Commission to Evaluate the Scope of Regulatory Review and Oversight over Health Care Transactions That Impact the Delivery of Health Care Services in the State

Wednesday, October 8, 2025
10:00 a.m. – 3:00pm
Room 202 (Labor Committee)
Cross State Office Building, State House Complex

MEETING AGENDA

10:00 am	Welcome and Commission members and staff introductions *Chairs, Senator Mike Tipping and Representative Michelle Boyer*
10:15 am	Review of Resolve 2025, chapter 106 (authorizing legislation for the commission) and Freedom of Access Act *Commission staff*
10:30 am	Review and discussion of current Maine laws related to certificate of need and regulatory oversight of health care transactions *William Montejo and Rich Lawrence, Division of Licensing and Certification Department of Health and Human Services*
11:15 am	Review of proposed legislation that informed establishment of Commission • LD 985, An Act to Impose a Moratorium on the Ownership or Operation of Hospitals in the State by Private Equity Companies or Real Estate Investment Trusts • LD 1578, An Act to Require the Department of Health and Human Services to Review Disruption to or Removal of Health Services • LD 1890, An Act to Facilitate the Development of Ambulatory Surgical Facilities by Exempting Certain Facilities from the Requirement to Obtain a Certificate of Need • LD 1972, An Act to Enhance Transparency and Value in Substantial Health Care Transactions by Changing the Review and Approval Process for Those Transactions *Commission staff*
12:00pm~12:45pm	Break
12:45 pm	Public Comment on Scope of Commission's Review and Suggested Policy Changes *Comment from interested parties and members of public*
2:00 pm	Commission Discussion of Next Steps and Planning for Future Meetings
3:00 pm	Adjourn

Public access also available through the Maine Legislature's livestream:
https://legislature.maine.gov/Audio/#202

APPROVED
JULY 1, 2025
BY GOVERNOR

CHAPTER
106
RESOLVES

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND TWENTY-FIVE

H.P. 1036 - L.D. 1578

Resolve, to Establish the Commission to Evaluate the Scope of Regulatory Review and Oversight over Health Care Transactions That Impact the Delivery of Health Care Services in the State

Emergency preamble. Whereas, acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, this resolve establishes a commission to evaluate the scope of regulatory review and oversight over health care transactions that impact the delivery of health care services in the State; and

Whereas, the Legislature believes it is important to conduct this evaluation because the State's health care delivery system faces significant financial and workforce challenges; and

Whereas, this legislation must take effect as soon as possible in order to provide adequate time for the commission to complete its work in a timely manner before submitting its report; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore, be it

Sec. 1. Commission established. Resolved: That the Commission to Evaluate the Scope of Regulatory Review and Oversight over Health Care Transactions That Impact the Delivery of Health Care Services in the State, referred to in this resolve as "the commission," is established.

Sec. 2. Commission membership. Resolved: That, notwithstanding Joint Rule 353, the commission consists of 15 members appointed as follows:

1. Two members of the Senate, including one member of the party holding the largest number of seats in the Legislature and one member of the party holding the 2nd largest number of seats in the Legislature, appointed by the President of the Senate;

2. Two members of the House of Representatives, including one member of the party holding the largest number of seats in the Legislature and one member of the party holding the 2nd largest number of seats in the Legislature, appointed by the Speaker of the House;

3. Two members representing hospitals, one member appointed by the President of the Senate and one member appointed by the Speaker of the House;

4. Two members representing health care providers, one of whom must represent an independently owned specialty practice and is appointed by the President of the Senate and the other of whom is appointed by the Speaker of the House;

5. One member representing a statewide association of nursing homes or other long-term care facilities, appointed by the President of the Senate;

6. One member of the public representing health insurance consumers, appointed by the Speaker of the House;

7. One member representing health insurance carriers, appointed by the President of the Senate;

8. One member representing a statewide association of health care purchasers, appointed by the Speaker of the House;

9. One member of the public who is a lawyer who has practiced in the field of certificate of need law or mergers or acquisitions of health care entities, appointed by the Speaker of the House;

10. The executive director of the Office of Affordable Health Care or the executive director's designee; and

11. The Commissioner of Health and Human Services or the commissioner's designee.

Sec. 3. Chairs. Resolved: That the first-named Senate member is the Senate chair and the first-named House of Representatives member is the House chair of the commission.

Sec. 4. Appointments; convening of commission. Resolved: That all appointments must be made no later than 30 days following the effective date of this resolve. The appointing authorities shall notify the Executive Director of the Legislative Council once all appointments have been completed. After appointment of all members, the chairs shall call and convene the first meeting of the commission. If 30 days or more after the effective date of this resolve a majority of but not all appointments have been made, the chairs may request authority and the Legislative Council may grant authority for the commission to meet and conduct its business.

Sec. 5. Duties. Resolved: That the commission shall:

1. Evaluate potential changes to the State's certificate of need laws, including, but not limited to, expanding the scope of review to the termination or disruption of health care services and changing the monetary thresholds that trigger review;

2. Evaluate potential legislative changes to require regulatory review and oversight of substantial health care transactions, such as transfers of ownership or control, among hospitals, health care facilities and health care provider organizations;

3. Evaluate the role of a private equity company or real estate investment trust taking a direct or indirect ownership interest, operational control or financial control of a hospital in the State; and

4. Examine any other issues to further the duties and purposes of the study.

The commission shall review and identify best practices learned from similar efforts in other states. The commission may hold hearings and invite testimony from experts and the public to gather information.

Sec. 6. Staff assistance. Resolved: That the Legislative Council shall provide necessary staffing services to the commission, except that Legislative Council staff support is not authorized when the Legislature is in regular or special session.

Sec. 7. Stakeholder participation. Resolved: That the commission may invite the participation of stakeholders to participate in meetings or subcommittee meetings of the commission to ensure the commission has the information and expertise necessary to fulfill its duties, including the Maine Health Data Organization.

Sec. 8. Report. Resolved: That, notwithstanding Joint Rule 353, no later than December 10, 2025, the commission shall submit a report that includes its findings and recommendations, including suggested legislation, to the Joint Standing Committee on Health Coverage, Insurance and Financial Services. The joint standing committee may report out legislation based on the report to the Second Regular Session of the 132nd Legislature.

Sec. 9. Outside funding. Resolved: That the commission may seek funding contributions to contribute to the costs of the study. All funding is subject to approval by the Legislative Council in accordance with its policies.

Emergency clause. In view of the emergency cited in the preamble, this legislation takes effect when approved.

Commission to Evaluate the Scope of Regulatory Review and Oversight Over Health Care Transactions That Impact the Delivery of Health Care Services in the State

Resolve 2025, c. 106

MEMBERSHIP LIST
Updated: 9/24/25

Name	Representation
Sen. Mike Tipping	Member of the Senate, including one member of the party holding the largest number of seats, appointed by the President of the Senate
Rep. Michelle Boyer	Member of the House of Representatives, including one member of the party holding the largest number of seats, appointed by Speaker of the House
Sen. David Haggan	Member of the Senate, including one member of the party holding the 2nd largest number of seats, appointed by the President of the Senate
Rep. Robert A. Foley	Member of the House of Representatives, including one member of the party holding the 2nd largest number of seats, appointed by Speaker of the House
Susan Cheff	Member representing health care providers, appointed by Speaker of the House
Kate Ende	Member of the public representing health insurance consumers, appointed by Speaker of the House
Adam Prescott	Member of the public who is a lawyer who has practiced in the field of certificate of need law or mergers or acquisitions of health care entities, appointed by the Speaker of the House
Trevor Putnoky	Member representing a statewide association of health care purchasers, appointed by the Speaker of the House
Marie Vienneau	Member representing hospitals, appointed by the Speaker of the House
Angela Cole Westhoff	Member representing a statewide association of nursing homes or other long-term care facilities, appointed by the President of the Senate
Kristine M. Ossenfort, Esq.	Member representing the insurance carriers, appointed by the President of the Senate
Christina Maquire	Member representing hospitals, appointed by the President of the Senate
Roger Poitras	Member representing an independently owned specialty health care practice, appointed by the President of the Senate
William Montejo	Commissioner of Health and Human Services or the Commissioner's designee
Meg Garratt-Reed	Executive Director of the Office of Affordable Health Care or the executive director's designee

Maine's Freedom of Access Act and the Conduct of the Business of the Legislature

Prepared for the Right to Know Advisory Committee
by the Office of Policy and Legal Analysis and the Office of the Attorney General
Updated January 2025

The Maine Freedom of Access Act requires governmental entities to conduct public business in the open and to provide access to public records. Legislative meetings and records are subject to the law and must be open to the public, with some limited exceptions set forth in the law.

Intent of the Freedom of Access Law
The Maine Freedom of Access Act provides that it is the intent of the Legislature that "actions [involving the conduct of the people's business] be taken openly and that the records of their actions be open to public inspection and their deliberations be conducted openly." The Freedom of Access Act, found in Title 1 of the Maine Revised Statutes, chapter 13, applies to all governmental entities, including the Legislature.

Public Proceedings
Under state law, all meetings of the Legislature, its joint standing committees, joint select committees and legislative subcommittees are public proceedings. A legislative subcommittee is a group of 3 or more committee members appointed for the purpose of conducting legislative business on behalf of the committee.

The public must be given notice of public proceedings and must be allowed to attend. Notice must be given in ample time to allow the public to attend and in a manner reasonably calculated to notify the general public. The public is also allowed to record the proceedings as long as the activity does not interfere with the orderly conduct of the proceedings.

Party caucuses are not committees or subcommittees of the Legislature, so their meetings do not appear to be public proceedings. Similarly, informal meetings of the members of a committee who are affiliated with the same party are not public proceedings as these members are not designated by the committee as a whole to conduct business of the committee. However, committee members should be careful when they caucus not to make decisions or otherwise use the caucus to circumvent the public proceeding requirements.

Limited Exception to Public Proceedings (Executive Sessions)
In very limited situations, joint standing committees may hold executive sessions to discuss certain matters. State law is quite specific as to those matters that may be deliberated in executive sessions. The executive session must not be used to defeat the purpose of the Act, which is to ensure that the people's business is conducted in the open.

The permitted reasons for executive session are set forth in the law, Title 1, section 405 and Title 3, section 156. The reasons most relevant to legislative work are discussion of confidential records and pre-hearing conferences on confirmations.

An executive session may be called only by a public, recorded vote of 3/5 of the members, present and voting, of the committee. The motion to go into executive session must indicate the precise nature of the business to be discussed and no other matters may be discussed. A committee may not take any votes or other official action in executive sessions.

If a committee wants to hold an executive session, the committee should discuss the circumstances with a nonpartisan legislative analyst from the Office of Policy and Legal Analysis or the Office of Fiscal and Program Review who can provide the committee with guidance about whether an executive session is permitted and, if so, how to proceed.

Public Records
The Freedom of Access Act defines "public records" broadly, to include all material in possession of public agencies, staff and officials if the materials were received or prepared for use in, or relate to, the transaction of public or governmental business. The scope of the definition means that most, if not all, papers and electronic records relating to legislative business are public records. This includes records that may be stored on an individual legislator's personal computer, tablet or smartphone if they relate to or were prepared for use in the transaction of public business, *e.g.*, constituent inquiries, emails, text messages or other correspondence about legislative matters. Information contained in a communication between a constituent and a legislator may be confidential if it meets certain narrow requirements.

Time-limited Exception from Public Disclosure for Certain Legislative Records
The Freedom of Access Act contains exceptions to the general rule that public records must be made available for public inspection and copying. One exception that is relevant to legislative work allows certain legislative papers to be withheld from public disclosure until the end of the legislative session in which they are being used. The exceptions are as follows:

- Legislative papers and reports (e.g. bill drafts, committee amendments and the like) are not public records until signed and publicly distributed; and
- Working papers, drafts, records and memoranda used to prepare proposed legislative papers or reports are not public records until the end of the legislative session in which the papers or reports are prepared or considered or to which they are carried over.

The Legislative Council's Confidentiality Policy and the Joint Rules provide guidance to legislative staff about how such records are to be treated before they become public records.

Confidential Records in the Possession of Committees
Committees may also need to be prepared to deal with other types of non-public records, such as individual medical or financial records that are classified as confidential under state or federal law.

If the committee comes into possession of records that are declared confidential by law, the Freedom of Access Act allows the committee to withhold those records from the public and to go into executive session to consider them (see discussion above for the proper process).

In addition, the committee should also find out whether there are laws that set specific limitations on, and penalties for, dissemination of those records. The Office of the Attorney General or a nonpartisan legislative analyst from the Office of Policy and Legal Analysis or the Office of Fiscal and Program Review can help the committee with these records.

Joint Rule 313 also sets forth procedures to be followed by a committee that possesses confidential records.

Legislative Review of Public Record Exceptions
All exceptions to the public records law are subject to a review process. A legislative committee that considers a legislative measure proposing a new statutory exception must refer the measure to the Judiciary Committee if a majority of the committee supports the proposed exception. The Judiciary Committee will review and evaluate the proposal according to statutory standards, then report findings and recommendations to the committee of jurisdiction. The Judiciary Committee regularly seeks input from the Right to Know Advisory Committee on public records, confidentiality and other freedom of access issues.

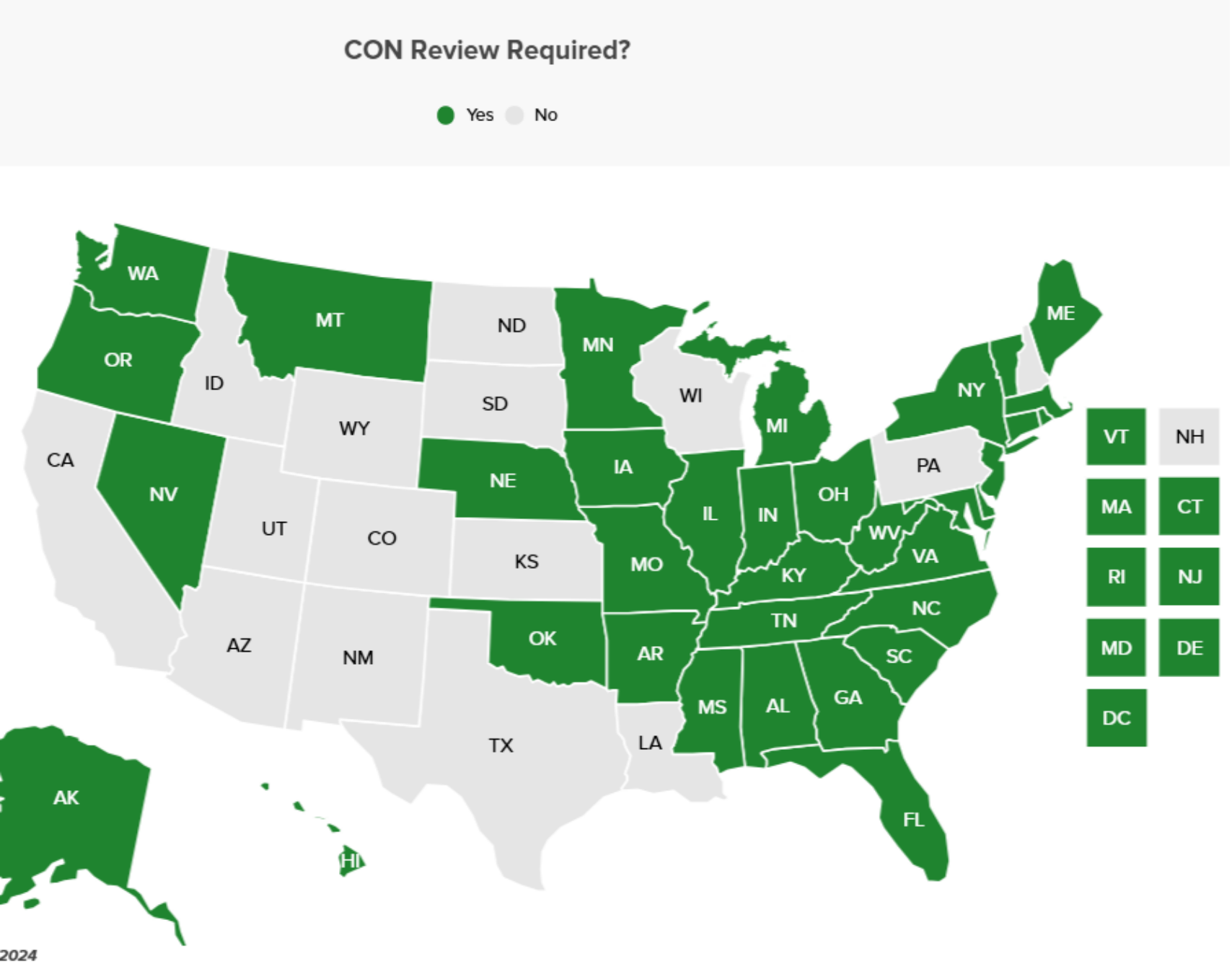
Public Access Ombudsman
The Public Access Ombudsman, an attorney located in the Department of the Attorney General, is available to provide information about public meetings and public records, to help resolve complaints about accessing proceedings and records and to help educate the public as well as public agencies and officials. Legislators may contact the Public Access Ombudsman, Brenda Kielty, at Brenda.Kielty@maine.gov, or (207) 626-8577 for assistance.

Maine's Certificate of Need (CON) Program

Presentation by DHHS, Division of Licensing and Certification

What is a Certificate of Need (CON)?

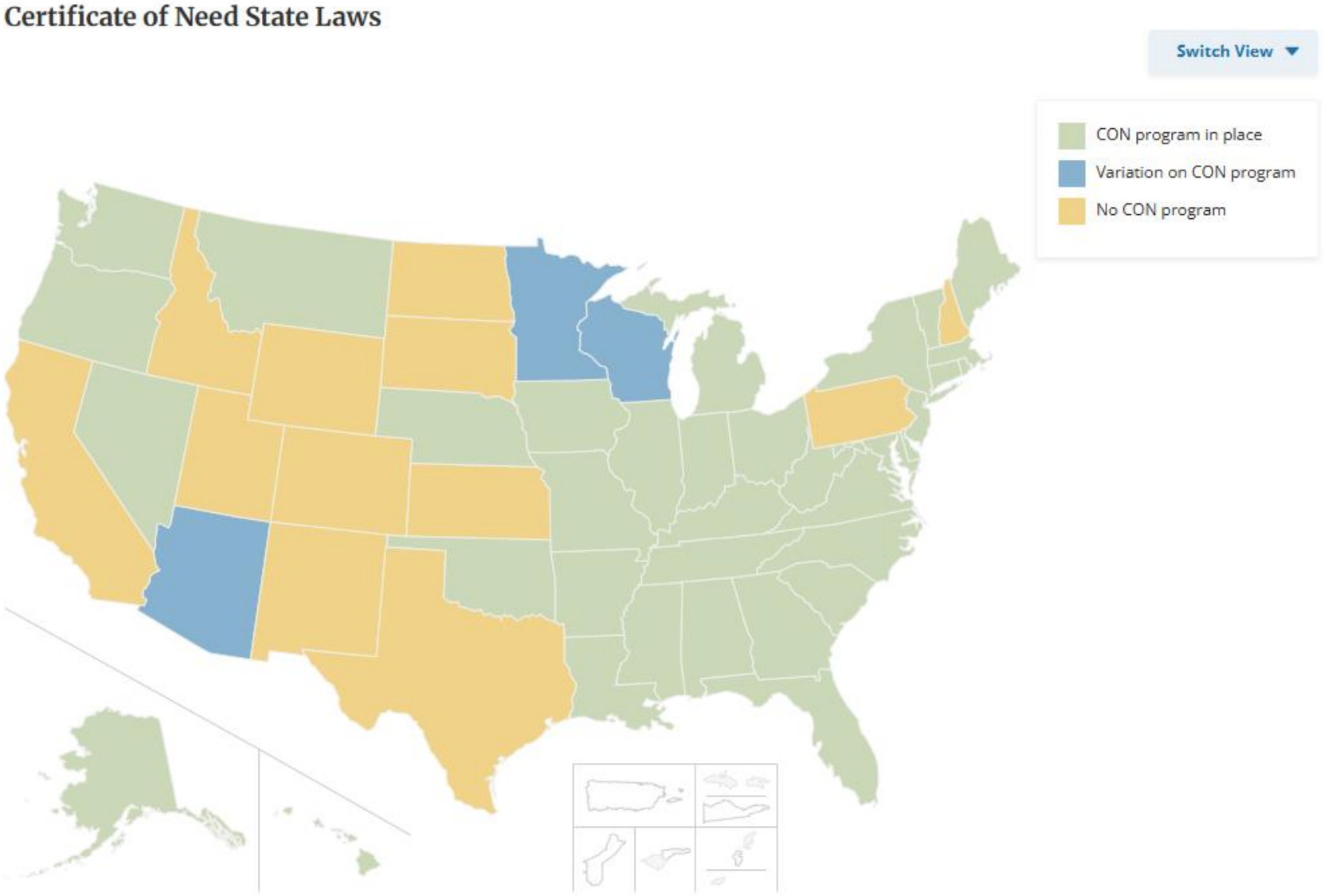
- **A Certificate of Need (CON)** is a regulatory program requiring certain types of healthcare providers to obtain state approval prior to making major changes in the healthcare landscape.



Across the Country

Source: The National Academy for State Health Policy (NASHP)

From NASHP, a "50-State Scan of State Certificate-of-Need Program" viewed 9/16/2025 at https://nashp.org/state-tracker/50-state-scan-of-state-certificate-of-need-programs/



Across the Country

Source: The National Conference of State Legislatures (NACL)

From NACL, “Certificate of Need State Laws” viewed 9/16/2025 at https://www.ncsl.org/health/certificate-of-need-state-laws

History of CON (From NACL):

New York was the first state to enact a CON law in 1964; 26 states enacted CON laws throughout the following decade. Early CON programs typically regulated capital expenditures greater than $100,000, facilities expanding bed capacity and facilities establishing or expanding health care services.

In 1972, several states adopted Section 1122 waivers, which provided federal funding to states regulating new health care services receiving Medicare and Medicaid dollars. Congress then passed the National Health Planning and Resources Development Act of 1974 bolstering federal funding for state and local health planning regulations.

The federal law required states to adopt CON laws similar to the federal model resulting in all states, except Louisiana, with some form of a CON program by 1982. This meant states had broad regulatory oversight over several facilities—including hospitals, nursing and intermediate care facilities, and ambulatory surgery centers—as well as the expansion or development of a facility's service capacity.

The federal mandate was repealed in 1987, along with the associated federal funding. Subsequently, several states repealed or modified their CON laws.

From NACL, "Certificate of Need State Laws" viewed 9/16/2025 at https://www.ncsl.org/health/certificate-of-need-state-laws

More From NACL:

State Actions Summary
In the past several years, many states have introduced or enacted legislation to modify their CON programs.
Changes range from fully repealing an existing CON program to creating a new CON program.
However, most state legislation makes targeted changes to CON oversight, such as excluding specific facilities from CON review.

From NACL, “Certificate of Need State Laws” viewed 9/16/2025 at https://www.ncsl.org/health/certificate-of-need-state-laws

From NACL:

- States with CON laws most often regulate hospitals, outpatient facilities and long-term care facilities.
- As of Jan. 1, 2024, 12 states have fully repealed their CON programs or allowed the program to expire. New Hampshire was the most recent state to repeal its CON program in 2016.
- Four states—Arizona, Louisiana, Minnesota and Wisconsin—do not officially operate a CON program, but they maintain several approval processes that function similarly to CON.
- At least six states—Michigan, Montana, New York, North Carolina, Tennessee and Washington—and Washington, D.C., enacted CON legislation in 2021. Montana's legislation was the most sweeping of these bills, exempting all facilities except long-term care facilities from CON review.
- In 2022, at least 12 states—Arizona, Connecticut (HB 5001 and 5506), Kentucky, Louisiana, Maryland, Michigan, Mississippi, New York, Ohio, Oklahoma, Vermont and Virginia—and Washington D.C., enacted legislation modifying their CON laws in some capacity.
- This trend remained consistent in 2023 as at least 10 states—Connecticut, Iowa, Maine, North Carolina (HB 259, HB 76, SB 115), South Carolina, Tennessee, Vermont, Virginia, Washington and West Virginia—enacted legislation altering their CON laws in some capacity.
  - Connecticut exempts the establishment of pilot program harm reduction centers from CON. South Carolina repealed all CON requirements except those that relate to nursing homes and a select few related to hospitals.

From NACL, "Certificate of Need State Laws" viewed 9/16/2025 at https://www.ncsl.org/health/certificate-of-need-state-laws

From NACL:

In line with prior years, in 2024, at least 12 states - Connecticut, Georgia, Iowa (HF 2402, SF 2160, SF 2385), Kentucky, Massachusetts, Nebraska, Oklahoma, South Carolina, Tennessee, Virginia, Washington, and West Virginia (SB 17 and SB 2028) - passed legislation to adjust their CON laws in some capacity.

- At least three states (Iowa, Tennessee, Massachusetts) enacted legislation that commissioned studies on the efficacy of their CON requirements, though the commissions vary in scope and size with some targeted on specific facilities and others being more holistic multiyear reviews.
- Psychiatric facilities continue to be a target of legislation, with at least four states (Georgia, Iowa, Oklahoma, Washington) creating CON exemptions on psychiatric facilities.

Related to CON, at least 13 states have a moratorium on certain health care activities and capital expenditures, meaning they will not grant CON or state approval for a specific activity. Moratoria are most common for long-term care related activities, such as expanding the number of long-term care beds in a facility.

From NACL, “Certificate of Need State Laws” viewed 9/16/2025 at https://www.ncsl.org/health/certificate-of-need-state-laws

Purpose of Maine's CON Program

Support	Support effective health planning.
Support	Support the provision of quality health care in a manner that ensures access to cost-effective services.
Support	Support reasonable choice in health care services while avoiding excessive duplication.
Ensure	Ensure that state funds are used prudently in the provision of health care services.
Ensure	Ensure public participation in the process of determining the array, distribution, quantity, quality and cost of these health care services.
Improve	Improve the availability of health care services throughout the State regardless of the consumer’s ability to pay.
Seek	Seek a balance between competition and regulation in the provision of health care.
Promote	Promote the development of primary and secondary preventive health care services.

Legal Authority

Statutory Basis:

- Title 22, **Maine Revised Statutes, Chapter 103-A**

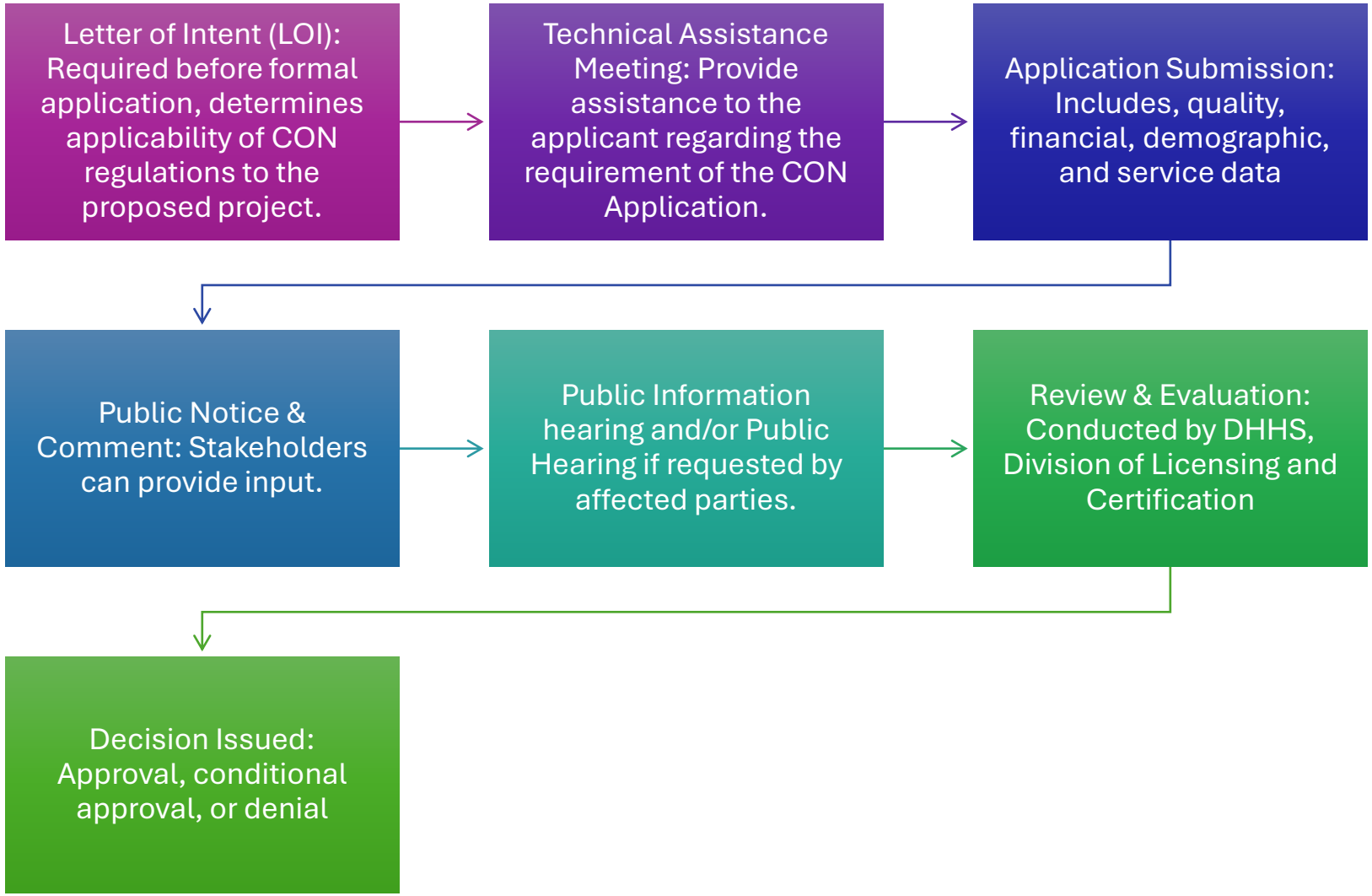
Regulatory Oversight:

- Maine Department of Health and Human Services (DHHS), Division of Licensing and Certification

When is a CON Required in Maine?

