitions:** The broad definitions and restrictions may complicate roll-up strategies, requiring careful structuring to avoid prohibited control and ensure compliance with reporting obligations.
- **Portfolio company management:** Existing management contracts and operational protocols should be reviewed and updated to eliminate any provisions that could be construed as clinical control or that include now-voided clauses.
- **Exit planning:** The voiding of noncompete and nondisparagement clauses may affect exit valuations and negotiation leverage, making it critical to reassess exit strategies and risk mitigation measures. Further, exits from new and existing investments in the healthcare industry going forward will be subject to regulatory procedures and require strict compliance with the new laws.

Trending nationwide legislation

Other states are also reacting to the growing role of private equity investment in healthcare through a range of policies.

SB 351 reflects one approach: California safeguarded the professional judgement of clinicians by reinforcing its corporate practice of medicine (CPOM) doctrine with statutory restrictions on private equity groups. Similarly, Oregon strengthened its CPOM doctrine with SB 951 (enacted June 6, 2025), prohibiting an MSO controlled by a private equity fund from exercising control over a medical practice in specified ways. North Carolina is also considering codifying CPOM prohibitions with SB 570, which likewise would prohibit clinical interference from MSOs, including via shared stakeholder arrangements.

California's AB 1415 takes another path: Increasing the transparency of private equity investment in healthcare through mandatory reporting to state regulators. Massachusetts also increased private equity oversight this year with H 5159 (enacted January 8, 2025), which adds notice requirements for transactions involving "significant equity investors." Private equity groups and MSOs are also subject to the civil investigative demand authority of the Massachusetts Attorney General's Office, as well as the regulatory authority of the Massachusetts Center for Health Information and Analysis, which will include disclosure and monitoring requirements. Indiana similarly enhanced the investigative ability of its attorney general's office and the regulatory oversight of its health department by requiring disclosures of private equity interests with HB 1666 (enacted May 6, 2025).

We anticipate that this growing trend toward greater regulation of private investments in the healthcare industry will continue in 2026 and beyond.

Looking ahead: Strategic considerations

California's new laws represent a significant shift for private equity investment in healthcare. To navigate this new regulatory environment, private equity groups should undertake a comprehensive review of all California-based healthcare investments, including management contracts, asset sale agreements and governance documents. Contract provisions that will be prohibited or void under the new laws should be amended, and firms should develop internal protocols for identifying and reporting material transactions to OHCA in a timely manner. We suggest engaging legal counsel early to assess ongoing and planned investments for compliance exposure and to adapt investment strategies as needed.

By proactively addressing compliance and adapting deal structures, private equity clients can mitigate risk, maintain deal momentum and continue to drive value in a rapidly evolving regulatory environment. Cooley is closely monitoring these developments and is available to assist with contract reviews, compliance planning and ongoing regulatory updates.

Notes

1. See Cal. Health & Safety Code § 1191(a) (eff. Jan. 1, 2026).
2. See id. § 127507(h).
3. See id. § 1191(a)(1).
4. See id. § 1191(a)(2).
5. See id. § 1191(c).
6. See id. § 1191(d).
7. See id. § 127507(c)(2)(A).
8. See id. § 127507(c)(2)(B), (15).

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