- Transfer of ownership; acquisition by lease, donation, transfer; acquisition of control.
- Acquisitions of major medical equipment (e.g., MRI, CT Scanners).
- Capital expenditures in excess of review thresholds.
- The offering or development of any new health service.
- Change in bed complement. Increase of over 10% in licensed bed category (excludes nursing homes).
- New health care facility.

Application Process Overview



Review Criteria

- ✓ Fit, willing and able – Is applicant able to provide services proposed in the project.
- ✓ Economic feasibility and sustainability (Financial Analysis)
- ✓ Public need for the project
- ✓ Orderly and Economic Development- impact on total health care expense and examination of alternatives to the project. Impact on access to services.
- ✓ Outcomes and Community Impact- Ensure high quality outcomes and assesses impact on other service providers.
- ✓ Service Utilization- Does the project result in inappropriate increases in service utilization.

Exemptions & Thresholds

Certain **projects are exempt**, such as:

- Routine renovations below review thresholds.
- Low-cost equipment below review thresholds.
- Healing through prayer
- Health Maintenance Organizations
- Home health care services.
- Hospice
- Assisted Living
- Assisted Housing
- Critical access hospitals converting acute care beds to hospital swing beds.

Thresholds are updated periodically and vary by service type

Recent Trends and Developments

Greater incidence of out of state providers, private equity and real estate investment trusts owning and managing Maine health care facilities.

More nursing home closures and greater concern about the financial viability of Maine hospitals.

Ongoing evaluation of CON's impact on **cost containment** and **access**

Criticism and Support

Critics say:

- Can limit competition and innovation
- May delay needed services

Supporters argue:

- Helps control costs
- Prevents unnecessary duplication
- Ensures access to services and equitable service distribution

Conclusion

Maine’s CON program plays a vital role in regulating health care growth.

Balances public need, cost control, and accessibility.

Stakeholder input and community health planning are central to the process.

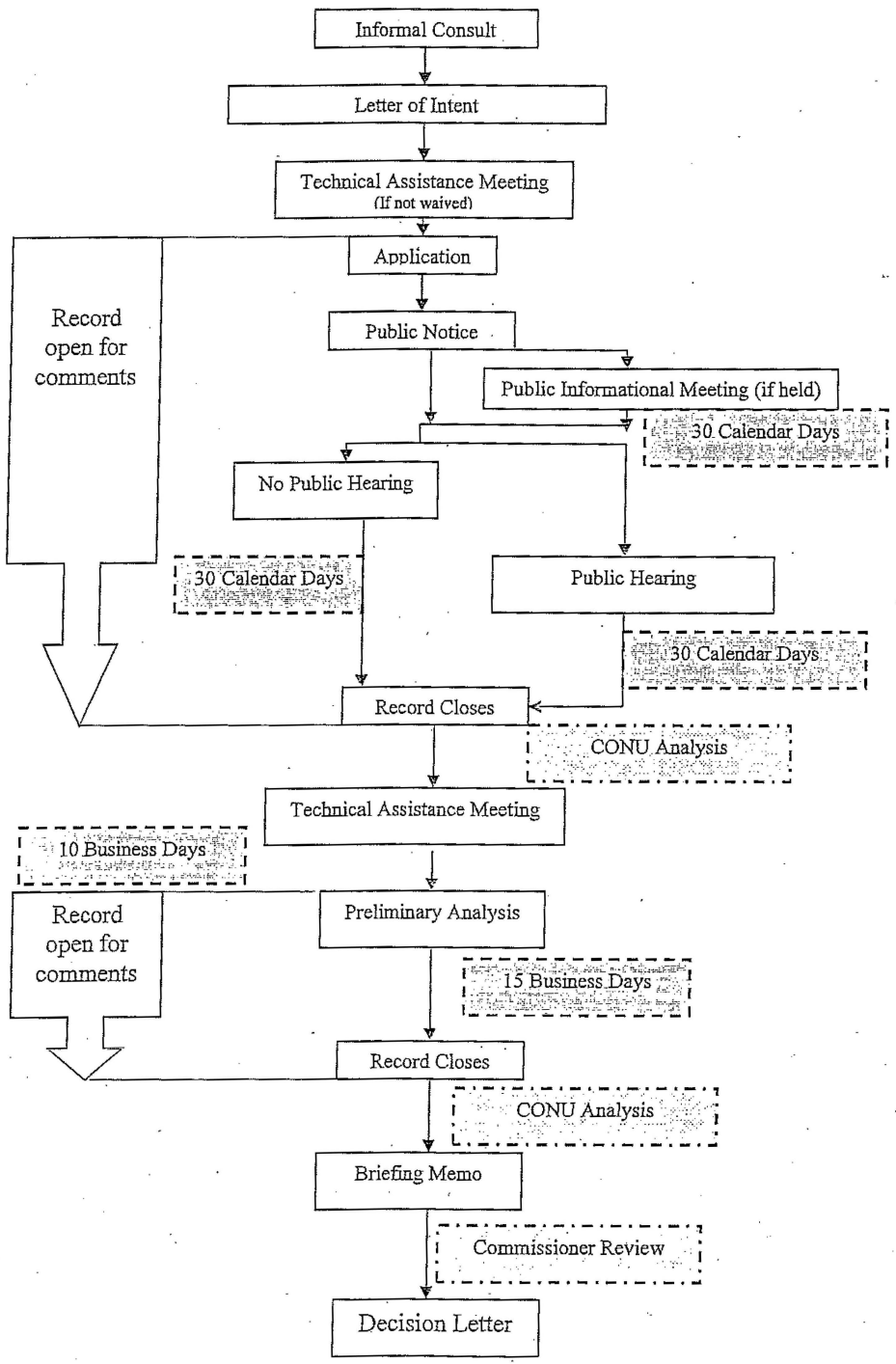
Appendix

1. Covered Projects, Threshold Amounts, Statutory Criteria
2. Visual Process

State of Maine Regulatory Thresholds for Certificate of Need Projects Covered Projects, Threshold Amounts, Statutory Citations			
Covered Projects	**Base Statutory Threshold Amount**	**Applicable Threshold as of 1/1/2024**	**Citation**
Capital Expenditures – new or existing hospitals; other existing healthcare facilities, excluding nursing facilities	$10,000,000	$13,793,936	22 M.R.S.A. §329 (3)
Nursing Facility: capital expenditures – new or existing nursing facility; expenditures related to nursing services	$5,000,000	$6,896,968	22 M.R.S.A. §329 (6)
New Nursing Facility - new nursing facility	$5,000,000	$5,000,000	22 M.R.S.A. §329 (4-A) (A)(1)
New Healthcare Facility –kidney disease treatment center including a freestanding hemodialysis facility; rehabilitation facility; ambulatory surgical facility; independent radiological service center; independent cardiac catheterization center or cancer treatment center (excludes hospitals or nursing facilities)	$3,000,000	$3,000,000	22 M.R.S.A. §329 (4-A) (B)(1)
Major Medical Equipment	$3,200,000	$4,414,059	22 M.R.S.A §328 (16)
New Health Service - capital expenditures	$3,000,000	$4,138,181	22 M.R.S.A. §328 (17-A) (A)
New Health Service – 3rd-year incremental annual operating costs	$1,000,000	$1,379,394	22 M.R.S.A.§328 (17-A) (B)
New Technology in private office of healthcare practitioner is a new health service	$3,200,000	$4,414,059	22 M.R.S.A. §328 (17-A) (C)
Indexed Threshold: Except for "new healthcare facility" thresholds, 22 M.R.S.A. §329 (4-A), the baseline threshold amounts shall be updated annually beginning January 1, 2013, as determined by United States Department of Labor, Bureau of Labor Statistics Consumer Price Index, medical care services index. See 22 M.R.S.A. §328 (16), (17-A), and §329 (3), (6).			

Updated: April 2015

Certificate of Need Process



CHAPTER 103-A

CERTIFICATE OF NEED

§326. Short title

This chapter may be known and cited as the "Maine Certificate of Need Act of 2002." [PL 2001, c. 664, §2 (NEW).]

SECTION HISTORY

PL 2001, c. 664, §2 (NEW).

§327. Declaration of findings and purposes

The Legislature makes the following statements of findings and purposes. [PL 2001, c. 664, §2 (NEW).]

1. Findings. The Legislature finds that unnecessary construction or modification of health care facilities and duplication of health services are substantial factors in the cost of health care and the ability of the public to obtain necessary medical services.
[PL 2001, c. 664, §2 (NEW).]

2. Purposes. The purposes of this chapter are to:

A. Support effective health planning; [PL 2001, c. 664, §2 (NEW).]

B. Support the provision of quality health care in a manner that ensures access to cost-effective services; [PL 2001, c. 664, §2 (NEW).]

C. Support reasonable choice in health care services while avoiding excessive duplication; [PL 2001, c. 664, §2 (NEW).]

D. Ensure that state funds are used prudently in the provision of health care services; [PL 2001, c. 664, §2 (NEW).]

E. Ensure public participation in the process of determining the array, distribution, quantity, quality and cost of these health care services; [PL 2001, c. 664, §2 (NEW).]

F. Improve the availability of health care services throughout the State; [PL 2001, c. 664, §2 (NEW).]

G. Support the development and availability of health care services regardless of the consumer's ability to pay; [PL 2001, c. 664, §2 (NEW).]

H. Seek a balance, to the extent a balance assists in achieving the purposes of this subsection, between competition and regulation in the provision of health care; and [PL 2001, c. 664, §2 (NEW).]

I. Promote the development of primary and secondary preventive health care services. [PL 2001, c. 664, §2 (NEW).]

[PL 2001, c. 664, §2 (NEW).]

SECTION HISTORY

PL 2001, c. 664, §2 (NEW).

§328. Definitions

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings. [PL 2001, c. 664, §2 (NEW).]

1. Access to care. "Access to care" means the ability to obtain in a timely manner needed personal health services to achieve the best possible health outcomes balanced by the health system's resource limitations. Access to care may be influenced by many factors, including, without limitation, travel, distance, waiting time, available resources, availability of a source of care and the health status of the population served.
[PL 2001, c. 664, §2 (NEW).]

2. Ambulatory surgical facility. "Ambulatory surgical facility" means a facility, not part of a hospital, that provides surgical treatment to patients not requiring hospitalization. "Ambulatory surgical facility" does not include the offices of private physicians or dentists, whether in individual or group practice.
[PL 2001, c. 664, §2 (NEW).]

3. Capital expenditure. "Capital expenditure" means an expenditure, including a force account expenditure or predevelopment activities, that under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance and, for the purposes of this chapter, includes capitalized interest on borrowed funds and the fair market value of any property or equipment that is acquired under lease or comparable arrangement or by donation.
[PL 2001, c. 664, §2 (NEW).]

3-A. Capital investment fund.
[PL 2011, c. 213, §2 (RP).]

4. Construction. "Construction," when used in connection with "health care facility," means the establishment, erection, building, purchase or other acquisition of a health care facility.
[PL 2001, c. 664, §2 (NEW).]

5. Development. "Development," when used in connection with health service, means the undertaking of those activities that on their completion will result in the offering of a new health service to the public.
[PL 2001, c. 664, §2 (NEW).]

6. Expenditure minimum for annual operating costs. "Expenditure minimum for annual operating costs" means, for services commenced after October 1, 1998, $400,000 for the 3rd fiscal year, including a partial first year.
[PL 2001, c. 664, §2 (NEW).]

7. Generally accepted accounting principles. "Generally accepted accounting principles" means accounting principles approved by the American Institute of Certified Public Accountants or a successor organization.
[PL 2001, c. 664, §2 (NEW).]

8. Health care facility. "Health care facility" means a hospital, psychiatric hospital, nursing facility, kidney disease treatment center including a freestanding hemodialysis facility, rehabilitation facility, ambulatory surgical facility, independent radiological service center, independent cardiac catheterization center or cancer treatment center. "Health care facility" does not include the office of a private health care practitioner, as defined in Title 24, section 2502, subsection 1-A, whether in individual or group practice. In an ambulatory surgical facility that functions also as the office of a health care practitioner, the following portions of the ambulatory surgical facility are considered to be a health care facility:

A. Operating rooms; [PL 2003, c. 469, Pt. C, §3 (NEW).]

B. Recovery rooms; [PL 2003, c. 469, Pt. C, §3 (NEW).]

C. Waiting areas for ambulatory surgical facility patients; [PL 2009, c. 383, §1 (AMD).]

C-1. Any space with major medical equipment; and [PL 2009, c. 383, §2 (NEW).]

D. Any other space used primarily to support the activities of the ambulatory surgical facility. [PL 2003, c. 469, Pt. C, §3 (NEW).]

[PL 2009, c. 383, §§1, 2 (AMD).]

9. Health maintenance organization. "Health maintenance organization" means a public or private organization that:

A. Provides or otherwise makes available to enrolled participants health care services, including at least the following basic health services: usual physician services, hospitalization services, laboratory services, x-ray services, emergency and preventive health services and out-of-area coverage; [PL 2001, c. 664, §2 (NEW).]

B. Is compensated, except for copayments, for the provision of the basic health services to enrolled participants on a predetermined periodic rate basis; and [PL 2001, c. 664, §2 (NEW).]

C. Provides physicians' services primarily through physicians who are either employees or partners of the organization or through arrangements with individual physicians or one or more groups of physicians. [PL 2001, c. 664, §2 (NEW).]

[PL 2001, c. 664, §2 (NEW).]

10. Health need. "Health need" means a situation or a condition of a person, expressed in health outcome measures such as mortality, morbidity or disability, that is considered undesirable and is likely to exist in the future.

[PL 2001, c. 664, §2 (NEW).]

11. Health planning. "Health planning" means data assembly and analysis, goal determination and the formulation of action recommendations regarding health services.

[PL 2001, c. 664, §2 (NEW).]

12. Health services. "Health services" means clinically related services that are diagnostic, treatment, rehabilitative services or nursing services provided by a nursing facility. "Health services" includes alcohol or drug dependence, substance use disorder and mental health services.

[PL 2017, c. 407, Pt. A, §64 (AMD).]

13. Health status. "Health status" means patient or population measures, or both, of good and poor health practices, rates of death and disease, both chronic and infectious, and the prevalence of symptoms or conditions, or both, of illness and wellness.

[PL 2001, c. 664, §2 (NEW).]

14. Hospital. "Hospital" means an institution that primarily provides to inpatients, by or under the supervision of physicians, diagnostic services and therapeutic services for medical diagnosis, treatment and care of injured, disabled or sick persons or rehabilitation services for the rehabilitation of injured, disabled or sick persons. "Hospital" also includes psychiatric and tuberculosis hospitals.

[PL 2001, c. 664, §2 (NEW).]

15. Hospital swing bed. "Hospital swing bed" means an acute care bed licensed by the Office of MaineCare Services, Division of Licensing and Regulatory Services for the use also as a nursing care bed. Swing beds may be established only in rural hospitals with fewer than 100 licensed acute care beds.

[PL 2019, c. 343, Pt. YY, §4 (AMD).]

16. Major medical equipment. "Major medical equipment" means a single unit of medical equipment or a single system of components with related functions used to provide medical and other health services that costs $3,200,000 or more. "Major medical equipment" does not include medical equipment acquired by or on behalf of a clinical laboratory to provide clinical laboratory services if the clinical laboratory is independent of a physician's office and a hospital and has been determined to meet the requirements of the United States Social Security Act, Title XVIII, Section 1861(s), paragraphs 10

and 11. In determining whether medical equipment costs more than the threshold provided in this subsection, the cost of studies, surveys, designs, plans, working drawings, specifications and other activities essential to acquiring the equipment must be included. If the equipment is acquired for less than fair market value, the term "cost" includes the fair market value. Beginning January 1, 2013 and annually thereafter, the threshold amount for review must be updated by the commissioner to reflect the change in the United States Department of Labor, Bureau of Labor Statistics Consumer Price Index medical care services index, with an effective date of January 1st each year.
[PL 2011, c. 424, Pt. A, §1 (AMD); PL 2011, c. 424, Pt. E, §1 (AFF).]

17. Modification. "Modification" means the alteration, improvement, expansion, extension, renovation or replacement of a health care facility or health maintenance organization or portions thereof, including the initial equipment, and the replacement of equipment or existing buildings.
[PL 2001, c. 664, §2 (NEW).]

17-A. New health service. "New health service" means:

A. The obligation of any capital expenditures by or on behalf of a new or existing health care facility of $3,000,000 or more that is associated with the addition of a health service that was not offered on a regular basis by or on behalf of the health care facility within the 12-month period prior to the time the services would be offered; [PL 2011, c. 424, Pt. A, §2 (AMD); PL 2011, c. 424, Pt. E, §1 (AFF).]

B. The addition of a health service that is to be offered by or on behalf of a new or existing health care facility that was not offered on a regular basis by or on behalf of the health care facility within the 12-month period prior to the time the services would be offered and that, for the 3rd fiscal year of operation, including a partial first year following addition of that service, is projected to entail incremental annual operating costs directly attributable to the addition of that health service of at least $1,000,000. For the purposes of this paragraph, the compensation attributable to the health care practitioner is not included in the calculation of 3rd-year operating costs; or [PL 2011, c. 424, Pt. A, §2 (AMD); PL 2011, c. 424, Pt. E, §1 (AFF).]

C. The addition in the private office of a health care practitioner, as defined in Title 24, section 2502, subsection 1-A, of new technology that costs $3,200,000 or more. The department shall consult with the Maine Quality Forum Advisory Council established pursuant to Title 24-A, section 6952, prior to determining whether a project qualifies as a new technology in the office of a private practitioner. With regard to the private office of a health care practitioner, "new health service" does not include the location of a new practitioner in a geographic area. [PL 2011, c. 424, Pt. A, §2 (AMD); PL 2011, c. 424, Pt. E, §1 (AFF).]

Beginning January 1, 2013 and annually thereafter, the threshold amounts for review in paragraphs A, B and C must be updated by the commissioner to reflect the change in the United States Department of Labor, Bureau of Labor Statistics Consumer Price Index medical care services index, with an effective date of January 1st each year.

"New health service" does not include a health care facility that extends a current service within the defined primary service area of the health care facility by purchasing within a 12-month time period new equipment costing in the aggregate less than the threshold provided in subsection 16;
[PL 2011, c. 424, Pt. A, §2 (AMD); PL 2011, c. 424, Pt. E, §1 (AFF).]

18. Nursing facility. "Nursing facility" means any facility defined under section 1812-A.
[PL 2001, c. 664, §2 (NEW).]

18-A. Nursing facility MaineCare funding pool. "Nursing facility MaineCare funding pool" means that limit established in accordance with section 333-A for nursing facility projects.
[PL 2007, c. 440, §1 (NEW).]

19. Obligation. An "obligation" for a capital expenditure that is considered to be incurred by or on behalf of a health care facility:

A. When a contract, enforceable under the law of the State, is entered into by or on behalf of the health care facility for the construction, acquisition, lease or financing of a capital asset; [PL 2001, c. 664, §2 (NEW).]

B. When the governing board of the health care facility takes formal action to commit its own funds for a construction project undertaken by the health care facility as its own contractor; or [PL 2001, c. 664, §2 (NEW).]

C. In the case of donated property, on the date on which the gift is completed under the applicable law of the State. [PL 2001, c. 664, §2 (NEW).]

[PL 2001, c. 664, §2 (NEW).]

20. Offer. "Offer," when used in connection with "health services," means that the health care facility or health maintenance organization holds itself out as capable of providing or having the means to provide a health service.

[PL 2001, c. 664, §2 (NEW).]

21. Person. "Person" means an individual; trust or estate; partnership; corporation, including associations, joint stock companies and insurance companies; the State or a political subdivision or instrumentality of the State, including a municipal corporation of the State; or any other legal entity recognized by state law.

[PL 2001, c. 664, §2 (NEW).]

22. Person directly affected by a review. "Person directly affected by a review" includes:

A. The applicant; [PL 2001, c. 664, §2 (NEW).]

B. A group of 5 persons residing or located within the health service area served or to be served by the applicant; [PL 2011, c. 648, §1 (AMD).]

C. A health care facility, a health maintenance organization or a health care practitioner that demonstrates that it provides similar services or, by timely filing a letter of intent with the department for inclusion in the record, indicates an intention to provide similar services in the future to patients residing in the health service area and whose services would be directly and substantially affected by the application under review; [PL 2001, c. 664, §2 (NEW).]

D. A 3rd-party payor, including, without limitation, a health maintenance organization, that pays health care facilities for services in the health service area in which the project is proposed to be located and whose payments would be directly and substantially affected by the application under review; and [PL 2001, c. 664, §2 (NEW).]

E. A person who demonstrates a direct and substantial effect upon that person's health care as a result of the application under review. [PL 2001, c. 664, §2 (NEW).]

[PL 2011, c. 648, §1 (AMD).]

23. Predevelopment activity. "Predevelopment activity" means any appropriately capitalized expenditure by or on behalf of a health care facility made in preparation for the offering or development of a new health service for which a certificate of need would be required and arrangements or commitments made for financing the offering or development of the new health service and includes site acquisitions, surveys, studies, expenditures for architectural designs, plans, working drawings and specifications.

[PL 2001, c. 664, §2 (NEW).]

24. Project. "Project" means any acquisition, capital expenditure, new health service or change in a health service, predevelopment activity or other activity that requires a certificate of need under section 329.

[PL 2001, c. 664, §2 (NEW).]

25. Rehabilitation facility. "Rehabilitation facility" means an inpatient facility that is operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program of medical services and other services that are provided under competent professional supervision.
[PL 2001, c. 664, §2 (NEW).]

26. Replacement equipment. "Replacement equipment" means a piece of capital equipment that replaces another piece of capital equipment that performs essentially the same functions as the replaced equipment.
[PL 2001, c. 664, §2 (NEW).]

27. State Health Plan.
[PL 2011, c. 90, Pt. J, §3 (RP).]

SECTION HISTORY

PL 2001, c. 664, §2 (NEW). RR 2003, c. 1, §15 (COR). PL 2003, c. 469, §§C2-6 (AMD). PL 2007, c. 324, §17 (REV). PL 2007, c. 440, §1 (AMD). PL 2007, c. 681, §§1, 2 (AMD). PL 2009, c. 383, §§1-4 (AMD). PL 2011, c. 90, Pt. J, §§2, 3 (AMD). PL 2011, c. 213, §2 (AMD). PL 2011, c. 424, Pt. A, §§1, 2 (AMD). PL 2011, c. 424, Pt. E, §1 (AFF). PL 2011, c. 648, §1 (AMD). PL 2017, c. 407, Pt. A, §64 (AMD). PL 2019, c. 343, Pt. YY, §4 (AMD).

§329. Certificate of need required

A person may not enter into any commitment for financing a project that requires a certificate of need or incur an expenditure for the project without having sought and received a certificate of need, except that this prohibition does not apply to obligations for financing conditioned upon the receipt of a certificate of need or to obligations for predevelopment activities. [PL 2001, c. 664, §2 (NEW).]

A certificate of need from the department is required for: [PL 2001, c. 664, §2 (NEW).]

1. Transfer of ownership; acquisition by lease, donation, transfer; acquisition of control. Any transfer of ownership or acquisition under lease or comparable arrangement or through donation or any acquisition of control of a health care facility under lease, management agreement or comparable arrangement or through donation that would have required review if the transfer or acquisition had been by purchase, except in emergencies when that acquisition of control is at the direction of the department or except if the transfer of ownership or acquisition of control involves only entities or health care facilities that are direct or indirect subsidiaries of the same parent corporation, is between a parent corporation and its direct or indirect subsidiaries or is between entities or health care facilities all under direct or indirect ownership of or ultimate control by the same parent corporation immediately prior to the transfer or acquisition;
[PL 2015, c. 453, §1 (AMD).]

2. Acquisitions of major medical equipment.
[PL 2007, c. 440, §2 (RP).]

2-A. Acquisitions of major medical equipment. Acquisitions of major medical equipment. The following provisions apply to acquisitions of major medical equipment.

A. The cost of all major medical equipment must be declared at fair market value.

(1) If an entity purchases major medical equipment from an unrelated entity, the purchase price is assumed to reflect the fair market value.

(2) If an entity purchases major medical equipment from a related entity and the department finds that the fair market value is greater than the purchase price, the department may revise

the cost of the major medical equipment to reflect the correct fair market value. [PL 2007, c. 440, §3 (NEW).]

B. The following acquisitions of major medical equipment do not require a certificate of need:

(1) Major medical equipment being replaced by the owner; and

(2) The use of major medical equipment on a temporary basis in the case of a natural disaster, major accident or major medical equipment failure. [PL 2011, c. 424, Pt. A, §3 (AMD); PL 2011, c. 424, Pt. E, §1 (AFF).]

C. All replaced major medical equipment must be removed from service. [PL 2007, c. 440, §3 (NEW).]

[PL 2011, c. 424, Pt. A, §3 (AMD); PL 2011, c. 424, Pt. E, §1 (AFF).]

3. Capital expenditures. Except as provided in subsection 6, the obligation by or on behalf of a new or existing health care facility of any capital expenditure of $10,000,000 or more. Capital expenditures in the case of a natural disaster, major accident or equipment failure or for replacement equipment that is not major medical equipment as defined in section 328, subsection 16 or for parking lots and garages, information and communications systems or physician office space or projects directed solely at reducing energy costs through energy efficiency, renewable energy technology or smart grid technology and that have been certified as likely to be cost-effective by the Efficiency Maine Trust pursuant to Title 35-A, section 10122 do not require a certificate of need. Beginning January 1, 2013 and annually thereafter, the threshold amount for review must be updated by the commissioner to reflect the change in the United States Department of Labor, Bureau of Labor Statistics Consumer Price Index medical care services index, with an effective date of January 1st each year;

[PL 2011, c. 424, Pt. A, §4 (AMD); PL 2011, c. 424, Pt. E, §1 (AFF).]

4. New health service. The offering or development of any new health service;

A. [PL 2003, c. 469, Pt. C, §7 (RP).]

B. [PL 2003, c. 469, Pt. C, §7 (RP).]

[PL 2003, c. 469, Pt. C, §7 (AMD).]

4-A. New health care facility. The construction, development or other establishment of a new health care facility. The following requirements apply to certificate of need for new health care facilities.

A. A new health care facility that is a nursing facility must obtain a certificate of need:

(1) If it requires a capital expenditure of more than $5,000,000; or

(2) If it proposes to add new nursing facility beds to the inventory of nursing facility beds within the State, in which case it must satisfy all applicable requirements of section 334-A. [PL 2011, c. 424, Pt. A, §5 (NEW); PL 2011, c. 424, Pt. E, §1 (AFF).]

B. A new health care facility other than a nursing facility must obtain a certificate of need:

(1) If it requires a capital expenditure of more than $3,000,000; or

(2) If it is a new health service; [PL 2011, c. 424, Pt. A, §5 (NEW); PL 2011, c. 424, Pt. E, §1 (AFF).]

[PL 2011, c. 424, Pt. A, §5 (AMD); PL 2011, c. 424, Pt. E, §1 (AFF).]

5. Changes in bed complement. An increase in the existing licensed bed complement or an increase in the licensed bed category of a health care facility, other than a nursing facility, of greater than 10%;

[PL 2001, c. 664, §2 (NEW).]

6. Nursing facilities. The obligation by a new or existing nursing facility, when related to nursing services provided by the nursing facility, of any capital expenditures of $5,000,000 or more. Beginning January 1, 2013 and annually thereafter, the threshold amount for review must be updated by the commissioner to reflect the change in the United States Department of Labor, Bureau of Labor Statistics Consumer Price Index medical care services index, with an effective date of January 1st each year.

A certificate of need is not required for the following:

A. A nursing facility converting beds used for the provision of nursing services to beds to be used for the provision of residential care services. If such a conversion occurs, MaineCare and other public funds may not be obligated for payment of services provided in the converted beds unless approved by the department pursuant to the provisions of sections 333-A and 334-A. In order to approve a conversion under this paragraph, the department must determine that any increased MaineCare residential care costs associated with the converted beds are fully offset by reductions in the MaineCare costs from the reduction in MaineCare nursing facility costs associated with the converted beds; [PL 2011, c. 424, Pt. B, §1 (AMD); PL 2011, c. 424, Pt. E, §1 (AFF).]

B. Capital expenditures in the case of a natural disaster, major accident or equipment failure; [PL 2009, c. 652, Pt. A, §29 (RPR).]

C. Replacement equipment, other than major medical equipment as defined in section 328, subsection 16; [PL 2009, c. 652, Pt. A, §29 (RPR).]

D. Information systems, communication systems, parking lots and garages; and [PL 2009, c. 652, Pt. A, §29 (RPR).]

E. Certain energy-efficient improvements, as described in section 334-A, subsection 4. [PL 2009, c. 652, Pt. A, §29 (RPR).]

[PL 2011, c. 424, Pt. B, §1 (AMD); PL 2011, c. 424, Pt. E, §1 (AFF).]

7. Other circumstances. The following circumstances:

A. Any proposed use of major medical equipment to serve inpatients of a hospital, if the equipment is not located in a health care facility and was acquired without a certificate of need, except acquisitions exempt from review under subsection 3; or [PL 2007, c. 440, §5 (AMD).]

B. If a person adds a health service not subject to review under subsection 4 at the time it was established and not reviewed and approved prior to establishment at the request of the applicant, and its actual 3rd fiscal year operating cost exceeds the expenditure minimum for annual operating costs in the 3rd fiscal year of operation following addition of these services; and [PL 2007, c. 440, §6 (AMD).]

[PL 2007, c. 440, §§5, 6 (AMD).]

8. Related projects. Any projects that the department determines are related projects if such projects, considered in the aggregate, would otherwise require a certificate of need under this section. [PL 2001, c. 664, §2 (NEW).]

SECTION HISTORY

PL 2001, c. 664, §2 (NEW). PL 2003, c. 469, §C7 (AMD). PL 2007, c. 440, §§2-6 (AMD). PL 2007, c. 681, §3 (AMD). PL 2009, c. 383, §§5, 6 (AMD). PL 2009, c. 383, §16 (AFF). PL 2009, c. 429, §1 (AMD). PL 2009, c. 430, §1 (AMD). PL 2009, c. 652, Pt. A, §29 (AMD). PL 2011, c. 424, Pt. A, §§3-5 (AMD). PL 2011, c. 424, Pt. B, §1 (AMD). PL 2011, c. 424, Pt. E, §1 (AFF). PL 2015, c. 453, §1 (AMD).

§330. Exceptions

Notwithstanding section 329, the requirements of this Act do not apply with respect to: [PL 2001, c. 664, §2 (NEW).]

1. Healing through prayer. A health care facility operated by a religious group relying solely on spiritual means through prayer for healing;
[PL 2001, c. 664, §2 (NEW).]

2. Activities; acquisitions. Activities or acquisitions by or on behalf of a health maintenance organization or a health care facility controlled, directly or indirectly, by a health maintenance organization or combination of health maintenance organizations to the extent mandated by the National Health Policy, Planning and Resources Development Act of 1974, as amended, and its accompanying regulations;
[PL 2001, c. 664, §2 (NEW).]

3. Home health care services. Home health care services offered by a home health care provider;
[PL 2001, c. 664, §2 (NEW).]

4. Hospice. Hospice services and programs;
[PL 2001, c. 664, §2 (NEW).]

5. Assisted living.

[PL 2003, c. 510, Pt. B, §6 (RP).]

5-A. Assisted housing. Assisted housing programs and services regulated under chapter 1664;
[PL 2003, c. 510, Pt. A, §15 (NEW).]

6. Existing capacity. The use by an ambulatory surgical facility licensed on January 1, 1998 of capacity in existence on January 1, 1998; and
[PL 2001, c. 664, §2 (NEW).]

7. Critical access hospitals. Conversion by a critical access hospital or a hospital in the process of becoming a critical access hospital of licensed acute care beds to hospital swing beds.
[PL 2003, c. 621, §1 (AMD).]

SECTION HISTORY

PL 2001, c. 664, §2 (NEW). PL 2003, c. 510, §§A15,B6 (AMD). PL 2003, c. 621, §1 (AMD).

§331. Subsequent review following changes in project

When a certificate of need has been issued and changes occur as specified in this section, a subsequent review is required. [PL 2001, c. 664, §2 (NEW).]

1. Criteria for subsequent review. The following activities require subsequent review and approval if the department has previously issued a certificate of need and one or more of the following circumstances occur within 3 years after the approved activity is undertaken:

A. There is a significant change in financing; [PL 2001, c. 664, §2 (NEW).]

B. There is a change affecting the licensed or certified bed capacity as approved in the certificate of need; [PL 2001, c. 664, §2 (NEW).]

C. There is a change involving the addition or termination of the health services proposed to be rendered; [PL 2001, c. 664, §2 (NEW).]

D. There is a change in the site or the location of the proposed health care facility; or [PL 2001, c. 664, §2 (NEW).]

E. There is a substantial change proposed in the design of the health care facility or the type of construction. [PL 2001, c. 664, §2 (NEW).]
[PL 2001, c. 664, §2 (NEW).]

2. Procedures for subsequent review. Any person proposing to undertake any activity requiring subsequent review and approval shall file with the department, within 30 days of the time that person

first has actual knowledge of the circumstances requiring subsequent review, a notice setting forth the following information:

A. The nature of the proposed change; [PL 2001, c. 664, §2 (NEW).]

B. The rationale for the change including, where appropriate, an explanation of why the change was not set forth in the original application or letter of intent; and [PL 2001, c. 664, §2 (NEW).]

C. Other pertinent detail subject to the procedures and criteria set forth in section 335. [PL 2001, c. 664, §2 (NEW).]

The department shall, within 30 days of receipt of the information, advise that person in writing whether the proposed change is approved. If not approved, the application must be treated as a new application under this Act. If approved, the department shall amend the certificate of need as appropriate.
[PL 2001, c. 664, §2 (NEW).]

SECTION HISTORY

PL 2001, c. 664, §2 (NEW).

§332. Subsequent review

1. Subsequent review following approval. When the commissioner has approved an application filed unconditionally or subject to conditions pursuant to section 335, subsection 8, the commissioner may conduct a subsequent review to ensure compliance with any terms or conditions of approval within 3 years after the approved activity is undertaken. The 3-year time limitation does not apply to a subsequent review to ensure that the requirement set forth in section 335, subsection 1, paragraph G continues to be met. In any subsequent review, the commissioner may hold a public hearing and may consider any material or significant changes in factors or circumstances relied upon by the commissioner in approving the application and significant and relevant information that either is new or was withheld by the applicant at the time of the process under section 335. If, upon review, the commissioner determines that any terms or conditions of the approval have not been met, the commissioner may take enforcement action consistent with subsection 3 and other applicable provisions of this Act.
[PL 2023, c. 343, §1 (AMD).]

2. Subsequent review following determination of nonapplicability. The commissioner may hold a public hearing to determine whether the proponent of the expenditure knowingly withheld significant and relevant information or made any material misrepresentations at the time the nonapplicability determination was rendered. The commissioner may take enforcement action consistent with the provisions of this Act if, upon review, the commissioner determines that:

A. At the time the nonapplicability determination was rendered the proponent of the expenditure knowingly withheld significant and relevant information or made any material misrepresentations; and [PL 2007, c. 440, §7 (NEW).]

B. If the proponent had provided proper information, a certificate of need would have been required for the expenditure or action. [PL 2007, c. 440, §7 (NEW).]
[PL 2007, c. 440, §7 (NEW).]

3. Enforcement actions. When the commissioner determines, following the procedures set forth in subsections 1 and 2, that the holder of a certificate of need when properly required has failed to meet the conditions set forth in the certificate of need approval or that a person covered by this Act has improperly obtained a nonapplicability ruling, the commissioner may take one or more of the following actions.

A. The commissioner may, pursuant to section 347, condition the person's license to prohibit the unauthorized activity and determine the ongoing conduct of that activity to be in violation of the respective chapter under which the person is licensed. A person that is subject to a ruling under

this paragraph may request, and the commissioner shall grant pursuant to the Maine Administrative Procedure Act, a stay of the effect of any such determination to condition the person's license to prohibit the particular activity pending final agency action. [PL 2007, c. 440, §7 (NEW).]

B. The commissioner may seek to enjoin the unlawful activity pursuant to section 349. [PL 2007, c. 440, §7 (NEW).]

C. The commissioner may impose civil penalties against the person pursuant to section 350. [PL 2007, c. 440, §7 (NEW).]

D. The commissioner may, pursuant to section 348, petition the Superior Court to withhold prospectively the reimbursement, payment or other financial assistance, either directly or indirectly, from a state agency or other 3rd-party payor that is directly related to the project or activity that required a certificate of need. [PL 2007, c. 440, §7 (NEW).]

E. In determining the appropriate sanction, the commissioner or the court shall consider a range of factors and public interests, as applicable to the circumstances, including but not limited to:

(1) The degree of negligent or intentional conduct;

(2) The clarity or vagueness of the relevant statute or rule;

(3) The clarity or vagueness of the prior approval or condition;

(4) The efforts of the person to maintain compliance;

(5) Whether the person knowingly withheld significant and relevant information or made any material misrepresentations at the time the nonapplicability determination was rendered;

(6) The public interest in maintaining the service; and

(7) All other proper factors at law and in equity. [PL 2007, c. 440, §7 (NEW).]

[PL 2007, c. 440, §7 (NEW).]

SECTION HISTORY

PL 2001, c. 664, §2 (NEW). PL 2001, c. 710, §9 (AMD). PL 2001, c. 710, §10 (AFF). PL 2007, c. 440, §7 (RPR). PL 2023, c. 343, §1 (AMD).

§333. Procedures after voluntary nursing facility reductions

1. Procedures. A nursing facility that voluntarily reduces the number of its licensed beds at any time prior to July 1, 2007, for any reason except to create private rooms may convert the beds back and thereby increase the number of nursing facility beds to no more than the previously licensed number of nursing facility beds, after obtaining a certificate of need in accordance with this section, as long as the nursing facility has been in continuous operation without material change of ownership. For purposes of this section and sections 333-A and 334-A, beds voluntarily removed from service prior to July 1, 2007 and available to be reinstated under this section are referred to as "reserved beds." Reserved beds remain facility property until they lapse as provided for in this section or are transferred. To reinstate reserved beds under this subsection, the nursing facility must:

A. Give notice of the number of beds it is reserving no later than 30 days after the effective date of the license reduction; [PL 2007, c. 440, §8 (AMD).]

A-1. Annually provide notice to the department no later than July 1st of each year of the nursing facility's intent to retain these reserved beds, subject to the limitations set forth in subsection 2, paragraph B. Notice provided under this paragraph preserves the reserved beds through June 30th of the following year. The annual notice on reserved beds may be filed by an individual nursing facility or by multiple nursing facilities through a membership organization approved by the department by a single filing; and [PL 2011, c. 648, §2 (AMD).]

B. Obtain a certificate of need to convert beds back under section 335, except that, if no construction is required for the conversion of beds back, the application must be processed in accordance with subsection 2. The department in its review shall evaluate the impact that the nursing facility beds to be converted back would have on those existing nursing facility beds and facilities within 30 miles of the applicant's facility and shall determine whether to approve the request based on current certificate of need criteria and methodology. [PL 2011, c. 424, Pt. B, §3 (AMD); PL 2011, c. 424, Pt. E, §1 (AFF).]

[PL 2011, c. 648, §2 (AMD).]

2. Expedited review. Except as provided in subsection 1, paragraph B, an application for a certificate of need to reopen beds reserved in accordance with this section must be processed on an expedited basis in accordance with rules adopted by the department providing for shortened review time and for a public hearing if requested by a person directly affected by a review. The department shall consider and decide upon these applications as follows:

A. Review of applications that meet the requirements of this section must be based on the requirements of section 335, subsection 7, except that the determinations required by section 335, subsection 7, paragraph B must be based on the historical costs of operating the beds and must consider whether the projected costs are consistent with the costs of the beds prior to closure, adjusted for inflation; and [PL 2001, c. 664, §2 (NEW).]

B. If the nursing facility fails to provide the annual notices required by subsection 1, paragraph B, the nursing facility's ability to convert beds back under this section lapses, and the beds must be treated as lapsed beds for purposes of this section and sections 333-A and 334-A. [PL 2011, c. 424, Pt. B, §4 (AMD); PL 2011, c. 424, Pt. E, §1 (AFF).]

[PL 2011, c. 648, §3 (AMD).]

3. Effect on other review proceedings. Lapsed beds may not be treated as available nursing facility beds for the purpose of evaluating need under section 335. Reserved beds must be counted as available nursing facility beds for the purpose of evaluating need under section 335 only if:

A. The nursing facility retains the ability to convert the reserved beds back to nursing facility use under the terms of this section; [PL 2007, c. 440, §10 (NEW).]

B. The nursing facility having the reserved beds is located within a reasonable distance of the population projected to be served by the project under review; and [PL 2007, c. 440, §10 (NEW).]

C. The nursing facility having the reserved beds is willing to convert them to meet a need identified in that project review. The department shall inquire of facilities having reserved beds in the area of the State to be served by a proposed project before determining whether reserved beds will be counted as available. [PL 2007, c. 440, §10 (NEW).]

[PL 2007, c. 440, §10 (RPR).]

4. Rulemaking. Rules adopted pursuant to this section are routine technical rules as defined by Title 5, chapter 375, subchapter 2-A.

[PL 2009, c. 383, §7 (AMD).]

SECTION HISTORY

PL 2001, c. 664, §2 (NEW). PL 2007, c. 440, §§8-10 (AMD). PL 2009, c. 383, §7 (AMD). PL 2011, c. 424, Pt. B, §§2-4 (AMD). PL 2011, c. 424, Pt. E, §1 (AFF). PL 2011, c. 648, §§2, 3 (AMD).

§333-A. Procedures for allowing reallocation of nursing facility capacity

1. Nursing facility MaineCare funding pool. Except as set forth in subsection 3-A and section 334-A, savings to the MaineCare program as a result of delicensing of nursing facility beds on or after

July 1, 2005, including savings from lapsed beds but excluding savings from reserved beds, must be credited to the nursing facility MaineCare funding pool, which must be maintained by the department to provide for the development of new beds or other improvements requiring a certificate of need. For those nursing facility projects that propose to add new nursing facility beds to the inventory of beds within the State, the balance of the nursing facility MaineCare funding pool, as adjusted to reflect current costs consistent with the rules and statutes governing reimbursement of nursing facilities, serves as a limit on the MaineCare share of all incremental 3rd-year operating costs of such projects unless such projects are approved under applicable provisions of section 334-A. Nursing facility projects that do not add new nursing facility beds to the inventory of beds within the State are not subject to the nursing facility MaineCare funding pool.
[PL 2011, c. 424, Pt. B, §5 (AMD); PL 2011, c. 424, Pt. E, §1 (AFF).]

2. Procedure. The balance of the nursing facility MaineCare funding pool must be used for development of additional nursing facility beds in areas of the State where additional beds are needed to meet the community need. The department must assess needs throughout the State and issue requests for proposals for the development of additional beds in areas where need has been identified by the department, except in the event of an emergency, when the department may use a sole source process. Proposals must be evaluated based on consideration of quality of care and cost, and preference must be given to existing nursing facilities in the identified need area that may increase licensed capacity by adding on to or renovating the existing facility.
[PL 2011, c. 424, Pt. B, §6 (AMD); PL 2011, c. 424, Pt. E, §1 (AFF).]

3. Emergencies and necessary renovations.

[PL 2011, c. 424, Pt. B, §7 (RP); PL 2011, c. 424, Pt. E, §1 (AFF).]

3-A. Transfers between nursing facility and residential care facility. A nursing facility may delicense and sell or transfer beds to a residential care facility for the purpose of permitting the residential care facility to add MaineCare-funded beds to meet identified needs for such beds. Such a transfer does not require a certificate of need but is subject to prior approval of the department on an expedited basis. The divisions within the department that are responsible for licensing and MaineCare reimbursement for nursing facilities and residential care facilities shall work cooperatively to review and consider whether to approve such transfers on an expedited basis. When the average then current occupancy rate for existing state-funded residential care beds within 30 miles of the applicant facility is 80% or less, the department in its review under section 335 shall evaluate the impact that the proposed additional state-funded residential care beds would have on these existing state-funded residential care beds and facilities. Beds and MaineCare resources transferred pursuant to this subsection are not subject to the nursing facility MaineCare funding pool. In order for the department to approve delicensing, selling or transferring under this subsection, the department must determine that any increased MaineCare residential care costs associated with the converted beds are fully offset by reductions in the MaineCare costs from the reduction in MaineCare nursing facility costs associated with the converted beds.
[PL 2011, c. 648, §4 (AMD).]

4. Rulemaking. The department may establish rules to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.
[PL 2007, c. 681, §6 (AMD).]

SECTION HISTORY

PL 2007, c. 440, §11 (NEW). PL 2007, c. 681, §§4-6 (AMD). PL 2009, c. 429, §2 (AMD). PL 2011, c. 90, Pt. J, §4 (AMD). PL 2011, c. 424, Pt. B, §§5-8 (AMD). PL 2011, c. 424, Pt. E, §1 (AFF). PL 2011, c. 648, §4 (AMD).

§334. Nursing facility projects

(REPEALED)

SECTION HISTORY

PL 2001, c. 664, §2 (NEW). PL 2003, c. 416, §1 (AMD). PL 2007, c. 440, §12 (RP).

§334-A. Nursing facility projects

1. Projects that expand current bed capacity.

[PL 2011, c. 424, Pt. B, §9 (RP); PL 2011, c. 424, Pt. E, §1 (AFF).]

1-A. Projects that expand current bed capacity. Nursing facility projects that propose to add new nursing facility beds to the inventory of nursing facility beds within the State may be considered under either of the following 2 options:

A. These projects may be grouped for competitive review purposes consistent with funds available from the nursing facility MaineCare funding pool and may be approved if sufficient funds are available from the nursing facility MaineCare funding pool or are added to the pool by an act of the Legislature, except that the department may approve, without available funds from the pool, projects to reopen beds previously reserved by a nursing facility through a voluntary reduction pursuant to section 333 if the annual total of reopened beds approved does not exceed 100; or [PL 2011, c. 424, Pt. B, §10 (NEW); PL 2011, c. 424, Pt. E, §1 (AFF).]

B. Petitioners proposing such projects may elect not to participate in a competitive review under paragraph A and the projects may be approved if:

(1) The petitioner, or one or more nursing facilities or residential care facilities or combinations thereof under common ownership or control, has agreed to delicense a sufficient number of beds from the total number of currently licensed or reserved beds, or is otherwise reconfiguring the operations of such facilities, so that the MaineCare savings associated with such actions are sufficient to fully offset any incremental MaineCare costs that would otherwise arise from implementation of the certificate of need project and, as a result, there are no net incremental MaineCare costs arising from implementation of the certificate of need project; or

(2) The petitioner, or one or more nursing facilities or residential care facilities or combinations thereof under common ownership or control, has acquired bed rights from another nursing facility or facilities or residential care facility or facilities or combinations thereof that agree to delicense beds or that are ceasing operations or otherwise reconfiguring their operations, and the MaineCare revenues associated with these acquired bed rights and related actions are sufficient to cover the additional requested MaineCare costs associated with the project. The divisions within the department that are responsible for licensing and MaineCare reimbursement for nursing facilities and residential care facilities shall work cooperatively to review and consider whether to approve such projects.

With respect to the option described in this paragraph, when the average then current occupancy rate for existing nursing facility beds at facilities within 30 miles of the applicant facility exceeds 85%, the department in its review under section 335 shall evaluate the impact that the proposed additional nursing facility beds would have on those existing nursing facility beds and facilities and shall determine whether to approve the request based on current certificate of need criteria and methodology.

Certificate of need projects described in this paragraph are not subject to or limited by the nursing facility MaineCare funding pool. [PL 2011, c. 648, §5 (AMD).]

[PL 2011, c. 648, §5 (AMD).]

2. Projects to relocate beds. Nursing facility projects that do not add new nursing facility beds to the inventory of nursing facility beds within the State, but instead propose to relocate beds from one or more nursing facilities to one or more existing or new nursing facilities:

A. May also propose renovation, replacement or other actions requiring certificate of need review; and [PL 2007, c. 440, §13 (NEW).]

B. May be approved by the department upon a showing by the petitioner that the project fulfills all pertinent requirements and the review criteria set forth in section 335. [PL 2011, c. 424, Pt. B, §11 (AMD); PL 2011, c. 424, Pt. E, §1 (AFF).]

Certificate of need projects described in this subsection are not subject to or limited by the nursing facility MaineCare funding pool.
[PL 2011, c. 424, Pt. B, §11 (AMD); PL 2011, c. 424, Pt. E, §1 (AFF).]

2-A. Other types of certificate of need projects. Other types of nursing facility projects that do not add new nursing facility beds to the inventory of nursing facility beds within the State and do not propose to relocate beds from one facility to another existing or new facility and that propose any renovation, replacement, transfer of ownership or other actions requiring certificate of need review, such as capital expenditures for equipment and renovations that are above applicable thresholds, may be approved by the department upon a showing that the project fulfills all pertinent requirements and the review criteria set forth in section 335.

A. [PL 2011, c. 424, Pt. B, §12 (RP); PL 2011, c. 424, Pt. E, §1 (AFF).]

B. [PL 2011, c. 424, Pt. B, §12 (RP); PL 2011, c. 424, Pt. E, §1 (AFF).]

Certificate of need projects described in this subsection are not subject to or limited by the nursing facility MaineCare funding pool.
[PL 2011, c. 424, Pt. B, §12 (AMD); PL 2011, c. 424, Pt. E, §1 (AFF).]

2-B. Emergencies and necessary nursing facility projects. If the department determines that an emergency exists, it may approve a necessary nursing facility certificate of need application on an expedited basis when the applicant proposes capital expenditures for renovations and improvements that are necessary:

A. To achieve compliance with code and related regulatory requirements; [PL 2011, c. 424, Pt. B, §13 (NEW); PL 2011, c. 424, Pt. E, §1 (AFF).]

B. To comply with the federal Health Insurance Portability and Accountability Act of 1996 and related patient privacy standards; [PL 2011, c. 424, Pt. B, §13 (NEW); PL 2011, c. 424, Pt. E, §1 (AFF).]

C. To address other patient safety requirements and standards; or [PL 2011, c. 424, Pt. B, §13 (NEW); PL 2011, c. 424, Pt. E, §1 (AFF).]

D. To address other necessary and time-sensitive patient safety or compliance issues. [PL 2011, c. 424, Pt. B, §13 (NEW); PL 2011, c. 424, Pt. E, §1 (AFF).]

Certificate of need projects described in this subsection are not subject to or limited by the nursing facility MaineCare funding pool.
[PL 2011, c. 424, Pt. B, §13 (NEW); PL 2011, c. 424, Pt. E, §1 (AFF).]

3. Evaluating costs. Beginning with all applications pending on February 15, 2012, in evaluating whether a project will increase MaineCare expenditures for a nursing facility for the purposes of this section, the department shall:

A. Allow gross square footage per licensed bed of not less than 500 square feet unless the applicant specifies a smaller allowance for the project. [PL 2011, c. 424, Pt. B, §14 (AMD); PL 2011, c. 424, Pt. E, §1 (AFF).]

B. [PL 2011, c. 424, Pt. B, §14 (RP); PL 2011, c. 424, Pt. E, §1 (AFF).]

C. [PL 2011, c. 424, Pt. B, §14 (RP); PL 2011, c. 424, Pt. E, §1 (AFF).]

[PL 2011, c. 424, Pt. B, §14 (AMD); PL 2011, c. 424, Pt. E, §1 (AFF).]

4. Cost associated with energy-efficient improvements. The cost associated with energy-efficient improvements in nursing facilities, as set forth in rules governing special reimbursement provisions for energy-efficient improvements adopted by the department, must be excluded from the cost of a project in determining whether the project is subject to review.
[PL 2009, c. 430, §5 (NEW).]

SECTION HISTORY

PL 2007, c. 440, §13 (NEW). PL 2009, c. 429, §§3-5 (AMD). PL 2009, c. 430, §§2-5 (AMD). PL 2011, c. 424, Pt. B, §§9-14 (AMD). PL 2011, c. 424, Pt. E, §1 (AFF). PL 2011, c. 648, §5 (AMD).

§335. Approval; record

This section applies to determinations by the commissioner under this chapter. [PL 2001, c. 664, §2 (NEW).]

1. Basis for decision. Based solely on a review of the record maintained under subsection 6, the commissioner shall approve an application for a certificate of need if the commissioner determines that the project:

A. Meets the conditions set forth in subsection 7; [PL 2003, c. 469, Pt. C, §8 (NEW).]

B. [PL 2011, c. 90, Pt. J, §5 (RP).]

C. Ensures high-quality outcomes and does not negatively affect the quality of care delivered by existing service providers; [PL 2003, c. 469, Pt. C, §8 (NEW).]

D. Does not result in inappropriate increases in service utilization, according to the principles of evidence-based medicine adopted by the Maine Quality Forum, as established in Title 24-A, section 6951, when the principles adopted by the Maine Quality Forum are directly applicable to the application; [PL 2023, c. 343, §2 (AMD).]

E. [PL 2013, c. 424, Pt. A, §10 (RP).]

F. In the case of a nursing facility project that proposes to add new nursing facility beds to the inventory of nursing facility beds within the State, is consistent with the nursing facility MaineCare funding pool and other applicable provisions of sections 333-A and 334-A; and [PL 2023, c. 343, §3 (AMD).]

G. In the case of a project requiring a certificate of need pursuant to section 329, subsection 1 or section 329, subsection 4-A, paragraph B, will not cause a reduction in access to, geographic proximity of, timeliness of or quality of any family planning services, as defined in section 1902, subsection 4, or any abortion services, except that the commissioner may approve a project that will cause such a reduction if the commissioner finds:

(1) That the project is economically and financially feasible only if an obstetrical care service is closed or reduced in capacity; and

(2) After considering all reasonable alternatives, that access to other health care services will be substantially reduced if the project is not approved. [PL 2023, c. 343, §4 (NEW).]

[PL 2023, c. 343, §§2-4 (AMD).]

1-A. Competitive review. The commissioner may review applications on a competitive basis if the applications propose the same or similar services.
[PL 2011, c. 648, §6 (AMD).]

2. Communications. Staff of the department with responsibility for the certificate of need program may meet with, or otherwise communicate with, any person who is not a department employee

and who wants to provide information to be considered in connection with an application for a certificate of need.
[PL 2011, c. 648, §7 (AMD).]

3. Limited communications. All communications regarding any letter of intent or application with the commissioner or with department staff responsible for the certificate of need program from any person who is not a department employee that the department staff reasonably believes is intended to influence the analyses relating to or the decision regarding an application for certificate of need must be made part of the record described in subsection 5-A. If such communications are not in written form or part of public meetings, these communications must be noted in writing by the commissioner or by department staff and that notation must be made part of the application record.
[PL 2011, c. 648, §8 (AMD).]

4. Decision. The commissioner's decision must be in writing and must contain appropriate references to the record. If the application is denied, the decision must specifically address comments received and made part of the record that favor granting the application. If the application is approved, the decision must specifically address comments received and made part of the record that favor denial of the application.
[PL 2001, c. 664, §2 (NEW).]

5. Record.

[PL 2007, c. 440, §17 (RP).]

5-A. Record. The record created by the department in the course of its review of an application must contain the following:

A. The letter of intent described in section 337, subsection 1, all other materials submitted by the applicant relating to the letter of intent and any written materials relating to the letter of intent; [PL 2007, c. 440, §18 (NEW).]

B. The application and all other materials submitted by the applicant for the purpose of making those documents part of the record; [PL 2007, c. 440, §18 (NEW).]

C. All information generated by or for the department in the course of gathering material to assist the commissioner in determining whether the conditions for granting an application for a certificate of need have or have not been met. This information may include, without limitation, the report of consultants, including reports by panels of experts assembled by the department to advise it on the application, memoranda of meetings or conversations with any person interested in commenting on the application, letters, memoranda and documents from other interested agencies of State Government and memoranda describing officially noticed facts; [PL 2007, c. 440, §18 (NEW).]

D. Stenographic or electronic recordings of any public hearing held by the commissioner or the staff of the department at the direction of the commissioner regarding the application; [PL 2007, c. 440, §18 (NEW).]

E. Stenographic or electronic recording of any public informational meeting held by the department pursuant to section 337, subsection 5; [PL 2007, c. 440, §18 (NEW).]

F. Any documents submitted by any person for the purpose of making those documents part of the record regarding any application for a certificate of need or for the purpose of influencing the outcome of any analyses or decisions regarding an application for certificate of need, except documents that have been submitted anonymously. Such source-identified documents automatically become part of the record upon receipt by the department; [PL 2007, c. 440, §18 (NEW).]

G. Preliminary and final analyses of the record prepared by the staff; [PL 2007, c. 440, §18 (NEW).]

H. Except with regard to a project related to nursing facility services, a written assessment by the Director of the Maine Center for Disease Control and Prevention of the impact of the project on the health of persons living in the State, including without limitation an assessment of the impact of the project on access to, geographic proximity of, timeliness of and quality of any family planning services, as defined in section 1902, subsection 4, and any abortion services; and [PL 2023, c. 343, §5 (AMD).]

I. Except with regard to a project related to nursing facility services, or a project that qualifies for a simplified review process under section 336, a written assessment by the Superintendent of Insurance of the impact of the project on the cost of insurance in the region and the State when required by the commissioner. The superintendent may request additional information from the applicant for the purpose of reviewing the application. Any such request must be transmitted through the department and becomes part of the official record. The applicant shall respond to the request within 30 days. Any such response must be transmitted through the department and becomes part of the official record. The inability of the superintendent to complete the review of the application due to the failure of the applicant to respond timely must be noted in the superintendent's assessment filed with the department and may be cause for the commissioner to deny approval of the project. [PL 2013, c. 424, Pt. B, §9 (AMD).]

[PL 2023, c. 343, §5 (AMD).]

6. Maintenance of the record. The record created pursuant to subsection 5-A first opens on the day the department receives a certificate of need application. From that day, all of the record is a public record. The letter of intent becomes a public record upon the receipt of the letter and is available for review from the date of receipt. Any person may examine all or part of the public record and purchase copies of any or all of that record during the normal business hours of the department.

A. The department shall accept public comments and additional information from the applicant for a period of 30 days after the public informational meeting held under section 337, subsection 5 or the public hearing held under section 339, subsection 2, whichever is later. The record will then close until public notice that the preliminary staff analysis has been made part of the record. [PL 2011, c. 648, §10 (NEW).]

B. A technical assistance meeting with the department must be scheduled at least 10 days before the department publishes the preliminary analysis of a certificate of need application. At the technical assistance meeting the department shall:

(1) Give applicants an opportunity to hear whether the certificate of need application is likely to be approved or denied;

(2) Give applicants an opportunity to address issues and concerns expressed by the department regarding compliance with this chapter; and

(3) Give applicants an opportunity to offer additional information to the department.

Any additional information submitted by the applicant becomes part of the public record. The department shall complete its review after the technical assistance meeting and before the department publishes the preliminary analysis. [PL 2011, c. 648, §10 (NEW).]

C. The department shall give notice that the preliminary analysis is complete and part of the public record by publication in a newspaper of general circulation in Kennebec County, in a newspaper published within the service area of the project and on the department’s publicly accessible website. [PL 2011, c. 648, §10 (NEW).]

D. The public and the applicant may submit comments on the preliminary analysis for 15 business days after the notice is published under paragraph C. [PL 2011, c. 648, §10 (NEW).]

E. The department may determine to reopen the record in circumstances that it determines to be appropriate for a limited time to permit submission of additional information, as long as the department gives public notice consistent with the provisions of this subsection. [PL 2011, c. 648, §10 (NEW).]

[PL 2011, c. 648, §10 (RPR).]

7. Expanded review process; approval. Except as provided in section 334-A, subsection 2-B with respect to emergency nursing facility projects, section 336 with respect to the simplified review process and subsection 9 of this section with respect to emergency certificates of need, the commissioner, or the commissioner's designee in the case of a simplified review under section 336 or an emergency review, shall issue a certificate of need if the commissioner or the commissioner's designee determines and makes specific written findings regarding that determination that:

A. The applicant is fit, willing and able to provide the proposed services at the proper standard of care as demonstrated by, among other factors, whether the quality of any health care provided in the past by the applicant or a related party under the applicant's control meets industry standards. If the applicant is a provider of health care services that are substantially similar to those services being reviewed and is licensed in the State, the requirements of this paragraph are deemed to have been met if the services previously provided in the State by the applicant are consistent with applicable licensing and certification standards; [PL 2011, c. 648, §11 (AMD).]

B. The economic feasibility of the proposed services is demonstrated in terms of the:

(1) Capacity of the applicant to support the project financially over its useful life, in light of the rates the applicant expects to be able to charge for the services to be provided by the project; and

(2) Applicant's ability to establish and operate the project in accordance with existing and reasonably anticipated future changes in federal, state and local licensure and other applicable or potentially applicable rules. If the applicant is a provider of health care services that are substantially similar to those services being reviewed and is licensed in the State, the applicant is deemed to have fulfilled the requirements of this subparagraph if the services provided in the State by the applicant during the most recent 3-year period are of similar size and scope and are consistent with applicable licensing and certification standards; [PL 2011, c. 648, §11 (AMD).]

C. There is a public need for the proposed services as demonstrated by certain factors, including, but not limited to:

(1) Whether, and the extent to which, the project will substantially address specific health problems as measured by health needs in the area to be served by the project;

(2) Whether the project will have a positive impact on the health status indicators of the population to be served;

(3) Whether the services affected by the project will be accessible to all residents of the area proposed to be served; and

(4) Whether the project will provide demonstrable improvements in quality and outcome measures applicable to the services proposed in the project; [PL 2003, c. 469, Pt. C, §11 (AMD).]

D. The proposed services are consistent with the orderly and economic development of health facilities and health resources for the State as demonstrated by:

(1) The impact of the project on total health care expenditures after taking into account, to the extent practical, both the costs and benefits of the project and the competing demands in the local service area and statewide for available resources for health care;

(2) The availability of state funds to cover any increase in state costs associated with utilization of the project's services; and

(3) The likelihood that more effective, more accessible or less costly alternative technologies or methods of service delivery may become available; and [PL 2003, c. 469, Pt. C, §11 (AMD).]

E. The project meets the criteria set forth in subsection 1. [PL 2003, c. 469, Pt. C, §12 (NEW).]

In making a determination under this subsection, the commissioner may use data from the Maine Health Data Organization established in chapter 1683 and other information available to the commissioner to the extent such data and information is applicable to the determination being made. The commissioner may give appropriate weight to information that indicates that the proposed health services are innovations in high-quality health care delivery, that the proposed health services are not reasonably available in the proposed area and that the facility proposing the new health services is designed to provide excellent quality health care.
[PL 2011, c. 648, §11 (AMD).]

8. Conditional approvals. The commissioner may grant an application subject to conditions that relate to the criteria for approval of the application.
[PL 2001, c. 664, §2 (NEW).]

9. Emergency certificate of need. Upon the written or oral request of an applicant asserting that an emergency situation exists, the department shall immediately determine whether an emergency situation exists and upon finding that an emergency situation does exist shall issue a certificate of need for a project necessary on account of the emergency situation. The scope of the certificate of need may not exceed that which is necessary to remedy or otherwise effectively address the emergency situation. The certificate of need may be subject to conditions consistent with the purpose of this Act that do not interfere with the applicant's ability to respond effectively to the emergency.

The commissioner shall find an emergency situation exists whenever the commissioner finds that an applicant has demonstrated:

A. The necessity for immediate or temporary relief due to a natural disaster, a fire, an unforeseen safety consideration, a major accident, equipment failure, foreclosure, receivership or an action of the department or other circumstances determined appropriate by the department; [PL 2001, c. 664, §2 (NEW).]

B. The serious adverse effect of delay on the applicant and the community that would be occasioned by compliance with the regular requirements of this chapter and the rules adopted by the department; and [PL 2001, c. 664, §2 (NEW).]

C. The lack of substantial change in the facility or services that existed before the emergency situation. [PL 2001, c. 664, §2 (NEW).]
[PL 2001, c. 664, §2 (NEW).]

SECTION HISTORY

PL 2001, c. 664, §2 (NEW). PL 2003, c. 469, §§C8-12 (AMD). PL 2003, c. 514, §1 (AMD). PL 2005, c. 369, §§7,8 (AMD). PL 2007, c. 440, §§14-19 (AMD). PL 2009, c. 383, §8 (AMD). PL 2011, c. 90, Pt. J, §§5, 6 (AMD). PL 2011, c. 213, §3 (AMD). PL 2011, c. 424, Pt. B, §15 (AMD). PL 2011, c. 424, Pt. E, §1 (AFF). PL 2011, c. 648, §§6-11 (AMD). PL 2013, c. 424, Pt. A, §10 (AMD). PL 2013, c. 424, Pt. B, §9 (AMD). PL 2023, c. 343, §§2-5 (AMD).

§336. Simplified review and approval process

Notwithstanding the requirements set forth in section 335, the department shall conduct a simplified review and approval process in accordance with this section unless a public hearing has been requested pursuant to section 339, subsection 2, paragraph D, in which case the project is subject to the expanded

review in section 335. The department shall by rule set forth this simplified review and approval process. To the extent practicable, a simplified review must be completed and the commissioner shall make a decision within 60 days after the application has been certified as complete by the applicant pursuant to section 337, subsection 4, unless a hearing is requested by a person directly affected by a review or the commissioner determines to hold a hearing. The following projects may qualify for a simplified review process: [PL 2011, c. 648, §12 (AMD).]

1. Maintenance projects. The commissioner shall issue a certificate of need for a project that primarily involves the maintenance of a health facility if the commissioner determines that the project:

A. Will result in no or a minimal additional expense to the public or to the health care facility's clients; [PL 2001, c. 664, §2 (NEW).]

B. Will be in compliance with other applicable state and local laws and regulations; and [PL 2001, c. 664, §2 (NEW).]

C. Will significantly improve or, in the alternative, not significantly adversely affect the health and welfare of any person currently being served by the health care facility. [PL 2001, c. 664, §2 (NEW).]

[PL 2001, c. 664, §2 (NEW).]

2. Life safety codes; previous certificate of need. The commissioner shall issue a certificate of need for a project that is required to meet federal, state or local life safety codes.
[PL 2011, c. 648, §12 (AMD).]

3. Acquisition of control. The commissioner shall issue a certificate of need for a project that involves the acquisition of control of a health facility when the acquisition consists of a management agreement or similar arrangement and primarily involves the day-to-day operation of the facility in its current form, or transfers ownership of a nursing facility to an existing provider of nursing facility services licensed in this State if the commissioner determines that the project meets the requirements of section 335, subsection 7, paragraph B and that the project is economically feasible in light of its impact on:

A. The operating budget of the facility and the applicant; and [PL 2001, c. 664, §2 (NEW).]

B. The applicant's ability to operate the facility without increases in the facility's rates beyond those that would otherwise occur absent the acquisition. [PL 2001, c. 664, §2 (NEW).]

The commissioner may not find that a project primarily involves day-to-day operation of the facility in its current form if the commissioner finds that the project would result in a reduction of access to, geographic proximity of, timeliness of or quality of any family planning services, as defined in section 1902, subsection 4, or any abortion services unless the commissioner determines that the exceptions described in section 335, subsection 1, paragraph G are met.
[PL 2023, c. 343, §6 (AMD).]

4. Capital expenditures for compliance or quality improvement. The commissioner shall issue a certificate of need for a proposed capital expenditure upon determining that:

A. The capital expenditure is required to eliminate or prevent imminent safety hazards, as defined by applicable fire, building or life safety codes and regulations; to comply with state licensure standards; to provide demonstrable improvements in patient safety or quality of care; or to comply with accreditation or certification standards that must be met to receive reimbursement under the United States Social Security Act, Title XVIII or payments under a state plan for medical assistance approved under Title XIX of that Act; [PL 2011, c. 648, §12 (AMD).]

B. The economic feasibility of the project is demonstrated in terms of its effects on the operating budget of the applicant, including its existing rate structure; [PL 2001, c. 664, §2 (NEW).]

C. There remains a public need for the service to be provided; and [PL 2001, c. 664, §2 (NEW).]

D. The corrective action proposed by the applicant is a cost-effective alternative available under the circumstances. [PL 2011, c. 648, §12 (AMD).]

[PL 2011, c. 648, §12 (AMD).]

5. Major medical equipment. The commissioner shall issue a certificate of need for replacement of major medical equipment that is not otherwise exempt from review pursuant to section 329, subsection 2-A, paragraph B, subparagraph (1) upon determining that a project meets the requirements of section 335, subsection 7.

[PL 2009, c. 383, §9 (NEW).]

6. Other projects. The commissioner may by rule identify other categories of projects that qualify for simplified review under this section that are consistent with the purposes of this section and will foster timely review and approval for qualifying projects.

[PL 2011, c. 648, §12 (NEW).]

SECTION HISTORY

PL 2001, c. 664, §2 (NEW). PL 2009, c. 383, §9 (AMD). PL 2011, c. 648, §12 (AMD). PL 2023, c. 343, §6 (AMD).

§337. Application process for certificate of need

1. Letter of intent. Prior to filing an application for a certificate of need, an applicant shall file a letter of intent with the department. The letter of intent forms the basis for determining the applicability of this chapter to the proposed expenditure or action. A letter of intent is deemed withdrawn one year after receipt by the department, unless sooner superseded by an application, except that the applicant is not precluded from resubmitting the same letter of intent.

[PL 2001, c. 664, §2 (NEW).]

2. Application filed. Paragraphs A to C apply in the given order to the application process for certificate of need.

A. After receiving the letter of intent, the department shall issue a letter or checklist, or both, to an applicant that stipulates and clarifies what will be required in the application. [PL 2001, c. 664, §2 (NEW).]

B. Within 15 days of filing the letter of intent, the applicant shall schedule a meeting with the department staff in order to assist the department in understanding the application and to receive technical assistance concerning the nature, extent and format of the documentary evidence, statistical data and financial data required for the department to evaluate the proposal. The applicant may waive the technical assistance meeting requirement under this paragraph. [PL 2011, c. 648, §13 (AMD).]

C. After receiving notice from the department that a certificate of need is required for a proposed expenditure or action, if the applicant wishes to proceed with the project, the applicant must file an application for a certificate of need. [PL 2001, c. 664, §2 (NEW).]

[PL 2011, c. 648, §13 (AMD).]

3. Application content; department-approved forms. An application for a certificate of need must describe with specificity how the proposed project meets each of the standards for granting a certificate of need that are applicable to the project. A statement or statements that the project will meet the standards without supporting facts backed by relevant documentation and analysis constitute sufficient cause to deny the application. An application subject to an expanded review must contain, if available and relevant to the particular service or technology, information on health status, public health need for the service or technology, quality assurance processes and prevention programs.

A. The department shall make available on the department's publicly accessible website multiple project-specific, department-approved certificate of need forms for at least the following certificate of need categories:

(1) Nursing facility projects;

(2) Hospital projects; and

(3) Other projects subject to review. [PL 2011, c. 648, §14 (NEW).]

B. The department-approved forms must set forth application elements that are relevant to each category and must elicit the information and data reasonably necessary to permit the department to carry out the review and approval process in a timely and cost-effective manner, with consideration for the costs and responsiblities imposed on applicants. [PL 2011, c. 648, §14 (NEW).]

C. Submission of the completed applicable department-approved forms and required information, together with other information that is appropriate to the application, and the applicant's certification that the application is complete pursuant to subsection 4 constitutes a sufficient record for the department to make a determination regarding the application for a certificate of need, unless a hearing is requested either by the department or by a person directly affected by a review. [PL 2011, c. 648, §14 (NEW).]

D. If an application is contested by another provider of services or a person directly affected by a review or the department determines that a public hearing must be held pursuant to section 339, subsection 2, additional information may be required by the department. [PL 2011, c. 648, §14 (NEW).]

[PL 2011, c. 648, §14 (AMD).]

4. Application complete. An application is certified as complete when the applicant delivers to the department a certification in writing that states that the application should be considered complete by the department. Subsequent to the applicant's certification under this subsection, the applicant may submit information that is responsive to any concern, issue, question or allegation of facts contrary to those in the application made by the department or any other person.

[PL 2001, c. 664, §2 (NEW).]

5. Public notice; public informational meeting. Within 5 business days of the filing of a certificate by an applicant that a complete certificate of need application is on file with the department, public notice that the application has been filed must be given by publication in a newspaper of general circulation in Kennebec County and in a newspaper published within the service area in which the proposed expenditure will occur. If an existing health care facility may close or lose bed capacity as a result of a proposal for which a certificate of need application has been filed, the department shall notify the municipal officers of the municipality in which that health care facility is located and the members of the State House of Representatives and the State Senate representing any part of that municipality. The notice must also be provided to all persons who have requested notification by means of asking that their names be placed on a mailing list maintained by the department for this purpose. The notice must also be published on the department's publicly accessible website. This notice must include:

A. A brief description of the proposed expenditure or other action, including the name and location of any existing health care facility that may close or lose bed capacity as a result of a proposal for which a certificate of need application has been filed; [PL 2013, c. 424, Pt. A, §11 (RPR).]

B. A description of the review process and schedule; [PL 2013, c. 424, Pt. A, §11 (RPR).]

C. A statement that any person may examine the application, submit comments in writing to the department regarding the application and examine the entire record assembled by the department at any time from the date of publication of the notice until the application process is closed for comment; [PL 2013, c. 424, Pt. A, §11 (RPR).]

D. If a public informational meeting is being held, the time and location of the public informational meeting, a statement that any person may appear at the meeting to question the applicant regarding the project or the department regarding the conditions the applicant must satisfy in order to receive a certificate of need for the project, and a statement that a public hearing may be requested by any person directly affected by a review if the request is received by the commissioner within 15 days following the public informational meeting pursuant to the provisions of section 339, subsection 2; and [PL 2013, c. 424, Pt. A, §11 (RPR).]

E. If a public informational meeting is not being held, a statement that a public hearing may be requested by any person directly affected by a review if the request is received by the commissioner within 15 days following the publication of the notice that an application has been filed. [PL 2013, c. 424, Pt. A, §11 (RPR).]

The department shall make an electronic or stenographic record of the public informational meeting.

A public informational meeting is not required for the simplified review and approval process in section 336 unless requested by the applicant, the department or a person directly affected by a review.
[PL 2013, c. 424, Pt. A, §11 (RPR).]

6. Voluntary withdrawal of application. During the review period, prior to the date that department staff submits a final report to the commissioner, an applicant may withdraw an application without prejudice by filing written notice of the withdrawal with the department. A withdrawn application may be resubmitted and will be processed as an entirely new application under this chapter.
[PL 2001, c. 664, §2 (NEW).]

7. Fees. The department shall adopt rules setting minimum and maximum filing fees under this chapter. A nonrefundable filing fee must be paid at the time an application is filed. If the approved capital expenditure or operating cost upon which a fee is based is higher than the initially proposed capital expenditure, then the filing fee must be recalculated and the difference, if any, must be paid before the certificate of need may be issued. In addition to filing fees, the department shall adopt rules to establish reasonable and necessary fees to carry out the provisions of this chapter. All fees received by the department under this subsection must be placed in a separate, nonlapsing account to be used in accordance with this chapter. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.
[PL 2011, c. 648, §16 (AMD).]

8. Suspension of review. An applicant may request and be granted a suspension of the review process prior to the date on which the department staff submits its final analysis to the commissioner.

A. A request for suspension of the review process must be for specific periods of no less than 10 days and not greater than 12 months. [PL 2011, c. 648, §17 (NEW).]

B. If there are no competing applicants, a request under this subsection must be granted. [PL 2011, c. 648, §17 (NEW).]

C. If there are competing applicants, the request under this subsection must be reviewed and approved or disapproved within 3 business days, taking into account the interests of the public and of competing applicants. [PL 2011, c. 648, §17 (NEW).]

D. If a request to suspend the review is granted, the department shall determine:

(1) If the suspension will suspend review of all competing applications; or

(2) If the suspension will not affect competing applications, which will continue to be reviewed without interruption. [PL 2011, c. 648, §17 (NEW).]

E. Failure to reactivate an application within the time period approved by the department results in automatic withdrawal of the suspended application. [PL 2011, c. 648, §17 (NEW).]
[PL 2011, c. 648, §17 (NEW).]

SECTION HISTORY

PL 2001, c. 664, §2 (NEW). PL 2009, c. 383, §§10, 11 (AMD). PL 2011, c. 424, Pt. D, §§1, 2 (AMD). PL 2011, c. 424, Pt. E, §1 (AFF). PL 2011, c. 636, §1 (AMD). PL 2011, c. 648, §§13-17 (AMD). PL 2013, c. 424, Pt. A, §11 (AMD).

§338. Consultation

1. Consultation on new technologies and needs. In connection with the development of policies and procedures to implement this Act, the commissioner may, from time to time, consult with persons with relevant skills and experience regarding:

A. New medical technologies and the impact of those technologies on the health care delivery system in the State; [PL 2003, c. 469, Pt. C, §13 (AMD).]

B. Unmet need for health care services in the State; [PL 2011, c. 648, §18 (AMD).]

C. The quality of health care; and [PL 2011, c. 648, §18 (AMD).]

D. The need to replace, renovate or upgrade health care facilities to meet current and future needs. [PL 2011, c. 648, §18 (NEW).]

[PL 2011, c. 648, §18 (AMD).]

SECTION HISTORY

PL 2001, c. 664, §2 (NEW). PL 2003, c. 469, §§C13,14 (AMD). PL 2011, c. 648, §18 (AMD).

§339. Review process; public hearing

1. Review process. The review process consists of an evaluation of the project application for a certificate of need by the department in light of:

A. The application itself; [PL 2001, c. 664, §2 (NEW).]

B. Material collected or developed by or for the department staff to test the assertions in the application; [PL 2001, c. 664, §2 (NEW).]

C. All comments received by any person regarding the project; and [PL 2001, c. 664, §2 (NEW).]

D. Any other material made part of the record. [PL 2001, c. 664, §2 (NEW).]

[PL 2001, c. 664, §2 (NEW).]

2. Public hearing. The following provisions apply to a public hearing under this chapter.

A. The commissioner or the commissioner's designee may hold a public hearing regarding the application. [PL 2001, c. 664, §2 (NEW).]

B. The commissioner, or the commissioner's designee, shall hold a public hearing if any person directly affected by a review requests, in writing, that such a public hearing be held and the request is timely received by the commissioner. If a public informational meeting on the application is conducted pursuant to section 337, subsection 5, the request for a public hearing must be received by the commissioner no later than 15 days following the informational hearing. If no public informational meeting is conducted, the request for a public hearing must be received within 15 days following the publication of the public notice required by section 337, subsection 5. [PL 2011, c. 648, §19 (AMD).]

C. An electronic or stenographic record of the public hearing must be made part of the record. [PL 2001, c. 664, §2 (NEW).]

D. A public hearing is not required for the simplified review and approval process set forth in section 336 unless requested by the applicant, the department or a person directly affected by a review. [PL 2011, c. 648, §20 (AMD).]

[PL 2011, c. 648, §§19, 20 (AMD).]

3. Preliminary staff analyses. As soon as practicable, the department staff shall provide the preliminary analyses of the application and the record to the applicant, the commissioner and any person who requests the analyses and record. Notice of the availability of the analyses must be published in a newspaper in general circulation in Kennebec County and a newspaper of general circulation serving the area in which the project is to be located and on the department's publicly accessible site on the Internet.
[PL 2001, c. 664, §2 (NEW).]

4. Final department staff analysis. A final department staff analysis must be submitted to the commissioner, together with the documentary record described in section 335, subsection 2, as soon as practicable after the closing of the record.
[PL 2001, c. 664, §2 (NEW).]

5. Reviews. To the extent practicable, a review must be completed and the commissioner shall make a decision within 60 days after the application has been certified as complete by the applicant for a simplified review, or within 90 days for an expanded review. The department shall establish criteria for determining when it is not practicable to complete a review within these time frames. Whenever it is not practicable to complete a review within these time frames, the department may extend the review period for up to an additional 30 days.
[PL 2011, c. 648, §21 (AMD).]

6. Public necessity. The department may delay action on an otherwise complete application for up to 120 days from the time the application has been certified as complete by the applicant if the department finds that a public necessity exists. The department shall provide written notice of the delay to the applicant and any other person who has requested in writing information regarding the application. For purposes of this subsection, the department shall find that a public necessity exists if:

A. The application represents a new service or technology not previously provided within the State; [PL 2001, c. 664, §2 (NEW).]

B. The application represents a potential significant impact on health care system costs; [PL 2001, c. 664, §2 (NEW).]

C. The application represents a new service or technology for which a health care system need has not been previously established; or [PL 2001, c. 664, §2 (NEW).]

D. There are several applications for the same or similar projects before the department. [PL 2001, c. 664, §2 (NEW).]
[PL 2011, c. 648, §22 (AMD).]

SECTION HISTORY

PL 2001, c. 664, §2 (NEW). PL 2009, c. 383, §12 (AMD). PL 2011, c. 424, Pt. D, §§3-5 (AMD). PL 2011, c. 424, Pt. E, §1 (AFF). PL 2011, c. 648, §§19-22 (AMD).

§340. Reconsideration

Any person directly affected by a review under this chapter may, for good cause shown, request in writing a hearing for the purpose of reconsideration of the decision of the department to issue or to deny a certificate of need. [PL 2001, c. 664, §2 (NEW).]

1. Timing for request. A request for hearing for reconsideration under this section must be received within 30 days of the department's decision.
[PL 2001, c. 664, §2 (NEW).]

2. Hearing. If the department determines that good cause for a hearing under this section has been demonstrated, the department shall commence a hearing within 30 days of receipt of the request. For purposes of this section, a request for a hearing is considered to show good cause if it:

A. Presents significant, relevant information not previously considered by the department; [PL 2001, c. 664, §2 (NEW).]

B. Demonstrates that there have been significant changes in factors or circumstances relied upon by the department in reaching its decision; [PL 2001, c. 664, §2 (NEW).]

C. Demonstrates that the department has materially failed to follow its adopted procedures in reaching its decision; or [PL 2001, c. 664, §2 (NEW).]

D. Provides other bases for a hearing that the department has determined constitute good cause. [PL 2001, c. 664, §2 (NEW).]

[PL 2001, c. 664, §2 (NEW).]

3. Decision. A decision must be rendered within 60 days of the commencement of a hearing under this section, except that the parties may agree to a longer time period.

[PL 2001, c. 664, §2 (NEW).]

SECTION HISTORY

PL 2001, c. 664, §2 (NEW).

§341. Remedy

Any person aggrieved by a final decision of the department made under the provisions of this Act is entitled to review in accordance with this chapter and with Title 5, chapter 375, subchapter VII. [PL 2001, c. 664, §2 (NEW).]

1. Finality. A decision of the department to issue a certificate of need or to deny an application for a certificate of need is not considered final until the department has taken final action on a request for reconsideration under section 340. A decision by the department is not final when opportunity for reconsideration exists with respect to matters involving new information or changes in circumstances pursuant to section 340, subsection 2, paragraphs A and B.

[PL 2001, c. 664, §2 (NEW).]

2. Competitive reviews. If a person or persons file for review under Title 5, chapter 375, regarding competitive reviews of proposals to construct new nursing facility beds, the court shall require the party seeking judicial review to give security in such sums as the court determines proper for the payment of costs and damages that may be incurred or suffered by any other party who is found to have been wrongfully delayed or restrained from proceeding to implement the certificate of need, except that, for good cause shown and recited in the order, the court may waive the giving of security. A surety upon a bond or undertaking under this subsection submits the surety to the jurisdiction of the court and irrevocably appoints the clerk of the court as the agent for the surety upon whom any papers affecting liability on the bond or undertaking may be served. The liability of the surety may be enforced on motion without the necessity of an independent action. The motion and such notice of the motion as the court prescribes may be served on the clerk of the court, who shall mail copies to the persons giving the security if their addresses are known.

[PL 2001, c. 664, §2 (NEW).]

SECTION HISTORY

PL 2001, c. 664, §2 (NEW).

§342. Rules

The department shall adopt any rules, standards, criteria, plans or procedures that may be necessary to carry out the provisions and purposes of this Act. The department shall provide for public notice and hearing on all proposed rules, standards, criteria, plans, procedures or schedules pursuant to Title 5, chapter 375. Unless otherwise provided by this chapter, rules adopted pursuant to this chapter are

routine technical rules as defined by Title 5, chapter 375, subchapter II-A. [PL 2001, c. 664, §2 (NEW).]

SECTION HISTORY

PL 2001, c. 664, §2 (NEW).

§343. Public information

The department shall prepare and publish at least annually a report on its activities conducted pursuant to this Act. The annual report must include information on all certificates of need granted and denied and on the assessment of penalties. With regard to all certificates granted on a conditional basis, the report must include a summary of information reported pursuant to section 332 and any accompanying statements by the commissioner or department staff submitted regarding the reports. [PL 2009, c. 383, §13 (AMD).]

SECTION HISTORY

PL 2001, c. 664, §2 (NEW). PL 2009, c. 383, §13 (AMD).

§344. Conflict of interest

In addition to the limitations of Title 5, section 18, a member or employee of the department who has a substantial economic or fiduciary interest that would be affected by a recommendation or decision to issue or deny a certificate of need or who has a close relative or economic associate whose interest would be so affected is ineligible to participate in the review, recommendation or decision-making process with respect to any application for which the conflict of interest exists. [PL 2001, c. 664, §2 (NEW).]

SECTION HISTORY

PL 2001, c. 664, §2 (NEW).

§345. Division of project to evade cost limitation prohibited

A health care facility or other party required to obtain a certificate of need may not separate portions of a single project into components, including, but not limited to, site facility and equipment, to evade the cost limitations or other requirements of section 329. [PL 2001, c. 664, §2 (NEW).]

SECTION HISTORY

PL 2001, c. 664, §2 (NEW).

§346. Scope of certificate of need

1. Application determinative. A certificate of need is valid only for the defined scope, premises and facility or person named in the application and is not transferable or assignable.
[PL 2001, c. 664, §2 (NEW).]

2. Maximum expenditure. In issuing a certificate of need, the department shall specify the maximum capital expenditures that may be obligated under this certificate. The department shall adopt rules regarding the determination of capital expenditure maximums, procedures to monitor capital expenditures obligated under certificates and procedures to review projects for which the capital expenditure maximum is exceeded or expected to be exceeded.
[PL 2001, c. 664, §2 (NEW).]

3. Issued certificate; duration and expiration. After the issuance of a certificate of need, the department shall periodically review the progress of the holder of the certificate in meeting the timetable for making the service or equipment available or for completing the project specified in the approved application. A certificate of need expires if the project for which the certificate has been issued is not commenced within 24 months following the issuance of the certificate. The department may grant an extension of a certificate for an additional specified time not to exceed 12 months if good cause is

shown why the project has not commenced. The department may require evidence of the continuing feasibility and availability of financing for a project as a condition for extending the life of the certificate. In addition, if on the basis of its periodic review of progress under the certificate the department determines that the holder of a certificate is not otherwise meeting the timetable and is not making a good faith effort to meet it, the department may, after a hearing, withdraw the certificate of need. The department shall adopt rules for the withdrawal of certificates of need.
[PL 2011, c. 648, §23 (AMD).]

SECTION HISTORY

PL 2001, c. 664, §2 (NEW). PL 2011, c. 648, §23 (AMD).

§347. Withholding of license

A new health care facility, as defined in section 328, is eligible to obtain a license under the applicable state law if the facility has obtained a certificate of need as required by this chapter. The license of any facility does not extend to include and may not otherwise be deemed to allow the delivery of any services, the use of any equipment that has been acquired, the use of any portion of a facility or any other change for which a certificate of need as required by this chapter has not been obtained. Any unauthorized delivery of services, use of equipment or a portion of a facility or other change is in violation of the respective chapter under which the facility is licensed. [PL 2001, c. 664, §2 (NEW).]

SECTION HISTORY

PL 2001, c. 664, §2 (NEW).

§348. Withholding of funds

A health care facility or other provider may be eligible to apply for or receive any reimbursement, payment or other financial assistance from any state agency or other 3rd-party payor, either directly or indirectly, for any capital expenditure or operating costs attributable to any project for which a certificate of need is required by this chapter only if the certificate of need has been obtained. Reimbursement, payment or other financial assistance, either directly or indirectly, from a state agency or other 3rd-party payor may be subject to an enforcement action by the commissioner to withhold or deny reimbursement, in whole or in part, with respect to a project granted a certificate of need when the commissioner determines that the applicant fails to meet any of the conditions set forth in the certificate of need approval in accordance with the procedures set forth in section 332. For the purposes of this section, the department shall determine the eligibility of a facility to receive reimbursement for all projects subject to the provisions of this chapter. [PL 2007, c. 440, §20 (AMD).]

SECTION HISTORY

RR 2001, c. 2, §A29 (COR). PL 2001, c. 664, §2 (NEW). PL 2007, c. 440, §20 (AMD).

§349. Injunction

The Attorney General, upon the request of the department, shall seek to enjoin any project for which a certificate of need as required by this chapter has not been obtained and shall take any other action as may be appropriate to enforce this chapter. [PL 2001, c. 664, §2 (NEW).]

SECTION HISTORY

PL 2001, c. 664, §2 (NEW).

§349-A. Compliance investigation

To ensure compliance with this chapter or rules adopted under this chapter, the department may investigate a health care facility or other entity subject to this chapter when the department has a reasonable basis to suspect that a violation has occurred. The health care facility or other entity subject to this chapter may not interfere with or impede the investigation. [PL 2009, c. 556, §1 (NEW).]

1. Right of entry. The department may enter and inspect the premises of a health care facility or other entity subject to this chapter with the permission of the owner or person in charge, or with an administrative inspection warrant issued pursuant to the Maine Rules of Civil Procedure, Rule 80E by the District Court authorizing entry and inspection, when the department has a reasonable basis to suspect that a provision of this chapter or a rule adopted under this chapter has been violated. The right of entry extends to any premises that the department has reason to believe is operated and maintained in violation of this chapter or rules adopted under this chapter. A letter of intent or an application for a certificate of need made pursuant to this chapter and rules adopted under this chapter constitutes permission for entry or inspection of the premises for which the certificate of need is sought in order to facilitate verification of the information submitted on or in connection with a letter of intent or an application for a certificate of need.
[PL 2009, c. 556, §1 (NEW).]

2. Access to information. The department, at any reasonable time, upon demand, has the right to inspect and copy books, accounts, papers, records and other documents or information, whether stored electronically, on paper or in other forms, including, but not limited to, documents and information regarding total capital expenditures and operating costs for a project, ownership or control of a health care facility or other entity subject to this chapter or health services provided, when the department has a reasonable basis to suspect that a provision of this chapter or a rule adopted under this chapter has been violated.
[PL 2009, c. 556, §1 (NEW).]

3. Findings of fact. Upon completion of an investigation pursuant to this section, the department shall prepare findings of fact and make a recommendation to the commissioner as to whether a provision of this chapter or a rule adopted under this chapter has been violated. If the commissioner determines that a violation has occurred, the commissioner may pursue one or more of the remedies authorized under this Act.
[PL 2009, c. 556, §1 (NEW).]

4. Rules. The department may adopt rules to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.
[PL 2009, c. 556, §1 (NEW).]

SECTION HISTORY

PL 2009, c. 556, §1 (NEW).

§350. Penalty

1. Violation. An individual, partnership, association, organization, corporation or trust that violates any provision of this chapter or any rate, rule or regulation pursuant to this chapter is subject to a fine imposed in conformance with the Maine Administrative Procedure Act and payable to the State of not more than $10,000. The department may hold these funds in a special revenue account that may be used only to support certificate of need reviews, such as for hiring expert analysts on a short-term consulting basis.
[PL 2009, c. 383, §14 (NEW).]

2. Administrative hearing and appeal. To contest the imposition of a fine under this section, the individual, partnership, association, organization, corporation or trust shall submit to the department a written request for an administrative hearing within 10 days of notice of imposition of a fine pursuant to this section. Judicial appeal must be in accordance with Title 5, chapter 375, subchapter 7.
[PL 2009, c. 383, §14 (NEW).]

SECTION HISTORY

PL 2001, c. 664, §2 (NEW). PL 2009, c. 383, §14 (RPR).

§350-A. Cost-of-living adjustment

(REPEALED)

(REALLOCATED FROM TITLE 22, SECTION 351)

SECTION HISTORY

RR 2001, c. 2, §A30 (RAL). PL 2007, c. 440, §21 (AMD). PL 2007, c. 681, §7 (AMD). PL 2009, c. 383, §15 (RP).

§350-B. Federal funding

(REALLOCATED FROM TITLE 22, SECTION 352)

The department is authorized to accept any federal funds to be used for the purposes of carrying out this chapter. [RR 2001, c. 2, Pt. A, §31 (RAL).]

SECTION HISTORY

RR 2001, c. 2, §A31 (RAL).

§350-C. Implementation reports

(REALLOCATED FROM TITLE 22, SECTION 353)

The holder of a certificate of need shall make written reports as provided in this section and as required by rule adopted by the department. [RR 2001, c. 2, Pt. A, §32 (RAL).]

1. Final plans and specifications. A holder of a certificate of need that has been issued for the construction or modification of a facility or portion of a facility shall file final plans and specifications for the project as required by the department to determine that the plans and specifications are in compliance with the certificate of need and with applicable licensure, life safety code and accreditation standards.
[RR 2001, c. 2, Pt. A, §32 (RAL).]

2. Reports. The department may require periodic reports, summary reports and cost and utilization reports as well as reports regarding the effect of the project on the health status, quality of care and health outcomes of the population served for no longer than 3 years following the completion of the project as set out in rule.
[PL 2011, c. 648, §24 (AMD).]

3. Summary report.
[PL 2011, c. 648, §24 (RP).]

4. Cost and utilization reports.
[PL 2011, c. 648, §24 (RP).]

5. Department action. The department may revoke any certificate of need the department has issued when the person to whom it has been issued fails to file reports or plans and specifications required by the department on a timely basis. The department shall review services that fall below the required volume and quality standards of a certificate of need.
[PL 2011, c. 648, §24 (AMD).]

SECTION HISTORY

RR 2001, c. 2, §A32 (RAL). PL 2011, c. 648, §24 (AMD).

LAW WITHOUT GOVERNOR'S SIGNATURE

JUNE 22, 2025

CHAPTER 401

PUBLIC LAW

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND TWENTY-FIVE

S.P. 416 - L.D. 985

An Act to Impose a Moratorium on the Ownership or Operation of Hospitals in the State by Private Equity Companies or Real Estate Investment Trusts

Emergency preamble. Whereas, acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, this legislation establishes a one-year moratorium on the ownership or operation of hospitals in the State by private equity companies or real estate investment trusts; and

Whereas, this legislation must take effect as soon as possible so that any transactions involving the State's hospitals and private equity companies or real estate investment trusts may not move forward for one year; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore,

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 22 MRSA §1730-A is enacted to read:

§1730-A. Moratorium on ownership or operation of hospitals by private equity companies and real estate investment trusts

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Hospital" has the same meaning as in Title 36, section 2881, subsection 2.

B. "Indirect ownership interest" means an ownership interest in an entity that has an ownership interest in a hospital.

C. "Operational control" means to:

(1) Influence or direct the actions or policies of any part of a hospital; or

(2) Choose, appoint or terminate a member of a board, manager, managing member, senior employee, consultant or other individual or entity that participates in the operational oversight of a hospital.

D. "Ownership interest" means possession or equity in capital, stock or profits in a hospital or ownership of real estate on which a hospital operates.

E. "Private equity company" means an entity whether or not publicly traded that collects capital investments from individuals or entities.

F. "Real estate investment trust" has the same meaning as in the United States Internal Revenue Code of 1986, Section 856.

2. Moratorium. A private equity company or real estate investment trust may not acquire or increase a direct or indirect ownership interest or operational control or financial control in a hospital in the State.

3. Repeal. This section is repealed June 15, 2026.

Sec. 2. Application. This Act does not apply to any transaction for which an application for a certificate of need under the Maine Revised Statutes, Title 22, section 329 has been filed on or before June 1, 2025.

Emergency clause. In view of the emergency cited in the preamble, this legislation takes effect when approved.

132nd MAINE LEGISLATURE

FIRST REGULAR SESSION-2025

Legislative Document	**No. 985**
S.P. 416	In Senate, March 11, 2025

An Act to Impose a Moratorium on the Ownership or Operation of Hospitals in the State by Private Equity Companies or Real Estate Investment Trusts

Reference to the Committee on Health and Human Services suggested and ordered printed.

DAREK M. GRANT
Secretary of the Senate

Presented by Senator TIPPING of Penobscot.
Cosponsored by Representative SHAGOURY of Hallowell and
Senators: BENNETT of Oxford, TALBOT ROSS of Cumberland.

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 22 MRSA §1730-A is enacted to read:

§1730-A. Moratorium on ownership or operation of hospitals by private equity companies and real estate investment trusts

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Hospital" has the same meaning as in Title 36, section 2881, subsection 2.

B. "Indirect ownership interest" means an ownership interest in an entity that has an ownership interest in a hospital.

C. "Operational control" means to:

(1) Influence or direct the actions or policies of any part of a hospital; or

(2) Choose, appoint or terminate a member of a board, manager, managing member, senior employee, consultant or other individual or entity that participates in the operational oversight of a hospital.

D. "Ownership interest" means possession or equity in capital, stock or profits in a hospital or ownership of real estate on which a hospital operates.

E. "Private equity company" means an entity whether or not publicly traded that collects capital investments from individuals or entities.

F. "Real estate investment trust" has the same meaning as in the United States Internal Revenue Code of 1986, Section 856.

2. Moratorium. A private equity company or real estate investment trust may not acquire or increase a direct or indirect ownership interest or operational control or financial control in a hospital in the State.

3. Repeal. This section is repealed June 15, 2029.

SUMMARY

This bill places a moratorium on a private equity company or real estate investment trust from acquiring or increasing a direct or indirect ownership interest or operational control or financial control in a hospital in the State until June 15, 2029.

132nd MAINE LEGISLATURE

FIRST SPECIAL SESSION-2025

Legislative Document **No. 1578**

H.P. 1036 House of Representatives, April 10, 2025

An Act to Require the Department of Health and Human Services to Review Disruption to or Removal of Health Services

Reference to the Committee on Health and Human Services suggested and ordered printed.

ROBERT B. HUNT
Clerk

Presented by Representative DODGE of Belfast.
Cosponsored by Senator GROHOSKI of Hancock and
Representatives: DEBRITO of Waterville, EATON of Deer Isle, FRIEDMANN of Bar Harbor, MILLIKEN of Blue Hill, Senators: BRENNER of Cumberland, CURRY of Waldo, TEPLER of Sagadahoc.

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 22 MRSA §332, sub-§1, as amended by PL 2023, c. 343, §1, is further amended to read:

1. Subsequent review following approval. When the commissioner has approved an application filed unconditionally or subject to conditions pursuant to section 335, subsection 8, the commissioner may conduct a subsequent review to ensure compliance with any terms or conditions of approval within 3 years after the approved activity is undertaken. The 3-year time limitation does not apply to a subsequent review to ensure that the requirement set forth in section 335, subsection 1, paragraph G continues to be met or to ensure the maintenance of health services after a circumstance described under section 331, subsection 1 has occurred or a change not described under section 331, subsection 1 that constitutes a significant disruption to or removal of a health service has occurred, as determined by the commissioner. In any subsequent review, the commissioner may hold a public hearing and may consider any material or significant changes in factors or circumstances relied upon by the commissioner in approving the application and significant and relevant information that either is new or was withheld by the applicant at the time of the process under section 335. If, upon review, the commissioner determines that any terms or conditions of the approval have not been met, the commissioner may take enforcement action consistent with subsection 3 and other applicable provisions of this Act.

SUMMARY

This bill provides that the 3-year limitation on a subsequent review of an approved certificate of need does not apply to a subsequent review to ensure the maintenance of health services after a circumstance described under the Maine Revised Statutes, Title 22, section 331, subsection 1 has occurred or a change not described under that provision that constitutes a significant disruption to or removal of a health service has occurred, as determined by the Commissioner of Health and Human Services.

132nd MAINE LEGISLATURE

FIRST SPECIAL SESSION-2025

Legislative Document **No. 1890**

H.P. 1261 House of Representatives, May 5, 2025

An Act to Facilitate the Development of Ambulatory Surgical Facilities by Exempting Certain Facilities from the Requirement to Obtain a Certificate of Need

Received by the Clerk of the House on May 1, 2025. Referred to the Committee on Health and Human Services pursuant to Joint Rule 308.2 and ordered printed pursuant to Joint Rule 401.

ROBERT B. HUNT
Clerk

Presented by Representative FOLEY of Wells.
Cosponsored by Senator CYRWAY of Kennebec and
Representatives: FLYNN of Albion, OLSEN of Raymond, POIRIER of Skowhegan, POMERLEAU of Standish.

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 22 MRSA §330, sub-§6, as enacted by PL 2001, c. 664, §2, is repealed.

Sec. 2. 22 MRSA §330, sub-§7, as amended by PL 2003, c. 621, §1, is further amended to read:

7. Critical access hospitals. Conversion by a critical access hospital or a hospital in the process of becoming a critical access hospital of licensed acute care beds to hospital swing beds~~.~~; and

Sec. 3. 22 MRSA §330, sub-§8 is enacted to read:

8. Certain ambulatory surgical facilities. The establishment or expansion of an ambulatory surgical facility, except that an ambulatory surgical facility that is owned or operated by a hospital is exempt only if the facility:

A. Is operated and paid only as an ambulatory surgical facility; and

B. Does not share space with a hospital or the outpatient surgery department of a critical access hospital, even if the ambulatory surgical facility and the hospital or outpatient surgery department of a critical access hospital are temporally separated.

For the purposes of this paragraph, "temporally separated" means that an ambulatory surgical facility and the entity it shares a space with are not open at the same time.

SUMMARY

This bill exempts certain ambulatory surgical facilities from the requirement to obtain a certificate of need from the Department of Health and Human Services to finance or incur expenditures for a project. An ambulatory surgical facility that is owned or operated by a hospital is exempt from the requirement only if the facility is operated and paid only as an ambulatory surgical facility and does not share space with a hospital or the outpatient surgery department of a critical access hospital, even if the facility and hospital or outpatient surgery department are not open at the same time.

For Review by Commission Members 10/8/2025
Distributed at Request of Rep. Foley
Re: Discussion of LD 1890

Certificate of Need—

Comparing ASCs and Hospitals in Maine and New Hampshire

Anthem

Comparing ASCs and Hospitals in Maine and New Hampshire

Hip replacement--outpatient (50 mile radius)*				
Maine (Portland)			**New Hampshire (Manchester)**	
ASC 1	$24,497		ASC 1	$10,815
Hospital A	$37,435		ASC 2	$10,960
Hospital B	$42,340		ASC 3	$15,655
Hospital C	$44,324		Hospital A	$17,729
Hospital D	$49,534		ASC 4	$25,415
Hospital E	$50,502		Hospital B	$27,331
Hospital F	$58,606		Hospital C	$32,417
Hospital G	$58,921		Hospital D	$33,772
Hospital H	$62,255		Hospital E	$49,497
Hospital I	$63,081		Hospital F	$50,321
			Hospital G	$64,639
			Hospital H	$72,380

Hip Replacement in ASCs Maine vs NH	
Maine	13.59%
New Hampshire	47.38%

Data obtained from Anthem.com Find Care logged in as a member

Comparing ASCs and Hospitals in Maine and New Hampshire

Total knee replacement--outpatient (50 mile radius)*				
Maine (Portland)			**New Hampshire (Manchester)**	
ASC 1	$22,776		ASC 1	$9,198
Hospital A	$39,005		Hospital A	$16,555
Hospital B	$43,394		ASC 2	$17,516
Hospital C	$43,605		ASC 3	$18,378
Hospital D	$48,918		ASC 4	$19,677
Hospital E	$57,119		ASC 5	$22,155
Hospital F	$58,334		ASC 6	$25,244
Hospital G	$62,432		Hospital B	$25,625
Hospital H	$63,475		Hospital C	$31,998
			Hospital D	$38,917

Knee Replacement in ASCs Maine vs NH	
Maine	14.08%
New Hampshire	47.58%

Data obtained from Anthem.com Find Care logged in as a member

Comparing ASCs and Hospitals in Maine and New Hampshire

Colonoscopy with biopsy (30 mile radius)				
Maine (Portland)			**New Hampshire (Manchester)**	
ASC 1	$1,758		ASC 1	$1,934
Hospital A	$4,502		ASC 2	$1,963
Hospital B	$4,897		ASC 3	$2,239
Hospital C	$5,841		ASC 4	$2,356
Hospital D	$6,207		ASC 5	$2,573
Hospital E	$6,336		ASC 6	$3,140
Hospital F	$6,915		ASC 7	$3,286
			ASC 8	$3,481

Diagnostic Colonoscopies in ASCs—Maine vs NH	
Maine	23.90%
New Hampshire	67.70%

Data obtained from Anthem.com Find Care logged in as a member

132nd MAINE LEGISLATURE

FIRST SPECIAL SESSION-2025

Legislative Document **No. 1972**

H.P. 1316 House of Representatives, May 13, 2025

An Act to Enhance Transparency and Value in Substantial Health Care Transactions by Changing the Review and Approval Process for Those Transactions

Reference to the Committee on Health and Human Services suggested and ordered printed.

ROBERT B. HUNT
Clerk

Presented by Representative ZAGER of Portland.
Cosponsored by Representatives: BOYER of Cape Elizabeth, CLUCHEY of Bowdoinham, FOLEY of Wells, MORRIS of Turner.

Be it enacted by the People of the State of Maine as follows:

PART A

Sec. A-1. 22 MRSA §329, sub-§1, as amended by PL 2015, c. 453, §1, is further amended to read:

1. Transfer of ownership; acquisition by lease, donation, transfer; acquisition of control <u>of a nursing facility</u>. Any transfer of ownership or acquisition under lease or comparable arrangement or through donation or any acquisition of control of a ~~health care~~ <u>nursing</u> facility under lease, management agreement or comparable arrangement or through donation that would have required review if the transfer or acquisition had been by purchase, except in emergencies when that acquisition of control is at the direction of the department or except if the transfer of ownership or acquisition of control involves only entities or health care facilities that are direct or indirect subsidiaries of the same parent corporation, is between a parent corporation and its direct or indirect subsidiaries or is between entities or ~~health care~~ <u>nursing</u> facilities all under direct or indirect ownership of or ultimate control by the same parent corporation immediately prior to the transfer or acquisition;

PART B

Sec. B-1. 22 MRSA c. 106 is enacted to read:

<u>CHAPTER 106</u>

<u>TRANSPARENCY AND VALUE IN HEALTH CARE TRANSACTIONS</u>

<u>§371. Definitions</u>

<u>As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings.</u>

<u>**1. Acquisition.** "Acquisition" means the direct or indirect purchase in any manner of a material amount of the assets or operations of a health care entity. "Acquisition" includes, but is not limited to, purchase by lease, transfer, exchange, option, receipt of a conveyance or creation of a joint venture or any other manner of purchase, such as by a health care system, private equity group, hedge fund, publicly traded company, real estate investment trust, management services organization, insurance carrier or any subsidiaries thereof.</u>

<u>**2. Affiliate.** "Affiliate" means:</u>

<u>A. A person, entity or organization that directly, indirectly or through one or more intermediaries controls, is controlled by or is under common control or ownership with another person, entity or organization;</u>

<u>B. A person whose business is operated under a lease, management or operating agreement by another entity or a person substantially all of whose property is operated under a management or operating agreement with that other entity;</u>

<u>C. An entity that operates the business or substantially all the property of another entity under a lease, management or operating agreement; or</u>

D. Any out-of-state operations and corporate affiliates of an affiliate as defined in paragraph A, B or C, including significant equity investors, real estate investment trusts and management services organizations.

3. Arrangement. "Arrangement" includes any agreement, association, partnership, joint venture, management services agreement, professional services agreement, health care staffing company agreement or other arrangement that results in a change of governance or change of control of a health care entity or a department, subdivision or subsidiary of a health care entity.

4. Carrier. "Carrier" has the same meaning as in Title 24-A, section 4301-A, subsection 3.

5. Change of control. "Change of control" means an arrangement in which any other person, corporation or partnership or any other entity acquires direct or indirect control over the operations of a health care entity in whole or in substantial part.

6. Control. "Control," including the terms "controlling," "controlled by" and "under common control with," means the direct or indirect power through ownership, contractual agreement or otherwise:

A. To vote 10% or more of any class of voting shares of a health care entity; or

B. To direct the actions or policies of a health care entity.

7. Health care entity. "Health care entity" means a health care provider, a health care facility or a provider organization. "Health care entity" does not include a nursing facility as defined by section 328, subsection 18.

8. Health care facility. "Health care facility" means a licensed institution providing health care services or a health care setting, including, but not limited to, hospitals and other licensed inpatient facilities, health systems consisting of one or more health care entities that are jointly owned or managed, ambulatory surgical or treatment centers, residential treatment centers, diagnostic, laboratory and imaging centers, freestanding emergency facilities, outpatient clinics and rehabilitation and other therapeutic health settings.

9. Health care provider. "Health care provider" means any person, corporation, partnership, governmental unit, state institution, medical practice or any other entity qualified or licensed under state law to perform or provide health care services to persons in the State.

10. Health care services. "Health care services" means services and payments for the care, prevention, diagnosis, treatment, cure or relief of a medical, dental or behavioral health condition, illness, injury or disease, including, but not limited to:

A. Inpatient, outpatient, habilitative, rehabilitative, dental, palliative, therapeutic, supportive, home health or behavioral services provided by a health care entity;

B. Pharmacy services, either retail or specialty, and any drugs, medical devices or medical supplies;

C. Performance of functions to refer, arrange or coordinate care;

D. Equipment used such as durable medical equipment, diagnostic equipment, surgical devices or infusion equipment; or

E. Technology associated with the provision of services or equipment in paragraphs A to D, such as telehealth, electronic health records, software, claims processing or utilization systems.

11. Health care staffing company. "Health care staffing company" means a person, firm, corporation, partnership or other business entity engaged in the business of providing or procuring, for temporary employment or contracting by a health care facility, any health care personnel but does not include an individual who independently provides the individual's own services on a temporary basis to health care facilities as an employee or contractor.

12. Management services organization. "Management services organization" means any organization or entity that contracts with a health care provider or provider organization to perform management or administrative services relating to, supporting or facilitating the provision of health care services.

13. Material change transaction. "Material change transaction" means any of the following occurring during a single transaction or in a series of related transactions involving a health care entity within the State that has total assets or annual revenues, or anticipated annual revenues for new entities, of at least $10,000,000, including both in-state and out-of-state assets and revenues or anticipated revenues:

A. A corporate merger including one or more health care entities;

B. An acquisition of one or more health care entities, including insolvent health care entities;

C. Any affiliation, arrangement or contract that results in a change of control for a health care entity;

D. The formation of a partnership, joint venture, accountable care organization, parent organization or management services organization for the purpose of administering contracts with carriers, 3rd-party administrators, pharmacy benefits managers or health care providers;

E. A sale, purchase, lease, affiliation or transfer of control of a board of directors or governing body of a health care entity;

F. A real estate sale or lease agreement involving a material amount of assets of a health care entity; or

G. The closure of a health care facility or the closure, discontinuance or significant reduction of any essential health care service provided by a health care entity that is either a provider organization or a health care facility or any new contracts or clinical or contractual affiliations that will eliminate or significantly reduce essential health care services. The department shall define by rule what constitutes a significant reduction and essential health care services for purposes of this chapter.

"Material change transaction" does not include a clinical affiliation of health care entities formed solely for the purpose of collaborating on clinical trials; graduate medical education programs; the mere offer of employment to, or hiring of, a single physician; or situations in which the health care entity directly, or indirectly through one or more intermediaries, controls, is controlled by or is under common control with all other parties to the transaction, such as a corporate restructuring.

14. Medical practice. "Medical practice" means a corporate entity or partnership organized for the purpose of practicing medicine and permitted to practice medicine in the State, including, but not limited to, partnerships, professional corporations, limited liability companies and limited liability partnerships.

15. Pharmacy benefits manager. "Pharmacy benefits manager" has the same meaning as in Title 24-A, section 4347, subsection 17.

16. Provider organization. "Provider organization" means any corporation, partnership, business trust, association or organized group of persons that is in the business of health care delivery or management, whether incorporated or not, that represents one or more health care providers in contracting with carriers for the payment of health care services. "Provider organization" includes, but is not limited to, physician organizations, physician-hospital organizations, independent practice associations, health care provider networks, accountable care organizations and management services organizations and any other organization that contracts with carriers for payment for health care services.

§372. Review of proposed material change transactions

1. Notice. This subsection governs notice regarding material change transactions.

A. A health care entity shall, before completing any material change transaction, file written notice with the department not fewer than 180 days before the date of the proposed material change transaction.

B. Written notice under paragraph A must contain the information the department determines necessary. The health care entity may include any additional information supporting the written notice of the material change transaction. Notice is complete when the department determines that all required information has been received.

C. All the information provided by the submitter as part of the notice under this subsection must be treated as a public record unless the submitter designates documents or information as confidential when submitting the notice and the department concurs with the designation in accordance with a process specified by rule. Information that is otherwise publicly available, or that has not been confidentially maintained by the source, must be considered public information. The department shall maintain the confidentiality of all confidential information that is obtained in relation to a material change transaction, except that the department may exchange confidential information with the Office of Affordable Health Care, established under Title 5, section 3122, subsection 1, necessary for the office to exercise its authority under this chapter and may disclose any information to an expert or consultant under contract with the department as long as the expert or consultant is bound by the same confidentiality requirements as the department. The confidential information and documents are not public records and are exempt from the provisions of Title 1, chapter 13.

D. Within 10 days of receiving written notice of a material change transaction, the department shall post on its publicly accessible website information about the material change transaction, including:

(1) A summary of the proposed transaction, including the identities of the parties to the transaction;

(2) An explanation of the groups or individuals likely to be affected by the transaction;

(3) Information about services currently provided by the health care entity, commitments made by the health care entity to continue such services and any services to be reduced or eliminated;

(4) Details about any public hearings and how to submit comments; and

(5) Any other information from the notice and other materials submitted by the health care entity that the department determines would be in the public interest, except for materials designated confidential under paragraph C.

E. For purposes of calculating time periods pursuant to this subsection, notice is considered received on the first business day after the department determines that notice is complete.

2. Preliminary review. This subsection governs preliminary reviews of material change transactions.

A. Within 60 days after receiving a notice described in subsection 1, the department, in consultation with the Office of Affordable Health Care, shall:

(1) Approve the material change transaction and notify the health care entity in writing that a comprehensive review is not required for the material change transaction;

(2) Approve the material change transaction subject to conditions set by the department and notify the health care entity in writing of the conditions under which the material change transaction may be completed; or

(3) Notify the health care entity in writing that the transaction is subject to a comprehensive review. The department may request additional information necessary to perform a comprehensive review under subsection 3.

B. A comprehensive review under subsection 3 is required when any of the following applies to the material change transaction:

(1) The material change transaction will result in the transfer of assets valued over $100,000,000;

(2) The material change transaction will lessen competition, including through the effects of vertical or cross-market transactions among different product or geographic markets; and

(3) The department, at its sole discretion, determines that the material change transaction is likely to have a material impact on the cost, quality or equity of or access to health care services in any region in the State.

C. This section does not limit or infringe upon the existing authority of any state agency, including the Department of Health and Human Services, the Department of Professional and Financial Regulation and the Department of the Attorney General, to review any transactions.

3. Comprehensive review process. This subsection governs the comprehensive review process for material change transactions.

A. No later than 90 days after determining a material change transaction is subject to a comprehensive review pursuant to subsection 2, paragraph B, the department shall conduct one or more public hearings or public meetings, one of which must be in the

county in which the health care entity is located, to hear comments from interested parties.

B. At the department's request, the Office of Affordable Health Care shall review the material change transaction's cost and market impact. The review may examine factors relating to the proposed transaction and the transacting parties and their relative market positions, including, but not limited to:

(1) The quality of the services provided by any health care provider party to the transaction, including patient experience;

(2) Consumer concerns, including, but not limited to, complaints or other allegations that the health care provider or provider organization has engaged in any unfair method of competition or any unfair or deceptive act or practice;

(3) The role of the transacting parties in serving at-risk, underserved and government payer patient populations;

(4) The prices charged by either of the transacting parties for health care services, including their relative prices compared to others' prices for the same health care services in the same geographic area;

(5) The cost and cost trends of the health care entity in comparison to total health care expenditures statewide;

(6) The impact of the transaction on the clinical workforce, including wages, working conditions, staffing levels, supply, patient access and continuity of patient-care relationships;

(7) The impact of a real estate sale or lease agreement on the financial condition of the health care entity and its ability to maintain patient care operations;

(8) The market share of any transacting party and the likely effects of the transaction on competition;

(9) Any previous transaction involving either transacting party, including, but not limited to, acquisitions or mergers of similar health care providers, whether or not in the same state;

(10) The availability and accessibility of health care services similar to those provided, or proposed to be provided, through the health care provider or provider organization within its primary service areas and dispersed service areas;

(11) The impact of the material change transaction on competing options for the delivery of health care services within the health care provider's or provider organization's primary service areas and dispersed service areas;

(12) The role of the transacting parties in providing low-margin or negative-margin services within their respective primary service areas and dispersed service areas;

(13) The parties' compliance with prior conditions and legal requirements related to competitive conduct, including without limitation compliance with reporting requirements regarding health care entity ownership and control under Title 22, section 8710-A and compliance with the laws and regulations of other states in which the parties operate;

(14) In the case of a proposed closure or discontinuance of a health care facility or any essential health care services, the impact of the closure or discontinuance on health care services access, outcomes, costs and equity for those in the health care facility's service area and the health care facility's plan for ensuring equitable access, quality, affordability and availability of essential health care services within the service area; and

(15) Any other factors that the Office of Affordable Health Care determines to be in the public interest.

C. The department and the Office of Affordable Health Care may request additional information or documents from the transacting parties necessary to conduct the review of the material change transaction's cost and market impact. Failure to respond or insufficient responses to requests for information by transacting parties may result in the extension of the deadline for the office to complete the review or the imposition of conditions for approval or the disapproval of the material change transaction under subsection 4.

D. The department and the Office of Affordable Health Care shall keep confidential all nonpublic information and documents obtained under this section and may not disclose the confidential information or documents to any person without the consent of the party that produced the confidential information or documents, except that the department and the office may disclose any information to an expert or consultant under contract with the State to review the proposed material change transaction as long as the expert or consultant is bound by the same confidentiality requirements as the department and the office. The confidential information and documents and work product of the Office of Affordable Health Care are not public records and are exempt from Title 1, chapter 13.

E. The department or the office may, in its sole discretion:

(1) Contract with, consult and receive advice from any state agency, including other offices of the Department of Health and Human Services, the Department of Professional and Financial Regulation, the Maine Health Data Organization established in section 8703, the Maine Quality Forum established in Title 24-A, section 6951 or any other state agency, on those terms and conditions that the department or the office considers appropriate; and

(2) Contract with experts or consultants to assist in reviewing the proposed material change transaction.

Notwithstanding Title 5, chapter 155 or any other provision of law to the contrary, agreements and contracts entered into pursuant to this chapter are not subject to the competitive bid requirements of the Chief Procurement Officer.

F. Not more than 150 days after receiving the request under paragraph B, the Office of Affordable Health Care shall produce a report on its review of the material change transaction's cost and market impact report containing the findings and conclusions of the review as long as the health care entity has complied with the requests for information or documents pursuant to this section within 21 days of the request or by a later date set by mutual agreement of the health care entity and the office. The report must be posted publicly and may not disclose confidential information.

G. The department may charge costs to the transacting parties for all actual, reasonable and direct costs incurred in reviewing, evaluating and making the determination referred to in this section, including, without limitation, administrative costs, costs incurred by the Office of Affordable Health Care and costs of contracted experts or consultants.

4. Approval authority. This subsection governs the department's approval authority.

A. The department may approve, conditionally approve or disapprove of any material change transaction for which the department receives notice under subsection 1. Any conditions imposed pursuant to this section must specify a time period for compliance, an expiration date or that the condition applies indefinitely.

B. The department shall inform the health care entity of the determination under paragraph A within 60 days of notice under subsection 1 or, in the case of comprehensive review, within 60 days of the department's receiving the report of the completed review of the material change transaction's cost and market impact from the Office of Affordable Health Care. A proposed material change transaction may not be completed before the department has informed the health care entity of the determination.

C. In making the determination pursuant to paragraph A, the department may consider any factors that the department considers relevant, including, but not limited to, the likely impact, as described in the cost and market impact review report when applicable, of the material change transaction on:

(1) Health care costs, prices and affordability;

(2) The availability or accessibility of health care services to the affected individuals and groups;

(3) The potential effects of the transaction on health outcomes, quality, access, equity or workforce for residents of this State or the potential loss or change in access to essential health care services;

(4) Health care provider cost trends and containment of total state health care spending;

(5) Access to health care services in medically underserved areas;

(6) Rectifying historical problems and contemporary factors contributing to a lack of health equity or access to health care services;

(7) The functioning and competitiveness of the markets for health care and health insurance;

(8) Whether the transaction is contrary to or violates any applicable law, including, without limitation, state antitrust laws, laws restricting the corporate practice of medicine and consumer protection laws;

(9) Whether the benefits of the transaction are likely to outweigh the anticompetitive effects from the transaction; and

(10) Whether the transaction is in the public interest.

D. This subsection does not limit or alter any authority of the Attorney General or any state agency to enforce any other law, including state or federal antitrust law, or to review nonprofit transactions.

5. Post-transaction oversight. This subsection governs post-transaction oversight.

A. This paragraph governs enforcement by the Attorney General.

(1) The Attorney General may subpoena any records necessary to enforce any provisions of this chapter or to investigate suspected violations of any provisions of this chapter or any conditions imposed by conditional approval pursuant to subsection 4.

(2) The Attorney General may enforce any requirement of this chapter and any conditions imposed by a conditional approval pursuant to subsection 4 to the fullest extent provided by law, including damages. In addition to any legal remedies the Attorney General may have, the Attorney General is entitled to specific performance, injunctive relief and other equitable remedies a court considers appropriate for any violation or imminent violation of any requirement of this chapter or breach of any of the conditions and is entitled to recover attorney's fees and costs incurred in remedying each violation.

(3) This subsection does not narrow, abrogate or otherwise alter the authority of the Attorney General to prosecute violations of antitrust or consumer protection requirements.

B. This paragraph governs enforcement by the department.

(1) The department may audit the books, documents, records and data of any entity that is subject to a conditional approval under subsection 4 to monitor compliance with the conditions.

(2) Any entity that violates any provision of this chapter, any rules adopted pursuant to this chapter or any condition imposed pursuant to a conditional approval under subsection 4 is subject to an administrative penalty of $10,000 per day for any violation of this chapter. The department may hold these funds in a special revenue account that may be used only to support material change transaction reviews, such as for hiring expert analysts on a short-term consulting basis.

(3) The department may refer any entity to the Attorney General to review for enforcement of any noncompliance with this chapter and any conditions imposed by conditional approval pursuant to subsection 4.

(4) In order to monitor effectively ongoing compliance with the terms and conditions of any material change transaction subject to prior notice, approval or conditional approval under this chapter, the department may, in its sole discretion, conduct a review or audit and may contract with experts and consultants to assist in this regard.

(5) One year, 2 years and 5 years following the completion of the material change transaction approved or conditionally approved by the department after a comprehensive review under subsection 3, and at future intervals determined at the discretion of the department, the health care entity or the person, corporation or

partnership or any other entity that acquired direct or indirect control over the health care entity shall submit reports to the department that:

(a) Demonstrate compliance with conditions placed on the transaction, if any;

(b) Analyze cost trends and cost growth trends of the parties to the transactions; and

(c) Analyze any changes or effects of the transaction on patient access, availability of services, workforce, quality or equity.

C. The department is entitled to charge costs to the transacting parties for all actual, reasonable and direct costs incurred in monitoring ongoing compliance with the terms and conditions of the material change transaction, including contractor and administrative costs.

6. Assessment. The department shall adopt rules setting minimum and maximum filing fees under this chapter. Initial fees may not be less than $1,000 nor more than $5,000. In addition to rules regarding filing fees, the department shall adopt rules to establish reasonable and necessary fees to carry out the provisions of this chapter. The department shall also assess an annual fee equal to one five-thousandth of 1% of all premiums earned in the prior year on all health insurers and health maintenance organizations operating in the State and all insurers writing employee benefit excess insurance as described in Title 24-A, section 707, subsection 1, paragraph C-1 in the State. The department may, at its sole discretion, waive this assessment for carriers with less than $25,000,000 in annual earned premium. When filing written notice pursuant to subsection 1, paragraph A, the health care entity shall pay a nonrefundable filing fee pursuant to this subsection. All fees received by the department under this subsection must be placed in a separate, nonlapsing account to be used in accordance with this chapter. The department shall hold these funds in a special revenue account that may be used only to support staff positions and other expenses necessary to administer this section.

§373. Rulemaking

The department may, after notice and hearing pursuant to Title 5, chapter 375, subchapter 2, adopt rules to carry out this chapter. Rules adopted pursuant to this section are routine technical rules pursuant to Title 5, chapter 375, subchapter 2-A.

PART C

Sec. C-1. 22 MRSA §8710-A is enacted to read:

§8710-A. Ownership and control of health care entities

1. Definitions. For the purposes of this section, unless the context otherwise indicates, all terms have the same meanings as under section 371.

2. Reporting of ownership and control of health care entities. A health care entity shall report to the organization on an annual basis and upon the completion of a material change transaction involving the health care entity in a form and manner required by the organization the following information:

A. Legal name of health care entity;

B. Business address of health care entity;

C. Locations of operations;

D. Business identification numbers of the health care entity, as applicable, including:

(1) Taxpayer identification number;

(2) National provider identifier;

(3) Employer identification number; and

(4) United States Department of Health and Human Services, Centers for Medicare and Medicaid Services certification number;

E. Name and contact information of a representative of the health care entity;

F. The name, business address, business identification numbers listed in paragraph D and federal tax classification for each person or entity that, with respect to the relevant health care entity:

(1) Has an ownership or investment interest;

(2) Has a controlling interest;

(3) Is a management services organization; or

(4) Is a significant equity investor;

G. A current organizational chart showing the business structure of the health care entity, including:

(1) Any entity listed in paragraph F;

(2) Affiliates, including entities that control or are under common control as the health care entity; and

(3) Subsidiaries;

H. For a health care entity that is a health care provider or a health care facility:

(1) The affiliated health care providers identified by name, license type, specialty, national provider identifier and other applicable identification number described in paragraph D; the address of the principal practice location; and whether the health care provider is employed or contracted by the health care entity; and

(2) The name and address of affiliated health care facilities by license number, license type and capacity in each major service area;

I. The names, national provider identifiers, if applicable, and compensation of the members of the governing board or board of directors or similar governance body for the health care entity; any entity that is owned or controlled by, affiliated with or under common control with the health care entity; and any entity described in paragraph F; and

J. Payor mix information for the reporting year by:

(1) The number of services provided and percent of total services provided by payor category; and

(2) The percent of total patient service revenue by payor category.

3. Exceptions. The following health care entities are exempt from the reporting requirements under subsection 2:

A. A health care entity that is an independent provider organization, without any ownership or control entities, consisting of 5 or fewer physicians, except that if such a health care entity experiences a material change transaction under chapter 106, the health care entity is subject to reporting pursuant to chapter 106; and

B. A health care provider or provider organization that is owned or controlled by another health care entity, if the health care provider or provider organization is shown in the organizational chart submitted under subsection 2, paragraph G and the controlling health care entity reports all the information required under subsection 2 on behalf of the controlled or owned entity, except that health care facilities are not subject to this exception.

4. Sharing of ownership information to improve transparency. This subsection governs the sharing of ownership information to improve transparency.

A. Information provided under this subsection is public information and may not be considered confidential, proprietary or a trade secret, except that any individual health care provider's taxpayer identification number that is also their social security number is confidential.

B. Not later than July 1, 2027 and annually thereafter, the organization shall post on a publicly accessible website a report with respect to the previous one-year period, including:

(1) The number of health care entities reporting for that previous one-year period, disaggregated by the business structure of each specified health care entity;

(2) The name, address and business structure of any entity with an ownership or controlling interest in a health care entity;

(3) Any change in ownership or control for each health care entity;

(4) Any change in the tax identification number of a health care entity; and

(5) As applicable, the name, address, tax identification number and business structure of other affiliates that are under common control with, subsidiaries of or management services entities of the health care entity, including the business type and the tax identification number of each.

C. The organization may share information reported under this section with the Office of Affordable Health Care, Attorney General, other state agencies and other state officials to reduce or avoid duplication in reporting requirements or to facilitate oversight or enforcement pursuant to the laws of the State, except that any tax identification numbers that are individual social security numbers may be shared only with other state agencies or other state officials that agree to maintain the confidentiality of such information.

PART D

Sec. D-1. Effective date. This Act takes effect January 1, 2026.

SUMMARY

This bill enacts law governing consequential transactions, such as transfers of ownership or control, among health care entities, including health care providers, health care facilities, provider organizations, pharmacy benefits managers and carriers. It establishes a preliminary and comprehensive review process carried out by the Department of Health and Human Services in consultation with the Office of Affordable Health Care and provides for post-transaction oversight. It creates provisions governing reporting on the ownership and control of health care entities upon the completion of a transaction. It also makes the provisions take effect January 1, 2026.

Commission to Evaluate the Scope of Regulatory Review and Oversight over Health Care Transactions That Impact the Delivery of Health Care Services in the State

Written Comments

Submitted to Commission as of October 8, 2025 8:00 am

McCarthyReid, Colleen

From: Scarlet Kinney <scarlet.kinney@gmail.com>
Sent: Thursday, October 2, 2025 10:27 AM
To: McCarthyReid, Colleen
Subject: Written Comments for Oct. 8 Commission Meeting

Please enter my comments into the testimony. Thanks.
As an elder served by Northern Light in eastern Maine, I have seen much needed services, such as Palliative Care, being ruthlessly cut without any explanation to staff or patients, leaving those of us who depend on it to see us through until we require hospice care high and dry. There also appears to be a shortage of doctors in the state, making seeing a specialist a months long wait, while conditions needing immediate specialist treatment worsen. Rural care hospitals and rural nursing services are also being shut down.
I was hospitalized recently for Type A flu with respiratory failure at Northern Light Ellsworth hospital, and the nursing care was frightening. There was basically no patient care, no help with personal care, none of the staff, who were primarily "travelers" (staff hired from other places), knew how to properly make a hospital bed, and when nursing care was actually given, providers where timed, and chided to move on if they spent more than six minutes with a patient, because their as though they were on an assembly line, not providing health care. I also witnessed a youngish male specialist staff cruelly chewing out an older female nurse in a loud voice right in front of me. I was embarrassed for the poor nurse and furious with the specialist. This kind of production line nursing care, and lack of professional respect for staff made my stay so unpleasant that I couldn't wait to get out of there.
Meanwhile, Northern Light built an entire new triage hospital in Blue Hill, no doubt improving its real estate value. This is an example of money spent for profit, not patient care.

I find these changes in health care to be cruel and hateful. I expect they're due to private equity buyouts of Maine hospitals as real estate purchases to be bled dry financially and then sold at a nice profit, with no care or thought given to the patients who are suffering because of it.
I think what's happening is heinous, and I urge the State to do everything it can to turn this greed-fueled situation around. Health care was once patient centered, and readily available. These short-term profit outfits are putting profit before patient care and this is causing illness, health care insecurity, and even in some cases, death. It must be stopped.
Sincerely, Scarlet Kinney

Scarlet Lynda Kinney MA
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Testimony of Tessa Storey
Commission to Examine Maine's Hospitals and Medical Infrastructure
October 8, 2025

Dear Members of the Commission,

My name is Tessa Storey. I am 33 years old and a relatively healthy Mainer who only began to have health issues this past year. I lived in Portland for 13 years and recently moved to Mount Desert Island. Since moving here, I have felt firsthand the lack of access to healthcare, even in one of the most visited places in the state. I've had to travel all the way back to Portland for basic dental care. And here on the island, the labor and delivery unit was closed, meaning people can no longer have a baby in their own community hospital. If that's the reality in a well-known destination like Mount Desert Island, I can only imagine how much harder it is for Mainers living in even more rural parts of our state.

I have built my adult life in Maine. I love this state deeply. But between rising costs and the shrinking access to healthcare, I have even found myself questioning whether I can stay here long-term. That is not a choice I want to make, but it's a choice many Mainers are being forced to consider.

That is why I am writing today in strong support of the work this Commission is doing to protect Maine's hospitals and medical infrastructure from private equity and corporate profiteering. Forty-two percent of our hospitals are already at risk of closing. We cannot allow short-term investors to come in, strip essential services, and leave our communities without the care we need to survive.

Research shows that when private equity takes over a hospital, patient care declines, staff pay decreases, and even deaths in the emergency room increase. Essential services are cut if they are not "profitable," regardless of whether the community depends on them. That is not the kind of "help" Maine hospitals need.

Last session, the emergency moratorium on private equity and real estate investment trust purchases of hospitals was an important first step. But it was only temporary. Now is the time to make sure that safeguard becomes permanent, and to create policies that keep our healthcare in the hands of our communities, not investors chasing a quick profit.

I urge you to put people over profit and ensure that Maine's hospitals remain strong, accessible, and accountable to the communities they serve.

Thank you for your time and for the work you are doing to protect healthcare in Maine.

Sincerely,
Tessa Storey
Mount Desert Island, Maine

October 7th, 2025

Dear Senator Tipping and esteemed members of The Commission to Evaluate the Scope of Regulatory Review and Oversight Over Health Care Transactions that Impact the Delivery of Health Care Services in the State.

My name is Eli Durand-McDonnell, I am from Bar Harbor, Maine and I work as the Policy Coordinator at Maine Youth Power, a youth-led, youth movement throughout rural and suburban Maine fighting to win human dignity, equity and a livable future for all. I am writing to you today on behalf of my organization to urge that you protect Mainers and our healthcare infrastructure from private equity acquisition.

In my line of work, I am lucky enough to talk with young people from all across the state. As we all know, Mainers take deep pride in their home state, and so many of the youth that I speak to are deeply committed to putting their roots down in Maine. However, I also frequently hear about the various challenges to staying within Maine that we face as young people, and there is an ongoing narrative about the "brain drain" of young people leaving the state for more economic opportunities and infrastructure.

Right now, this commission has the chance to protect hospitals, protect patients, and protect all Mainers, young and old, by establishing safeguards against predatory private equity firms that don't have the well being of patients in mind, simply their profit margins. These safeguards are exactly the sort of investments in Maine that will keep young people in this state for generations to come, and this commission can play a crucial role in starting those investments.

Thank you for your consideration,
Eli Durand-McDonnell

MSNA Maine State Nurses Association
National Nurses Organizing Committee
National Nurses United
OUR PATIENTS. OUR UNION. OUR VOICE.

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Comments by Maine State Nurses Association/National Nurses Organizing Committee

Via email to colleen.mccarthyreid@legislature.maine.gov

Senator Mike Tipping, Chair
Representative Michelle Boyer, Chair
Commission to Evaluate the Scope of Regulatory Review and Oversight Over Health Care Transactions that Impact the Delivery of Health Care Services in the State
State House Station
Augusta, Maine 04333

Re: Comments to the Commission to Evaluate the Scope of Regulatory Review and Oversight Over Health Care Transactions that Impact the Delivery of Health Care Services in the State (Commission)

October 6, 2025

Dear Chair Tipping, Chair Boyer, and members of the Commission,

On behalf of more than 4,000 registered nurses and other health care workers providing patient care in our state, Maine State Nurses Association/National Nurses Organizing Committee (MSNA) appreciates that the Commission is tackling the critical issue of health care transactions in our state. Unchecked corporate consolidation and health care facility closures result in higher prices, reduced access to care, and rampant hospital and unit closures that put our patients' lives at risk. The state agencies' authority to review openings but not closures of health care facilities contributes to these problems.

As the Commission begins its work, MSNA provides comments on the scope of the Commission's work and specific recommendations for the legislation that the Commission is tasked with recommending to the legislature. We urge the Commission to craft legislation that will provide Maine enforcement agencies the authority to review harmful transactions, stop hospital unit closures, develop programs to aid hospitals with financial need, and include communities in these essential decisions.

MSNA has substantial expertise in health care transactions and in developing solutions to prevent hospital closures and reductions in services. We stand ready to assist the Commission in crafting strong legislation and recommendations for its report. The situation facing Maine patients is urgent. We urge you to make the most of this opportunity and to develop real solutions to protect our patients.

I. The Commission should combine its review of health care transaction policy with an exploration of ways to stop hospital and unit closures and support reopening.

The Commission should take a broad view of its mandate and craft a comprehensive solution to the problems of health care access in Maine. The Commission is tasked with reviewing certificate of need laws, legislative changes to review and oversight of health care transactions, the role of private equity in hospital ownership, and other issues to further the duties and purposes of the study. The Commission should develop legislation that expands Maine enforcement agencies' authority to review health care transactions and health care service reductions. Agencies' enforcement authority should include transactions that create vertical integration, such as when health systems purchase physician practices, as well as horizontal consolidation of health care entities of the same type. Additionally, we encourage the Commission to explore funding sources or programs to support safe staffing and reopen services in hospitals in financial need.

MSNA urges the Commission to use its time and resources to develop strong legislation to immediately stop hospital closures, unit closures, and reductions in services and staffing. As hospital closures and service reductions can cost people their lives, this legislation should be introduced in 2026.

We also urge the Commission to review options to empower the Department of Health and Human Services (DHHS) to identify programs that can serve as long-term solutions to help hospitals that are in financial need reopen services that they have closed.

We appreciate the opportunity for public comment at the Commission's meetings and in writing. Additionally, as the Commission undertakes its work in the coming months, it should include community meetings to discuss health care access issues and potential solutions, particularly in areas where hospitals have closed or reduced services and staffing, for example, in obstetric and birthing units.

II. Key elements for a health care transactions bill.

MSNA is part of National Nurses Organizing Committee (NNOC) which is an affiliate of National Nurses United (NNU). NNOC and NNU have experience with health care transactions and hospital closures on laba federal level and in several states. Through this experience, we have identified several factors that are essential to a strong bill on the issues under the Commission's mandate. **We have included materials in the Appendix that NNOC and NNU have submitted in other states and at the federal level that give significantly more detail on ways to improve antitrust laws with a focus on health care impacts.**

The Commission should recommend legislation to **empower the Attorney General and/or the Department of Health and Human Services to review health care transactions, closures,**

service and staffing reductions, and to approve, deny, or add conditions for approval of a health care transaction, closure, or service or staffing reduction.

Current Maine law provides piecemeal authority to review health care transactions. The certificate of need (CON) law[1] allows state review of new health care facilities and services, and changes in ownership, to ensure they fill a genuine public need and will not negatively affect the quality of care delivered by existing providers. The CON law allows conditional approvals but provides little detail as to the types of conditions permitted.[2] The Attorney General has the power to enforce Maine's very general anti-monopoly law[3] and to ensure that nonprofit hospitals and medical service organizations are comporting with the law governing use of nonprofit funds.[4] However, there is no law allowing review of hospital closures or service or staffing reductions. There is also limited ability to constrain abuse of market power by corporations that control significant segments of a market, including health systems. It is not sufficient to protect incumbents with a CON law without setting standards for the health care services they provide.

The Commission should recommend that the Attorney General and/or the Department of Health and Human Services be empowered to review health care transactions, closures, and service and staffing reductions based on factors related to health care access, patient health and mortality, impacts on workers, and the public interest. Health care consolidation has given a few entities outsized power over patients' access to health care and health care workers' access to good jobs with safe working conditions. That power allows health care entities to raise prices, reduce services, and otherwise harm the public interest. To combat the harms of excess market power, MSNA urges the Commission to recommend that Maine adopt what is known in anti-trust law as a "labor impact standard" and "public interest standard" in its health care transaction review. Basically, that means that state agencies are empowered to deny or add conditions to transactions that are likely to give entities excessive power over the labor market or harm the public interest. LD 1972 provides a strong starting point for the Commission to develop this law.

The state should be able to approve, deny, or add conditions for approval of a health care transaction, closure, or service or staffing reduction to reduce the risk that the party in control after the transaction will act in ways that harm health care access, patient health and mortality, workers, or the public interest. Existing certificate of need law does permit conditions for approvals, but it lacks detail and does not extend to all types of change. Examples of conditions to target specific potential risks include requirements that services remain open, requirements that the facility maintain minimum safe staffing ratios, requirements for health impact assessments, or prohibitions on anticompetitive contracting with insurers.

[1] 22 M.R.S.A. § 326 et seq.
[2] 22 M.R.S.A. § 335.
[3] 10 M.R.S.A. § 1101 et seq.
[4] 5 M.R.S.A. § 194-A et seq.

The Commission should recommend that health care transactions legislation include a requirement to provide six months' notice to the public prior to approval of transactions, closures, and service and staffing reductions. It should also require the state and parties to the transaction to host public hearings in the affected communities. Sufficient notice is essential to allow workers and community members to understand the proposed transaction and organize to explain its impacts to policymakers and help develop solutions to prevent closures or avoid potential harms from transactions. Without giving the public sufficient time and opportunity to participate in the process, the state will not be able to perform an accurate review based on public interest factors.

When a few health systems control large portions of the health care market, as they do in Maine as well as most states nationally, they have the power to engage in behavior that hurts workers or patients and increases their market power even further. The Commission should explore potential improvements to Maine's antitrust law, for health care or in general, to more clearly establish a "single firm conduct" standard that gives Maine enforcement agencies' authority to take enforcement action against large health care corporations that abuse their market power in ways that harm health care workers or patients, like closing services and raising health care prices, or engages in conduct that harms health care workers or patients in order to gain market power, like outsourcing care or hiring private equity firms to restructure health care services. While Maine's existing law does bar single firms from monopolizing or attempting to monopolize trade, a more detailed standard may improve the Attorney General's ability to successfully handle this type of case.

For more detail on this concept, see the California Antimonopoly Coalition Report on Antitrust Reform introduced in the Appendix.[5]

III. Additional legislative elements to prevent and reverse hospital and unit closures.

a. Include a legislative mandate for a minimum set of services for a hospital.

The Commission should recommend legislation that stops the rash of hospital and hospital unit closures in the short term by requiring acute care hospitals to provide a minimum set of basic services as a condition of licensure, including obstetrics, birthing, pediatrics, and surgical services in addition to services required by 10-144 C.M.R. Ch. 112. This concept is not new for Maine hospitals. Maine hospital licensing regulations already require a list of basic services, including medical staff, nursing services, emergency services, food and dietetic services, medical records, imaging services, pathology or laboratory services, and pharmacy services. Expanding the list to include obstetrics, birthing, pediatrics, and surgical services would demonstrate that the

[5] "Updating California's Antitrust Law to Promote a Vibrant, Inclusive, and Competitive State Economy," https://economicsecurityproject.org/news/new-report-proposes-updated-antitrust-framework-ca/.

Commission recognizes the importance of providing a full complement of essential hospital services to our rural communities.

The recent hospital closures of obstetrics and related services increasingly threaten the health of pregnant women and newborns in Maine. Hospitals are the backbone of comprehensive perinatal services in our communities, providing specialized expertise, staffing, and resources to manage high-risk pregnancies and to handle complications during the birthing process. Yet, there are no guardrails to ensure all communities have access to basic and essential maternity services, particularly acute care that can only be safely provided in a hospital. In the past decade, Maine has seen eleven birthing units close. Four of those units closed in the past year.[6] Our nurses see patients who must travel long distances to access obstetrics and birthing services, leading them to miss important prenatal services and putting their health at risk from delays during complicated labor.

We recognize that significant numbers of Maine hospitals do not currently provide these services. While hospitals that do provide birthing services now would be required to maintain them, hospitals that do not currently provide these services should be required to submit a service compliance plan to bring them online over time, with support from the state. Thus, the state could recognize that birthing services are essential to a hospital while considering, on a case-by-case basis, the barriers to quickly reopening units when relevant.

b. Create a program to help keep hospital units open and reopen closed units.

To facilitate transactional review of closures and keeping all basic services open in every hospital, the Commission should recommend the creation of a program to help hospitals that can demonstrate financial need to receive support to reopen closed units, such as obstetrical and birthing units.

DHHS could establish a program to examine the underlying causes of closures and provide monetary and non-monetary support for reopening. For hospitals in financial need, the program could provide targeted, conditional funding to these hospitals, requiring review of how hospital and health systems manage their finances and examination of non-operating revenue and balance sheets to ensure genuine need. For example, the Commission could look into the critical access hospital staff enhancement payments that recently ended as an example of one way to support safe staffing in critical access hospitals.[7]

[6] Rose Lundy. Maine Monitor. Sept. 28, 2025. "Mount Desert Island Hospital announced the closure of its birthing unit in July, citing sharply declining birth rates." https://www.newscentermaine.com/article/news/regional/the-maine-monitor/where-maine-delivery-wards-nursing-homes-closed-last-decade/97-17594c6f-40c5-4d0f-841a-6dae71011ea8.

[7] *See* P.L. 2023, ch 643, Sec. LL-1, amended 22 M.R.S. Sec. 1714-C.

The program could also provide support to resolve other challenges leading to unit closures. For example, the department could identify specific ways to support health care professionals working in rural areas, such as expanded student loan repayment or housing support. It could also support training programs for doctors and nurses to maintain competency in specialty care areas, such as state supported programs to ensure OB/GYNs and labor and delivery nurses can maintain competencies in perinatal services when they work in a hospital with relatively few births.

c. The Commission should explore revenue sources to fund these programs and recommend that they be included in legislation.

The Commission has a mandate to study what is necessary to improve certificate of need laws and health care transactions. While there are many improvements that could be made to the transaction review process that can be funded with fees to transacting parties, a program to help hospitals and units remain open would benefit from a larger budget. The Commission should use its resources to explore revenue sources that could help support such a program.

IV. Specific bills

a. LD 1972, An Act to Enhance Transparency and Value in Substantial Health Care Transactions by Changing the Review and Approval Process for Those Transactions

LD 1972 bill would be a strong starting point for the Commission's work. Particularly important aspects include the six months' notice to public before transactions and the empowerment of the Department of Health and Human Services to perform a comprehensive review of both mergers and health care facility and unit closures with consideration of health care access, impacts on workers, and the public interest.

If the Commission includes a version of this bill in its recommendations, it should include the health services currently required by Maine's hospital licensing regulations at 10-144 C.M.R. Ch. 112 (medical staff, nursing services, emergency services, food and dietetic services, medical records, imaging services, pathology or laboratory services, and pharmacy services) and add obstetrics, birthing, pediatrics, and surgical services for acute care hospitals.

b. LD 1578, An Act to Require the Department of Health and Human Services to Review Disruption to or Removal of Health Services

The original version of LD 1578 extended the look-back period after a certificate of need is approved, allowing the Department of Health and Human Services to review some disruptions and removals of health services. This change would be welcome, but it is not broad enough to address many of the problems facing Maine's health care sector. LD 1972 is a stronger starting point on certificate of need changes.

c. LD 1890, An Act to Facilitate the Development of Ambulatory Surgical Facilities by Exempting Certain Facilities from the Requirement to Obtain a Certificate of Need

The Commission should not support this bill or other efforts to remove Certificate of Need requirements for ambulatory surgical centers. Ambulatory surgical centers do not provide the full range of services that a hospital does, increasing the risks of surgery. In addition, ambulatory surgical centers often strip profitable services from hospitals making local hospitals less financially viable and leaving communities without the full range of hospital services that they need. Excluding ambulatory surgical centers from Certificate of Need requirements would exacerbate health care access and other problems Maine faces.

d. LD 985, An Act to Impose a Moratorium on the Ownership or Operation of Hospitals in the State by Private Equity Companies or Real Estate Investment Trusts

An extended or permanent moratorium on ownership or operation of hospitals in the state by private equity or real estate investment trusts would help protect Maine health care from their predatory practices. Banning private equity is not sufficient to fulfil the Commission's mandate, but it is one valuable method to prevent corporate raids from shutting down Maine hospitals.

Sincerely,

Carmen Comsti, Director of Government Relations
Maine State Nurses Association/National Nurses Organizing Committee

Appendix:

NNOC and NNU Comments in Other States and to Federal Agencies on Health Care Transactions and Antitrust Reform

National Nurses United, "Fact Sheet: Health Care & Federal Antitrust Labor Market Impact Review," June 4, 2024 (See attached)

California Nurses Association/National Nurses United's comments on health care transactions to the California Law Revision Commission (June 2024): Our union in California, CNA/NNOC, submitted several comments to the California Law Revision Commission which is studying comprehensive antitrust reform, including on expanding pre-merger notice requirements, expanding Attorney General authority to challenge health care entity and other transactions, expanding Attorney General and other agency authority to review vertical and cross-market mergers under labor market and consumer impact/public interest theories of harm, among other things.

- See https://clrc.ca.gov/pub/2024/MM24-24s7.pdf (Pages 13-178)
- See also coalition letter at https://clrc.ca.gov/pub/2024/MM24-24s7.pdf (Pages 9-12)

California Antimonopoly Coalition Report on Antitrust Reform (May 2025): Our California union, CNA/NNOC, drafted parts of a coalition report on antitrust reform to California's Law Revision Commission. The report includes recommendations related to antitrust reform that would protect workers (See pages 46-52) and that would create stronger enforcement mechanisms against abusive and harmful impacts of corporate consolidation through a "single-firm conduct" standard (See 12-24).

- "Updating California's Antitrust Law to Promote a Vibrant, Inclusive, and Competitive State Economy," https://economicsecurityproject.org/news/new-report-proposes-updated-antitrust-framework-ca/

National Nurses United, Comments to the Federal Trade Commission on "Draft Merger Guidelines, Docket FTC-2023-0043," *Federal Register*, Document # FTC-2023-0043-0001, September 18, 2023, https://www.regulations.gov/comment/FTC-2023-0043-1485.

California Nurses Association, Comments to the Office of Health Care Affordability on "Proposed Emergency Regulatory Action – Promotion of Competitive Health Care Markets; Health Care Affordability (Cost and Market Impact Review)," August 31, 2023, https://hcai.ca.gov/wp-content/uploads/2023/10/Merged-Regs-Public-Comment.pdf, (Pages 70-85).

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FACT SHEET: Health Care & Federal Antitrust Labor Market Impact Review
June 4, 2024
National Nurses United

I. Introduction

This fact sheet addresses recent developments and evolving legal analysis for antitrust regulators regarding labor markets in the health care sector. Unions and workers have long engaged with antitrust review processes and other legal tools to respond to employer consolidation and anticompetitive practices that harm workers and the labor market. Specifically, this fact sheet discusses recent developments with respect to the Federal Trade Commission's and the U.S. Department of Justice's merger guidelines and other antitrust law to include worker impact analysis, prohibitions on noncompete and *de facto* noncompete agreements, labor market and labor welfare standards, and the role of unions in anticompetition law investigation and enforcement.

II. Monopsony, Worker Harm, and Merger Guideline 10

While labor market impacts of mergers and other single-firm conduct related to monopsony power have historically been ignored by federal regulators, the federal antitrust and consumer protection regulators, including the Federal Trade Commission (FTC) and the U.S. Department of Justice (DOJ), have in the past few years began to concertedly develop regulation and guidance that would explicitly extend antitrust law enforcement to examine labor market power concentration and curbing its negative impacts on workers. Key to the monopsonist labor market analysis is the analysis of harm to workers as sellers in a labor market. Section 7 of the Clayton Act's framework to examine the effects of a merger of sellers can be used to provide a framework to examine the effects of horizontal combinations of buyers (or monopsony power), which includes the consolidation of employer power as buyers in a labor market.[1]

In July 2021, President Joe Biden issued an Executive Order, Executive Order 14036, asking antitrust agencies to both broaden enforcement efforts and to combat abuses of labor market concentration as well as concentration in healthcare markets, stating:

> [I]t is the policy of my Administration to enforce the antitrust laws to combat excessive concentration of industry, the abuses of market power, and the harmful effects of

[1] See Federal Trade Commission and U.S. Department of Justice, "Merger Guidelines" (Dec. 18, 2023), pp. 26-27, https://www.ftc.gov/system/files/ftc_gov/pdf/2023_merger_guidelines_final_12.18.2023.pdf.

> monopoly and monopsony – especially as the issues arise in labor markets, […] healthcare markets (including insurance, hospital, and prescription drug markets) […][2]

Executive Order 14036 was shortly followed by proposed updates to the FTC and DOJ merger guidelines and to Hart-Scott-Rodino Act merger filings. In January 2022, the FTC and DOJ issued a Request for Information on its Merger Guidelines, asking for public comment, in part, on the questions related to monopsony power analysis and labor markets, including metrics to be considered for markets involving labor.[3] The agencies stated that they "are particularly interested in aspects of competition the guidelines may underemphasize or neglect, such as labor market effects and non-price elements of competition like innovation, quality, potential competition, or any 'trend toward concentration.'"[4] In December 2023, the FTC and DOJ finalized its updated merger guidelines, making it explicit in Merger Guideline 10 that the agencies would look at labor market competition and the potential harm to workers as part of its antitrust enforcement practices.[5]

Additionally, in July 2023, the FTC noticed proposed updates to Hart-Scott-Rodino Act merger filings, which as proposed would require companies to provide information about their employees "to aid the agencies' evaluation of the impact of proposed transactions on competition for workers in labor markets."[6] The proposed rule would require the companies to detail employee job classifications, post-merger geographical information about workers, and worker and worker safety information, including a firm's history of labor law violations during a 5-year period before the filing. Past labor law violations would include penalties or findings filed by the U.S. Department of Labor, the National Labor Relations Board, and the Occupational Health and Safety Administration.

a. Employer Concentration and Worker Harms in Healthcare

An important aspect of federal regulator's explicit enforcement practices related to labor market concentration is that the agencies recognize that lessening competition for workers not only may result in lower wages for workers but also lower job quality for workers. The inclusion of reduced job quality as a factor in merger review is a recognition that employer concentration in a

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[2] Executive Order 14036, "Executive Order on Promoting Competition in the American Economy," The White House (July 9, 2021), https://www.whitehouse.gov/briefing-room/presidential-actions/2021/07/09/executive-order-on-promoting-competition-in-the-american-economy/.

[3] Federal Trade Commission; Antitrust Division of the U.S. Department of Justice, "Request for Information on Merger Enforcement," *Regulations.gov*, Docket No. FTC-2022-0003 (Jan. 17, 2022), https://www.regulations.gov/docket/FTC-2022-0003.

[4] *Id*. at 2.

[5] *Supra,* note 2.

[6] Federal Trade Commission, "Notice of Proposed Rule, Premerger Notification; Reporting and Waiting Period Requirements," Federal Register, 88 Fed. Reg. 42,178-218 (Aug. 29, 2023), https://www.ftc.gov/legal-library/browse/federal-register-notices/16-cfr-parts-801-803-premerger-notification-reporting-waiting-period-requirements.

labor market may negatively impact the bargaining power of workers over terms and conditions of employment. In short, the FTC and DOJ's updated merger guidelines establish a framework to analyze how decreased worker bargaining power *vis-à-vis* their employer has a negative impact on wages and other working conditions.

The agencies describe in Merger Guideline 10 that "worsen[ing] benefits or working conditions" or "in other degradations of workplace quality" may result from substantially lessening competition for workers.[7] The agencies further explain in a footnote to Merger Guideline 10 what may constitute labor market harm or reduced job quality:

> A decrease in wages is understood as relative to what would have occurred in the absence of the transaction; in many cases, a transaction will not reduce wage levels, but rather slow wage growth. Wages encompass all aspects of pecuniary compensation, including benefits. Job quality encompasses non-pecuniary aspects that workers value, such as working conditions and terms of employment.[8]

Merger Guideline 10 is consistent with the research literature on labor market concentration. A 2021 study by David Arnold on the effects of mergers and acquisitions on worker wages in the U.S. found that local concentration depresses wages by 4 to 5% relative to a fully competitive benchmark.[9] Arnold found that, after mergers and acquisitions that cause significant increases in local labor market concentration, earnings fall by over 2% for workers at the firms involved in the merger or acquisition. The study found the largest effects in already concentrated markets. Mergers generating large concentration changes also reduced wages at other firms in the labor market.

The effects of monopsony power on wages found by Arnold extend to the health care sector, and monopsony power arising from labor market consolidation in the health care sector can led to industry-driven staffing reductions, expansion of restrictive employment covenants, diluted union density, and, among other negative impacts on workers, unsafe working conditions. Generally, market concentration results in lower staffing levels and reduced hiring. A 2021 study by Marinescu et al. observing labor markets in France found a 10% increase in labor concentration is associated with 3.2% fewer new hires.[10] For hospitals, increased market

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[7] *Supra,* note 2, at 26-27.

[8] *Ibid*.

[9] Arnold, David, "Mergers and Acquisitions, Local Labor Market Concentration, and Worker Outcomes," working paper (Oct. 2021). *See also* Arnold, David, "Mergers and Acquisitions, Local Labor Market Concentration, and Worker Outcomes," (2019), doi: 10.2139/ssrn.3476369.

[10] Marinescu I et al, "Wages, Hires, and Labor Market Concentration," *J Econ Behav & Org.* (2021), 184(C), 506-605. *See also* Wasser D, "Literature Review: Monopsony, Employer Consolidation, and Health Care Labor Markets." *Cent for Econ and Pol'y Res* (Jan. 2022). https://www.cepr.net/report/literature-review-monopsony-employer-consolidation-and-health-care-labor-markets/.

competition is associated with increased registered nurse staffing levels.[11] Employer monopsony power in health care settings has a two-fold impact with respect to nurse and health care worker staffing—monopsony in the labor market can lead to both reduction in employment rates within a labor market and it can enable employers to engage in practice that result in understaffing or unsafe staffing in particular worksites.

The new merger guidelines recognize that the impact of labor market monopsony power go beyond the impact on labor market prices—i.e., wages—in that concentration of employer power through market consolidation can result in employer abuse or exploitation of workers and employer power to violate labor and employment law. With respect to job quality, the health care labor market supply is increasingly elastic—when working conditions are poor, nurses and other workers tend to leave bedside care jobs or their professions altogether; and when employers fail to protect health care workers on the job, these workers experience career ending occupational injuries and illnesses at high rates.[12] Similarly, as the Covid-19 pandemic demonstrated, without optimal infectious disease control measures on the job, nurses and other health care workers can also become infected and die from deadly infectious diseases, including Covid-19.[13] These kinds of non-price factors in the labor market—including staffing and other working conditions—can be impacted by concentration of employer power and could fall under the rubric of job quality in addition to wages.

b. Union Density and Worker Bargaining Power

Diluted union density and loss of worker bargaining power in a highly monopsonist labor market may negatively impact not only wages but other working conditions and job quality for nurses and other healthcare workers. Unionization has material benefit to economic benefits for health care workers such as paid sick leave and vacations, retirement benefits, disability benefits, and health insurance as well as improvements to their working conditions such as job security, safe staffing, and safe patient care practices.

In the health care sector, union density and labor market competition among employers play a significant role in improving wages and working conditions for both union and nonunion registered nurses. Unionization and union density impact the power of workers to bargain for improved wages and working conditions against a monopsonist employer. Employer concentration in a labor market post-merger or acquisition may dilute the union density within a

[11] *See* Shin DY et al. 2020. "The Impact of Market Conditions on RN Staffing in Hospitals: Using Resource Dependence Theory and Information Uncertainty Perspective." *Risk Manag Healthcare Pol'y.* 13, 2103-14. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7568637/.

[12] *See* National Nurses United, "Deadly Shame: Redressing the Devaluation of Registered Nurse Labor Through Pandemic Equity," National Nurses United (Dec. 2020), https://www.nationalnursesunited.org/sites/default/files/nnu/graphics/documents/1220_Covid19_DeadlyShame_PandemicEquity_WhitePaper_FINAL.pdf.

[13] *See ibid.*

more concentrated health system, diminishing the bargaining power of health care workers within highly concentrated health system within a labor market. However, mergers of union and nonunion facilities may diminish union density within a labor market and may dilute the bargaining power of health care workers *vis-à-vis* a monopsonist employer and, thus, diminish the net positive effect on wages and working conditions that unions have on nonunion health care workers. In a competitive labor market where union density is high, there is what is called a "union threat effect" where nonunion employers within a market may raise wages to avoid the threat of increased unionization. For example, with respect to nurses, high union density may result in a union threat effect on wages.[14]

Recent research by Prager and Schmitt shows that an increase in health care labor market concentration is associated with lower wages and less bargaining power for workers.[15] In markets with a labor market concentration of 2,500 points or higher on the Herfindahl-Hirschman index (HHI) of hospital full-time employee concentration within a commuting zone, wages are 1 to 4% lower than in perfectly competitive labor markets. Prager and Schmitt also found that large hospital transactions that significantly increase concentration may result in a 6.3% decrease in wages for nurses. Importantly, they also found that a strong labor union presence "meaningfully attenuate[s]" post-merger wage depression but does not eliminate it.

Dilution of union density within a health system post-merger of a union and nonunion facility may impact those workers ability to maintain the wage premium union workers receive compared to their nonunion counterparts. For example, studies of nurse wages controlling for various variables, including type of health facility, geographic region, age, experience, position, and education, concluded that being in a union increases nurse wages, with estimated union wage premiums ranging between almost 8% to over 13%.[16] Importantly, unionization can significantly diminish gender and racial wage gaps for nurses and other workers. The results of one study, applying several control variables, demonstrated that in the nonunion setting Black registered nurses earned almost 8% less in average hourly wage than white RNs but, for unionized Black registered nurses, this racial wage penalty was minimal (0.85%) or, in other words, being in a union reduced the racial wage gap for Black nurses by almost 89%.[17] Additionally, union membership shrinks the wage gap for nonunion professional women, who earn 73 cents for each dollar earned by their male counterparts, while professional women in unions earn 83 cents for each dollar earned by their male counterparts.[18]

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[14] Coombs C et al., "The Bargaining Power of Health Care Unions and Union Wage Premiums for Registered Nurses," *J Lab Res* (Jun 4, 2015), 36(4), 442–61, doi:10.1007/s12122- 015-9214-z.

[15] Prager E, Schmitt M, "Employer Consolidation and Wages: Evidence from Hospitals," *American Economic Review* (Feb. 2021)*,* 111: 397-427. https://www.jstor.org/stable/27027692.

[16] Coombs C, *supra*, note 15; McGregory R, "An Analysis of Black–White Wage Differences in Nursing: Wage Gap or Wage Premium?" *Rev Black Pol Econ* (Mar. 2011), 40(1), 31–37, doi:10.1007/s12114-011-9097-z.

[17] McGregory, *supra,* note 15.

[18] Gould E, McNicholas C, "Unions Help Narrow the Gender Wage Gap," *Working Economics Blog.* Economic Policy Institute (2017), https://www.epi.org/blog/unions-helpnarrow-the-gender-wage-gap.

III. Merger Enforcement Actions & Labor Market Harm

While the U.S. Supreme Court has confirmed that antitrust law applies to buyer anticompetitive behavior and harmful effects of monopsony as it does to seller anticompetitive behavior and monopolies[19], theories of monopsony harm have rarely involved an analysis of labor market competition and harm to workers. Enforcement actions related to buyers have revolved around pricing-related anticompetitive behavior among buyers or cartel markets for goods and services. In the labor market context, antitrust challenges, albeit uncommon, typically arise as challenges under Section 1 of the Sherman Act as prohibited contracts "in restraint of trade"[20] or under Section 5 of the Federal Trade Commission Act as unfair or deceptive acts or practices that affect commerce.[21] However, until the Biden Administration's 2021 instruction to antitrust agencies to pursue enforcement against on the basis of labor market harms, the FTC and DOJ have never blocked or challenged a merger on the basis of its monopsonist labor market effects.

Importantly, antitrust law recognizes that worker consolidation of power is different than employer consolidation of labor market buying power. Section 6 of the Clayton Act creates an exception to antitrust law for workers and labor – unions – and activities for the purposes of "mutual help" of members of labor organizations – workers – from "lawfully carrying out the legitimate objects thereof."[22] This section of the Clayton Act further states that "nor shall such organizations, or the members thereof, be held or construed to be illegal combinations or conspiracies in restraint of trade, under the antitrust laws."[23]

a. Penguin Random House/Simon & Schuster Merger

In November 2021, shortly after the Biden Administration issued Executive Order 14036 directing antitrust agencies to take enforcement action related to labor market harm, the DOJ for the first time sued to block a merger, the acquisition of publisher Simon & Schuster by publisher Penguin Random House, on the basis of monopsony harm to a set of workers as sellers of labor as a result of buyer consolidation. The DOJ argued that the merger of Penguin Random House and Simon & Schuster, two of the largest publishers in the United States, would result in "substantial harm to authors of anticipated top-selling books and ultimately, consumers."[24] In its press release on the blocking litigation, the DOJ explained that "this merger will cause harm to

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[19] See *Weyerhaeuser Co. v. Ross-Simmons Hardwood Lunder Co.*, 549 U.S. 312, 317-18 (2007) (holding that "general theoretical similarities of monopoly and monopsony combined with the theoretical and practical similarities of predatory pricing and predatory bidding convince us that our two-pronged [Sherman Act test] should apply to predatory-bidding claims").

[20] 15 U.S.C. § 1.

[21] 15 U.S.C. § 45.

[22] 15 U.S.C. § 17.

[23] *Id.*

[24] Complaint, *U.S. v. Bertelsmann SE & CO. KGaA, et al*., No. 21-2886-FYP (D.D.C.) (Nov. 2, 2021), https://www.justice.gov/opa/press-release/file/1445916/dl.

American workers, in this case authors, through consolidation among buyers – a fact pattern referred to as 'monopsony.'"[25] The DOJ alleged that the proposed merger would eliminate buyer competition in the market for authors, resulting in lower advances, worse services, and less favorable contract terms for authors and ultimately fewer and less variety in books published for customers.

In October 2022, the DOJ obtained a permanent injunction blocking Penguin Random House's acquisition of Simon & Schuster.[26] Notably, the publishers argued that the definition of the analyzed market was inappropriately focused on a submarket of targeted sellers – the authors of anticipated top-selling books – and the anticompetitive harm to this submarket. The court's analysis centered on whether the market was appropriately defined and whether the merger would allow publishing companies to pay this submarket of authors less money for the rights to publish their work as well as the vulnerabilities of this submarket of authors to anticompetitive behavior, their unique needs, and preferences. The deal was scrapped by November 2022.

b. Kroger/Albertsons Companies, Inc. Merger

In February 2024, filing an administrative complaint and authorizing suit to block the acquisition of Kroger Company and Albertsons Companies, Inc., the FTC made its first challenge to a merger since the adoption of the updated guidance on the basis, in major part, of a labor market harm theory.[27] With eight states, the FTC also sued in the U.S. District Court in Oregon to block the merger.[28] The lawsuit and complaint allege that the merger would substantially lessen competition not only for grocery markets, negatively impacting consumers and raising grocery prices, but also allege that labor market competition would be eliminated, negative impacting Kroger and Albertsons workers and their ability to collectively bargain for stronger union contracts with improved wages, benefits, and working conditions.[29] Recognizing that Kroger and

[25] U.S. Department of Justice, "Justice Department Sues to Block Penguin Random House's Acquisition of Rival Publisher Simon & Schuster," Press Release, Office of Public Affairs (Nov. 2, 2021), https://www.justice.gov/opa/pr/justice-department-sues-block-penguin-random-house-s-acquisition-rival-publisher-simon.

[26] U.S. Department of Justice, "Justice Department Obtains Permanent Injunction Blocking Penguin Random House's Proposed Acquisition of Simon & Schuster," Press Release, Office of Public Affairs (Oct. 31, 2022), https://www.justice.gov/opa/pr/justice-department-obtains-permanent-injunction-blocking-penguin-random-house-s-proposed; Memorandum Opinion, *U.S. v. Bertselsmann SE & CO. KGaA, et al.*, No. 21-2886-FYP (D.D.C.) (Oct. 31, 2022), https://www.justice.gov/atr/case-document/file/1549941/dl .

[27] Complaint ¶ 7, *The Kroger Company and Albertsons Companies, Inc.* (*Kroger/Albertsons*), FTC No. D-9428 (Feb. 26, 2024), https://www.ftc.gov/system/files/ftc_gov/pdf/d9428_2310004krogeralbertsonsp3complaintpublic.pdf; Federal Trade Commission, "FTC Challenges Kroger's Acquisition of Albertsons," Press Release, Office of Public Affairs (Feb. 26, 2024), https://www.ftc.gov/news-events/news/press-releases/2024/02/ftc-challenges-krogers-acquisition-albertsons.

[28] Complaint for Temporary Restraining Order and Injunctive Relief, *FTC et al. v. Kroger et al.,* No. 3:24-cv-00347 (D. Or. Feb. 26, 2024).

[29] See Complaint, *Kroger/Albertsons,* at ¶¶ 7, 57-82; Complaint, *FTC et al. v. Kroger et al.*, at ¶¶ 7, 101.

Albertsons are, respectively, the first and second largest traditional supermarket chain and largest employer of unionized grocery workers in the United States, the Kroger/Albertsons case is the first enforcement action by the FTC to analyze the impact of a merger on union workers and their collective bargaining power in relation to a monopsonist employer.[30]

An important aspect to the FTC and state challenges to the Kroger/Albertsons merger is that in many markets across the country both Kroger and Albertsons operate stores that employe union grocery workers, the vast majority of the workers who are represented by United Food and Commercial Workers (UFCW).[31] FTC argues that the relevant labor market to analyze the probable effects of the merger is defined by union grocery labor with the local collective bargaining agreement area as the relevant geographic market.[32]

The consolidation of Kroger and Albertsons would, the FTC argues, allow the new combined employer to gain increased bargaining leverage over workers and their unions to the workers' detriment, resulting in subpar terms of employment, slower wage growth, worse benefits, and potential degradation of working conditions.[33] The FTC's complaints highlights that workers and the union representatives play Kroger and Albertsons against each other, obtaining a favorable deal from one employer and then leveraging that deal against the other respondent to demand similar or better terms, but that this kind of leveraging is only possible because of the risk to the employers from losing either customers or workers to their competitor.[34] The complaints contrast situations where lack of alignment between Kroger and Albertsons during collective bargaining negotiations with union workers resulted in union contracts with more favorable salaries and benefits for workers with situations where the two employers had successfully coordinated.[35]

The FTC and states' complaints additionally analyze the potential negative effect the merger would have on union workers' ability to credibly leverage the threat of a strike or boycott to negotiate better contract terms.[36] The complaints explain how the merger would result in some geographical areas, including Denver, in Kroger/Albertsons being the only employer of union grocery labor. The FTC provides examples in Denver where UFCW Local 7 members who worked at Kroger's King Soopers supermarkets engaged in a strike, encouraging both customers and workers to transfer prescriptions to and shop at Albertsons stores. The Denver strike of King Soopers resulted in Kroger losing sales and profits, with Kroger agreeing to improvements to wages and safety protections in its workers' collective bargaining agreement. UFCW Local 7

[30] Complaint, *Kroger/Albertsons,* at ¶¶ 7, 57-82; Complaint, *FTC et al. v. Kroger et al.*, at ¶¶ 7, 76-101.
[31] Complaint, *Kroger/Albertsons,* at ¶¶ 61-62; Complaint, *FTC et al. v. Kroger et al.*, at ¶¶ 80-81.
[32] Complaint, *Kroger/Albertsons,* at ¶¶ 63-67; Complaint, *FTC et al. v. Kroger et al.*, at ¶¶ 82-86.
[33] Complaint, *Kroger/Albertsons,* at ¶¶ 69-82; Complaint, *FTC et al. v. Kroger et al.*, at ¶¶ 88-101.
[34] Complaint, *Kroger/Albertsons,* at ¶¶ 71-72; Complaint, *FTC et al. v. Kroger et al.*, at ¶¶ 90-91.
[35] Complaint, *Kroger/Albertsons,* at ¶¶ 78-81; Complaint, *FTC et al. v. Kroger et al.*, at ¶¶ 97-100.
[36] Complaint, *Kroger/Albertsons,* at ¶¶ 73-77; Complaint, *FTC et al. v. Kroger et al.*, at ¶¶ 92-96.

later was able to leverage the improved contract terms with Kroger into the same improvements in its contracts with Albertsons.

The FTC's administrative complaint and litigation are still in early stages with a hearing on the motion for preliminary injunction set to be heard before the U.S. District Judge in the District of Oregon on August 26, 2024.

a. Tapestry/Capri Merger

Most recently, the FTC sued to block Tapestry, Inc's acquisition of Capri Holdings Limited, which would combine three competitors in the "accessible luxury" brand market, in part for the deal's negative impact on the workers' wages, benefits, and working conditions.[37] Applying a different analysis of labor market impacts than the Kroger/Albertsons merger, the FTC complaint indicates that the companies employ thousands of non-union retail workers and that the companies follow the others' labor practices closes and that public disclosure of their employment policies prompts the companies to improve workplaces and worker benefits to attract and retain employees.[38] The FTC's blocking suit was filed in the U.S. District Court for the Southern District of New York.[39]

IV. FTC's Noncompete Rule

Federal regulators have also begun to expand their application of antitrust law to labor market conduct outside of the merger context. These challenges largely have involved wage fixing, noncompete provisions, or no-poach agreements among competitor employers as contracts in restraint of trade under Section 1 of the Sherman Act. Health care firm conduct has been subject to some leading cases on Section 1 enforcement against wage fixing and unlawful coordination of pay scales for doctors and nurses.[40]

More recently, federal antitrust agencies have also been looking to reign in the use of other restrictive covenants in employment contracts like provisions of a worker not to compete with a competitor firm, commonly referred to as non-competes. On January 5, 2023, the FTC issued a Notice of Proposed Rulemaking that seeks to ban most non-competes.[41] Issuing its Final Rule just in April 23, 2024, the FTC would eliminate most non-competes entirely, based on the FTC's authority under Section 5 of the Federal Trade Commission Act to restrict unfair methods of

[37] Complaint ¶ 8, *Tapestry, Inc. and Capri Holdings Limited*, FTC No. 9429 (Apr. 22, 2024).
[38] *Id*. at ¶¶ 9, 43-44, 55-57.
[39] *FTC v. Tapestry, Inc. et al*., No. 1:2024-cv-03109 (S.D.N.Y. Apr. 23, 2024).
[40] *See, e.g*., *Kartell v. Blue Shield of Mass*., 749 F.2d 922 (1st Cir. 1984).
[41] FTC, "Notice of Proposed Rulemaking, Non-Compete Clause Rule," 88 Fed. Reg. 3,482 (Jan. 5, 2023), https://www.federalregister.gov/documents/2023/01/19/2023-00414/non-compete-clause-rule.

competition.[42] The Final Rule importantly includes independent contractors as well as statutory employees in the definition of "workers" to which the Rule applies. In order to streamline compliance, the FTC eliminated a proposed provision that would have required employers to legally modify existing non-competes and formally rescind them. Instead, the FTC requires employers to provide workers subject to an existing non-compete, with the exception of senior executives, with notice that the non-compete agreement will not be enforced against them in the future.

Notably, the FTC's Final Rule bans not just express non-compete provisions, but also agreements that "function to prevent" workers from seeking or accepting other work or starting a business after their employment."[43] The Proposed Rule had suggested that certain *de facto* non-competes, such as non-disclosure agreements (NDAs), non-solicitation agreements, or training repayment agreement provisions (TRAPs) could be considered a prohibited non-competes.[44] The preamble to the Final Rule, the FTC addresses the request by commenters to categorically ban NDAs, TRAPs, and non-solicitation agreements, instead explaining that the agency adopts a functional test:

> [T]he term "functions to prevent" clarifies that, if an employer adopts a term or condition that is so broad or onerous that it has the same functional effect as a term or condition prohibiting or penalizing a worker from seeking or accepting other work or starting a business after their employment ends, such a term is a non-compete clause under the final rule.[45]

Similar to non-compete provisions in employment contracts, TRAPs and other *de facto* non-competes can limit worker freedom within the labor market. Many employers mandate as a condition of employment or coerce employees to sign agreements that force them to pay the employers money if they quit before a prescribed period of time. Regulators and researchers have begun attempts to quantify the use of these contracts. The Consumer Financial Protection Bureau (CFPB) issued a report on "employer-driven debt" arrangements, including TRAPs and other "stay or pay" contracts, in 2023.[46] The CFPB found that employers began the use of TRAPs in the 1990s, predominantly for higher-skilled, higher wage workers but found TRAPs today being used for health care workers, transportation workers, and the retail industry. Similarly, in 2022, a National Nurses United survey of registered nurses (RNs) across the

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[42] In November 2022, the FTC also adopted a statement of enforcement policy on unfair methods of competition under Section 5 of the FTC Act. FTC, "Statement of Chair Lina M. Khan, Section 5 Policy Statement," (Nov. 10, 2022), https://www.ftc.gov/system/files/ftc_gov/pdf/Section5PolicyStmtKhanSlaughterBedoyaStmt.pdf

[43] *See supra*, note 41, at 38,362 (describing Section 910.1(a) of the Final Rule).

[44] *Id.* at 38,362-66.

[45] *Id.* at 38,364.

[46] Consumer Financial Protection Bureau, "Consumer risks posed by employer-driven debt," CFPB Office of Consumer Populations, Issue Spotlight (Jul. 20, 2023), https://www.consumerfinance.gov/data-research/research-reports/issue-spotlight-consumer-risks-posed-by-employer-driven-debt/full-report/.

country found that almost 40% of RNs who started their careers within the past decade were subject to a TRAP.[47] In March 2023, a number of legal and business academics published new research finding that up to 1 in 12 workers in the United States are subject to a TRAP.[48]

For example, the preamble to the Final Rule cites examples of TRAPs that can "function" as a non-compete provided by a commenter. The FTC highlights as potential provisions that function as non-competes both a TRAP "that required entry-level workers at an IT staffing agency who were earning minimum wage or nothing at all during their training periods to pay over $20,000 if they failed to complete a certain number of billable hours" and a TRAP "requiring nurses to work for three years or else repay all they have earned, plus paying the company's 'future profits,' attorney's fees, and arbitration costs."[49] The FTC goes on to state that these kinds of TRAPs "may be functional non-competes because when faced with significant out-of-pocket costs for leaving their employment—dependent on the context of the facts and circumstances—workers may be forced to remain in their current jobs, effectively prevented from seeking or accepting other work or starting a business."[50]

While the FTC expressly declined to categorically prohibit all TRAPs, its discussion in the Proposed Rule regarding the need for a categorical ban on non-completes is helpful in understanding the harmful impact of these types of employment contracts on labor market competition:

> The Commission is proposing a categorical ban on non-compete clauses because, fundamentally, non-compete clauses obstruct labor market competition through a similar mechanism for all workers. Non-compete clauses block workers in a labor market from switching to jobs in which they would be better paid and more productive. This harms workers who are subject to non-compete clauses. This also harms other workers in the labor market, since jobs that may be better matches for those workers are filled by workers who are unable to leave their jobs due to non-compete.[51]

While some employer assert that employer financial investment into an employee's training may justify restrictions on labor market mobility, this may serve merely as a pretense to justify the restrictive covenant to work a minimum period of time with the employer. Indeed, some health

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[47] Berger R, "Caught in a TRAP," *National Nurse Magazine* (Dec. 2022), https://nnumagazine.uberflip.com/i/1489186-national-nurse-magazine-october-november-december-2022/15.

[48] Prescott J, Schwab S, Starr E, "First Evidence on the Use of Training Repayment Agreements in the US Labor Force," *Promarket* (Mar. 27, 2024), https://www.promarket.org/2024/03/27/first-evidence-on-the-use-of-training-repayment-agreements-in-the-us-labor-force/.

[49] *Id.* at 38,365.

[50] *Ibid.*

[51] FTC, "Notice of Proposed Rulemaking, Non-Compete Clause Rule," Federal Register, 88 Fed. Reg. 3,482 (January 19, 2023), https://www.federalregister.gov/documents/2023/01/19/2023-00414/non-compete-clause-rule.

care employers, which have come under scrutiny for their use of TRAPs, assert that they will stop using TRAPs but will still use other "stay or pay" hiring or signing "bonuses."[52]

Finally, as further indication of the FTC's renewed scrutiny on anti-competitive activity in the employment context by a single firm outside of mergers, the FTC recently entered into a memorandum of understanding with the U.S. Department of Labor, agreeing to share information about potential labor and competition law violations, including "non-compete and nondisclosure provisions."[53]

[52] *See, e.g.*, Betancourt M, "Health Care Companies Are Using Debt to Trap Nurses on the Job," *Mother Jones* (Sept. – Oct. 2023), https://www.motherjones.com/politics/2023/08/nurse-debt-trap-training-repayment-agreement/.

[53]" Memorandum of Understanding Between the U.S. Department of Labor and the Federal Trade Commission," at 2 (Aug. 30, 2023), https://www.ftc.gov/system/files/ftc_gov/pdf/23-mou-146_oasp_and_ftc_mou_final_signed.pdf.

McCarthyReid, Colleen

From: Emily Wright <emilyjanewright75@gmail.com>
Sent: Monday, October 6, 2025 10:01 AM
To: McCarthyReid, Colleen
Subject: in support of state oversight for closure of hospital services and specifically OB closures

Hello,

My name is Emily Wright and I am a Registered Nurse with over a decade of experience in acute care, the past few years being in Obstetric Care.

I am writing to you today to express my deep concerns that there currently exists no state oversight for closures of Obstetric (OB) units in the state of Maine.

As you are aware we have a crisis of care as more and more rural OB units are closing across the state and women and families are left in health care deserts having to travel hours to seek the care they need and deserve, or forgo that care all together. Access to proper healthcare, in all stages of the life cycle, is a human right, not a privilege, one that is being denied to birthing women and families.

As a result of these mass closures we have already begun to see patients unable to obtain essential diagnostic testing they need until late in their third trimester. Thus, withholding care that could be life changing for the unborn child and family. We have seen paramedics get their "stork" wings, due to babies being born in the back of ambulances, despite babies arriving at care facilities needing resuscitation or worse. All in the name of saving health care facilities money?! It is unethical and just plain wrong. It can not continue and the decision can not rest on the shoulders of those whose primary goal is to make and save the hospitals money. It must be determined by the state, by those who see the needs of the communities.

I implore you to take these examples and the needs of those most vulnerable, the birthing people and their families into consideration, when making your decision.

Thank you,
Emily Wright RN

--
Emily J Wright RN
she/her/hers
207 801 1012

You are not a drop in the ocean, you are the entire ocean in a drop.

McCarthyReid, Colleen

From: anne marie wilberg <mientje4663@gmail.com>
Sent: Tuesday, October 7, 2025 11:21 AM
To: McCarthyReid, Colleen
Subject: Testimony for Commission to Evaluate the Scope of Regulatory Review and Oversight over Health Care Transactions
Attachments: LD1578 Testimony.pdf

I am excited to see that this commission has been established and will be addressing this complex issue. While I recognize that the Committee's charge encompasses a broad range of concerns, I hope that significant attention will be given to the very real and urgent challenges created by the escalating number of birthing unit closures across our state.

During the last legislative session, I submitted testimony in support of LD 1578. Although that bill did not pass as a stand-alone measure, its intent and key provisions were incorporated into other related proposals, ultimately leading to the creation of this Commission.

While I understand the need to keep the Committee's membership manageable, I am concerned that there is a lack of specific expertise or direct experience in providing or coordinating perinatal care outside of the C suite. Such insight is essential to ensure that the Commission's recommendations address the unique and pressing realities of maternal health care access in Maine.

As I noted in my earlier testimony—which I have attached—the process that allows hospitals to close their birthing units with extremely limited notice to the community is unacceptable. It directly contradicts existing DHHS recommendations for sufficient advance notice, yet there are no consequences when hospitals disregard these guidelines. If closures truly cannot be avoided, there are far better ways to approach the process—through early communication, community engagement, and thoughtful transition planning—to minimize harm to patients, providers, and communities.

--
sincerely.

Anne Marie van Hengel. MD. FACOG
Secretary/Treasurer-elect Maine Section ACOG

207 939 1815

Testimony in Support of LD 1578

Anne Marie van Hengel, MD, FACOG
Portland , Maine

May 9 2025

Introduction

My name is Anne Marie van Hengel. I have over 30 years of experience providing obstetrical care to families across Maine, and I am now actively involved in statewide efforts to improve perinatal outcomes.

Through this work, I have seen firsthand the serious and growing challenges that Maine—and the rest of the nation—is facing when it comes to access to maternity care, particularly in rural areas.

The reasons behind the closure of rural birthing units are multifactorial and complex. There are legitimate concerns—workforce shortages, financial pressures, and regulatory hurdles—that contribute to the strain on hospitals and providers. But complexity is no excuse for silence, secrecy, or inaction. We must ensure that transparent communication, strategic planning, and community input are at the center of any decisions that affect how and where people can give birth.

Full Testimony

I am writing today in strong support of LD 1578.

While I listened carefully to the heartfelt testimony about the impact of birthing unit closures—stories that are both moving and deeply troubling—for me, the most compelling rationale to support this bill lies in the lack of process, transparency, and accountability that has accompanied many of these closures.

As you have heard, we have seen an alarming acceleration in birthing unit closures in Maine: four already this year, and several more last year. Although a few were thoughtfully planned with viable alternatives considered, most have occurred with little or no notice. The Department of Health and Human Services has recommended a 120-day notice period, yet this has been repeatedly ignored. Some hospitals have closed their birthing units with as little as 30 days' notice.

It is inconceivable to me that hospital leadership was unaware of the financial pressures that made continued operation unfeasible. Hospital budgets are developed well in advance. These challenges would have been recognized months—if not years—before the decision to close was made.

Decisions of this magnitude should not be made without input from the providers and staff who deliver care, and without engaging the communities that will be affected. When decisions are made behind closed doors, it undermines public trust and places patients and

providers in increasingly difficult positions.

This bill will not, in and of itself, prevent hospitals from closing birthing units. The underlying issues—workforce shortages, declining reimbursement, and the financial fragility of rural health care—still need to be addressed. But what this bill does do is ensure that if closures must happen, they occur in a way that allows for thoughtful planning, community involvement, and mitigation of harm.

With Maine having received a TMAH (Transforming Maternal Health Access) grant, there are significant efforts underway to develop and implement a comprehensive strategy to address the rural maternity health care access crisis. This work is crucial, but it is not an acute solution. These systems-level changes will take time to build and enact. Meanwhile, several more hospitals are currently struggling with the same issues—financial instability, workforce challenges, and difficult decisions about whether they can continue offering obstetric services. We cannot afford to wait for longer-term solutions to come to fruition while communities continue to lose access to essential maternity care.

LD 1578 seeks to establish a clear and reasonable process. When a hospital recognizes that its birthing unit is in jeopardy, it should be required to communicate early with DHHS, explore potential solutions to avoid closure, and, if closure is truly unavoidable, provide adequate time—not just for administrative transitions, but for:

- Patients to arrange alternative care,
- Communities to prepare and adjust, and
- Emergency departments to receive appropriate training to handle OB-related emergencies safely.

This is not simply about logistics. It is about respect for patients, providers, and rural communities, and about protecting the health and safety of pregnant individuals and their newborns.

LD 1578 offers a step toward ensuring that future birthing unit closures are managed with greater transparency, foresight, and responsibility. I urge you to vote in favor of this bill.

Sincerely,

Anne Marie van Hengel, MD, FACOG

McCarthyReid, Colleen

From: shenders@maine.rr.com
Sent: Tuesday, October 7, 2025 5:38 PM
To: McCarthyReid, Colleen
Subject: testimony for 10/8

I am a retired nurse educator. The American Nurses Association defines health care as a basic human right (ANA,1989). Compassion has been foundational to the development of the professional nursing and professional practice is based on a ANA Code of Ethics (2025). Nurses have been at the patient's side on the battle field, in rural homes, in urban communities, in hospitals, and office practices. Nurses know that health care is not a business like any other business; it is a professional service providing care to vulnerable individuals, families and groups.

We have a moral, ethical obligation to look at profit margins and how money is spent when the health and well-being of our population is at stake. Unfettered capitalism does not provide an answer. Business is not required to behave in socially responsible ways and when the owners have no ties to a community, there is no stopping the damage that can be done.

Resources are finite and as former Governor Brennon said, "Health care is but one social concern". Social concerns need be administered with justice and mercy. The market place of unfettered capitalism has neither justice nor mercy. We have homeless, housing insecure and sick citizens who fear for their survival. A roof, food and basic health care are not something working people who do not earn a lot of money can count on. An economist, Rashi Fein, said that "people live in a society not an economy". Our task is to shape the economy to create the society we want and need.

Susan Henderson
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National Nurses United
OUR PATIENTS. OUR UNION. OUR VOICE.

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Comments from Brynne O'Neal
Regulatory Policy Specialist, Maine State Nurses Association/National Nurses Organizing Committee

Commission to Evaluate the Scope of Regulatory Review and Oversight Over Health Care Transactions that Impact the Delivery of Health Care Services in the State

October 8, 2025

Hello. I am Brynne O'Neal, a Regulatory Policy Specialist with Maine State Nurses Association/ National Nurses Organizing Committee, a labor union representing over 4,000 registered nurses and other health care workers in Maine. We thank the Chair and Commissioners for considering this important topic. We are submitting written comments with more detail on our recommendations on the agenda items discussed today.

Given the urgency of the situation in Maine, we appreciate the tight statutory timeline. It is crucial that Maine's hospitals remain open and offer needed services, including obstetrical services. Our patients depend on their community hospitals.

LD 1972, from this past session, is a good place to start expanding health care transaction review authority of Maine enforcement agencies. The Commission should also consider expanding regulatory review authority to vertical integration as well as horizontal integration of health care entities and, importantly, to include review of hospital and unit closures. There are increasing numbers of hospitals and large health care corporations acquiring physician practices. And many Maine hospitals are part of large health systems that can close units and hospitals knowing that patients will have to drive to other hospitals owned by the same system. We also support a permanent private equity moratorium, following the example of Chair Tipping's bill from this year.

Importantly, the Commission should consider expanding enforcement agencies' ability to place conditions on health care transactions and closures, including requirements that services remain open, that the facility maintain minimum safe staffing ratios, required health impact assessments, or prohibitions on anticompetitive contracting with insurers.

In the short term, the Commission can develop strong legislation to immediately stop hospital closures and reductions in services and staffing. The Commission can also identify long-term solutions to help hospitals that are in genuine financial need to support safe staffing and reopening of closed services, such as obstetrics units. Additionally, the Commission can explore ways to recapture some of the federal tax cuts that benefit rich corporations at the state level and reallocate those funds to meet the needs of patients.

Our national union, National Nurses United, is working to combat the threat of hospital closures across the country. But if the federal political situation does not change, funding cuts are coming. That threat makes your work on this Commission all the more urgent. The time is now for the legislature to set up oversight and funding programs to keep hospitals open. Patients' lives depend on it.

Maine State Nurses Association has broad expertise, particularly in health care antitrust law reform, in our research and policy departments. We are happy to serve as a resource for the Commission as you develop your recommendations.

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Comments from Erin Oberson, RN

Commission to Evaluate the Scope of Regulatory Review and Oversight Over Health Care Transactions that Impact the Delivery of Health Care Services in the State

October 8, 2025

My name is Erin Oberson and I've been a registered nurse for 24 years. I'm a proud member of the Maine State Nurses Association. I currently work in obstetrics at the Northern Light Eastern Maine Medical Center and previously worked in the obstetrics unit at Mount Desert Island Hospital, before the unit closed.

Recent OB closures in northern rural Maine have put patients in danger and crowded care into larger hospitals like EMMC. We've seen OB closures in Calais, Waldo county, Fort Kent, and recently Mount Desert Island and Houlton.

These closures hurt my patients. After the closure of Houlton's OB, they send OB patients to us, over an hour and a half away. These delays are dangerous. One patient went to Houlton with signs of preterm labor and was set to transfer to EMMC, but after waiting for hours for transport, they left against medical advice and her partner drove her to us.

Babies will be born regardless of whether their local hospital has an OB unit or not, placing mother and baby in grave danger. For example, I know of another patient with labor complications who went to Houlton after their OB closed, and a non-obstetrical team had to perform an emergency c-section.

When OB units close, other area hospitals must absorb those patients without additional resources to care for them. This happened at EMMC one weekend recently when both Maine Coast Ellsworth—where Mount Desert Island residents go now—and Machias OB units were diverting patients to other hospitals, so women had no access to care between our facility in Bangor and Presque Isle, 2 and a half hours away. We have only 7 labor rooms but had 12 patients in labor with no additional staff. That is not safe for patients or nurses.

I also see more patients who missed important routine prenatal screenings because it takes so much time and money to get to a facility that still provides these services. Predictably, this often results in longer hospital stays, after a baby is born.

Labor doesn't always go according to plan. A healthy pregnancy can turn into a medical emergency in minutes. When this happens, we need a hospital, trained staff, surgical teams, neonatal intensive care units ready 24/7.

I ask the Commission to prioritize legislation that can be introduced this session requiring hospitals to maintain their OB units and to authorize the state to review closure decisions. Hospital and unit closures disrupt our communities and could cost our patients their lives.

Finally, I ask that you identify programs that can serve as long-term solutions to help hospitals reopen OB and other services that they have closed.

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Comments from Portia Judson, RN
Commission to Evaluate the Scope of Regulatory Review and Oversight Over Health Care Transactions that Impact the Delivery of Health Care Services in the State

October 8, 2025

My name is Portia Judson and I have been a registered nurse for 10 years. I currently work at Mount Desert Island Hospital as an ER nurse and I'm a member of the Maine State Nurses Association.

Mount Desert Island Hospital closed its obstetrics department earlier this year. Our hospital cannot serve the needs of our patients without an OB. Recently, I saw a patient come into the hospital 23 weeks pregnant with a history of complications in prior pregnancies. She was having horrible abdominal pain and was terrified. When we did not hook her up to a fetal heart monitor, because we had no one to use it, she asked about our OB coverage. We told her we no longer had the department. She asked for her husband and immediately insisted they leave and go to a hospital with an OB department.

This woman's terror was stark and real. I couldn't honestly tell her that if she, or her baby, needed it, transport would be available, much less whether it would arrive in time to save them. It was exactly the type of thing nurses all worry about. —especially on an island. Thankfully it turned out alright, this time. I don't know about next time.

Patients like these are why specialist OB care in hospitals is so important to the entire community. And the community needs to be involved in decisions about unit closures.

When Mount Desert Island Hospital closed its obstetrics unit, the community got about three months advance notice. My union held a town hall to share our concerns and speak with our community members, because the state required no process to hear from the community. We strongly urge the Commission to ensure public participation in future decisions about hospital transactions by recommending the state require 6 months' notice and public hearings before closures, mergers, or other significant transactions.

In that same spirit, I encourage the Commission itself to host community meetings to inform its work, particularly in areas where hospitals have closed or reduced services and staffing, for example, in obstetric units.

7 October 2025

To the members of the Commission to Evaluate Regulatory Review and Oversight of Healthcare Transactions:

We at the Maine Academy of Family Physicians are concerned about the worsening crisis of access to maternity and obstetric care throughout our state. To that end, we have developed a task force to work to address this issue—one that affects many of our patients and our members especially in rural Maine. We are working with various community stakeholders statewide and are actively pursuing state policy that will help to address the problem. We are committed to the safe and accessible care of our pregnant patients and their families, no matter where they live. We will strongly support efforts by the Commission that will maintain birthing units in rural Maine, and offer our partnership in the endeavor.

Sincerely,

Marya R. Goettsche Spurling, MD, FAAFP

On behalf of the Board of Directors, Maine Academy of Family Physicians

Commission to Evaluate the Scope of Regulatory Review and Oversight over Health Care Transactions That Impact the Delivery of Health Care Services in the State

Written Comments

Submitted to Commission as of October 8, 2025 8:00 am

McCarthyReid, Colleen

From: Scarlet Kinney <scarlet.kinney@gmail.com>
Sent: Thursday, October 2, 2025 10:27 AM
To: McCarthyReid, Colleen
Subject: Written Comments for Oct. 8 Commission Meeting

Please enter my comments into the testimony. Thanks.
As an elder served by Northern Light in eastern Maine, I have seen much needed services, such as Palliative Care, being ruthlessly cut without any explanation to staff or patients, leaving those of us who depend on it to see us through until we require hospice care high and dry. There also appears to be a shortage of doctors in the state, making seeing a specialist a months long wait, while conditions needing immediate specialist treatment worsen. Rural care hospitals and rural nursing services are also being shut down.
I was hospitalized recently for Type A flu with respiratory failure at Northern Light Ellsworth hospital, and the nursing care was frightening. There was basically no patient care, no help with personal care, none of the staff, who were primarily "travelers" (staff hired from other places), knew how to properly make a hospital bed, and when nursing care was actually given, providers where timed, and chided to move on if they spent more than six minutes with a patient, because their as though they were on an assembly line, not providing health care. I also witnessed a youngish male specialist staff cruelly chewing out an older female nurse in a loud voice right in front of me. I was embarrassed for the poor nurse and furious with the specialist. This kind of production line nursing care, and lack of professional respect for staff made my stay so unpleasant that I couldn't wait to get out of there.
Meanwhile, Northern Light built an entire new triage hospital in Blue Hill, no doubt improving its real estate value. This is an example of money spent for profit, not patient care.

I find these changes in health care to be cruel and hateful. I expect they're due to private equity buyouts of Maine hospitals as real estate purchases to be bled dry financially and then sold at a nice profit, with no care or thought given to the patients who are suffering because of it.
I think what's happening is heinous, and I urge the State to do everything it can to turn this greed-fueled situation around. Health care was once patient centered, and readily available. These short-term profit outfits are putting profit before patient care and this is causing illness, health care insecurity, and even in some cases, death. It must be stopped.
Sincerely, Scarlet Kinney

Scarlet Lynda Kinney MA
The Standing Bear Center for Shamanic Studies
www.scarletkinney.com
Turtle Mountain Mythic Art
207.664.0752

Testimony of Tessa Storey
Commission to Examine Maine's Hospitals and Medical Infrastructure
October 8, 2025

Dear Members of the Commission,

My name is Tessa Storey. I am 33 years old and a relatively healthy Mainer who only began to have health issues this past year. I lived in Portland for 13 years and recently moved to Mount Desert Island. Since moving here, I have felt firsthand the lack of access to healthcare, even in one of the most visited places in the state. I've had to travel all the way back to Portland for basic dental care. And here on the island, the labor and delivery unit was closed, meaning people can no longer have a baby in their own community hospital. If that's the reality in a well-known destination like Mount Desert Island, I can only imagine how much harder it is for Mainers living in even more rural parts of our state.

I have built my adult life in Maine. I love this state deeply. But between rising costs and the shrinking access to healthcare, I have even found myself questioning whether I can stay here long-term. That is not a choice I want to make, but it's a choice many Mainers are being forced to consider.

That is why I am writing today in strong support of the work this Commission is doing to protect Maine's hospitals and medical infrastructure from private equity and corporate profiteering. Forty-two percent of our hospitals are already at risk of closing. We cannot allow short-term investors to come in, strip essential services, and leave our communities without the care we need to survive.

Research shows that when private equity takes over a hospital, patient care declines, staff pay decreases, and even deaths in the emergency room increase. Essential services are cut if they are not "profitable," regardless of whether the community depends on them. That is not the kind of "help" Maine hospitals need.

Last session, the emergency moratorium on private equity and real estate investment trust purchases of hospitals was an important first step. But it was only temporary. Now is the time to make sure that safeguard becomes permanent, and to create policies that keep our healthcare in the hands of our communities, not investors chasing a quick profit.

I urge you to put people over profit and ensure that Maine's hospitals remain strong, accessible, and accountable to the communities they serve.

Thank you for your time and for the work you are doing to protect healthcare in Maine.

Sincerely,
Tessa Storey
Mount Desert Island, Maine

October 7th, 2025

Dear Senator Tipping and esteemed members of The Commission to Evaluate the Scope of Regulatory Review and Oversight Over Health Care Transactions that Impact the Delivery of Health Care Services in the State.

My name is Eli Durand-McDonnell, I am from Bar Harbor, Maine and I work as the Policy Coordinator at Maine Youth Power, a youth-led, youth movement throughout rural and suburban Maine fighting to win human dignity, equity and a livable future for all. I am writing to you today on behalf of my organization to urge that you protect Mainers and our healthcare infrastructure from private equity acquisition.

In my line of work, I am lucky enough to talk with young people from all across the state. As we all know, Mainers take deep pride in their home state, and so many of the youth that I speak to are deeply committed to putting their roots down in Maine. However, I also frequently hear about the various challenges to staying within Maine that we face as young people, and there is an ongoing narrative about the "brain drain" of young people leaving the state for more economic opportunities and infrastructure.

Right now, this commission has the chance to protect hospitals, protect patients, and protect all Mainers, young and old, by establishing safeguards against predatory private equity firms that don't have the well being of patients in mind, simply their profit margins. These safeguards are exactly the sort of investments in Maine that will keep young people in this state for generations to come, and this commission can play a crucial role in starting those investments.

Thank you for your consideration,
Eli Durand-McDonnell

MSNA Maine State Nurses Association
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Comments by Maine State Nurses Association/National Nurses Organizing Committee

Via email to colleen.mccarthyreid@legislature.maine.gov

Senator Mike Tipping, Chair
Representative Michelle Boyer, Chair
Commission to Evaluate the Scope of Regulatory Review and Oversight Over Health Care Transactions that Impact the Delivery of Health Care Services in the State
State House Station
Augusta, Maine 04333

Re: Comments to the Commission to Evaluate the Scope of Regulatory Review and Oversight Over Health Care Transactions that Impact the Delivery of Health Care Services in the State (Commission)

October 6, 2025

Dear Chair Tipping, Chair Boyer, and members of the Commission,

On behalf of more than 4,000 registered nurses and other health care workers providing patient care in our state, Maine State Nurses Association/National Nurses Organizing Committee (MSNA) appreciates that the Commission is tackling the critical issue of health care transactions in our state. Unchecked corporate consolidation and health care facility closures result in higher prices, reduced access to care, and rampant hospital and unit closures that put our patients' lives at risk. The state agencies' authority to review openings but not closures of health care facilities contributes to these problems.

As the Commission begins its work, MSNA provides comments on the scope of the Commission's work and specific recommendations for the legislation that the Commission is tasked with recommending to the legislature. We urge the Commission to craft legislation that will provide Maine enforcement agencies the authority to review harmful transactions, stop hospital unit closures, develop programs to aid hospitals with financial need, and include communities in these essential decisions.

MSNA has substantial expertise in health care transactions and in developing solutions to prevent hospital closures and reductions in services. We stand ready to assist the Commission in crafting strong legislation and recommendations for its report. The situation facing Maine patients is urgent. We urge you to make the most of this opportunity and to develop real solutions to protect our patients.

I. The Commission should combine its review of health care transaction policy with an exploration of ways to stop hospital and unit closures and support reopening.

The Commission should take a broad view of its mandate and craft a comprehensive solution to the problems of health care access in Maine. The Commission is tasked with reviewing certificate of need laws, legislative changes to review and oversight of health care transactions, the role of private equity in hospital ownership, and other issues to further the duties and purposes of the study. The Commission should develop legislation that expands Maine enforcement agencies' authority to review health care transactions and health care service reductions. Agencies' enforcement authority should include transactions that create vertical integration, such as when health systems purchase physician practices, as well as horizontal consolidation of health care entities of the same type. Additionally, we encourage the Commission to explore funding sources or programs to support safe staffing and reopen services in hospitals in financial need.

MSNA urges the Commission to use its time and resources to develop strong legislation to immediately stop hospital closures, unit closures, and reductions in services and staffing. As hospital closures and service reductions can cost people their lives, this legislation should be introduced in 2026.

We also urge the Commission to review options to empower the Department of Health and Human Services (DHHS) to identify programs that can serve as long-term solutions to help hospitals that are in financial need reopen services that they have closed.

We appreciate the opportunity for public comment at the Commission's meetings and in writing. Additionally, as the Commission undertakes its work in the coming months, it should include community meetings to discuss health care access issues and potential solutions, particularly in areas where hospitals have closed or reduced services and staffing, for example, in obstetric and birthing units.

II. Key elements for a health care transactions bill.

MSNA is part of National Nurses Organizing Committee (NNOC) which is an affiliate of National Nurses United (NNU). NNOC and NNU have experience with health care transactions and hospital closures on laba federal level and in several states. Through this experience, we have identified several factors that are essential to a strong bill on the issues under the Commission's mandate. **We have included materials in the Appendix that NNOC and NNU have submitted in other states and at the federal level that give significantly more detail on ways to improve antitrust laws with a focus on health care impacts.**

The Commission should recommend legislation to **empower the Attorney General and/or the Department of Health and Human Services to review health care transactions, closures,**

service and staffing reductions, and to approve, deny, or add conditions for approval of a health care transaction, closure, or service or staffing reduction.

Current Maine law provides piecemeal authority to review health care transactions. The certificate of need (CON) law[1] allows state review of new health care facilities and services, and changes in ownership, to ensure they fill a genuine public need and will not negatively affect the quality of care delivered by existing providers. The CON law allows conditional approvals but provides little detail as to the types of conditions permitted.[2] The Attorney General has the power to enforce Maine's very general anti-monopoly law[3] and to ensure that nonprofit hospitals and medical service organizations are comporting with the law governing use of nonprofit funds.[4] However, there is no law allowing review of hospital closures or service or staffing reductions. There is also limited ability to constrain abuse of market power by corporations that control significant segments of a market, including health systems. It is not sufficient to protect incumbents with a CON law without setting standards for the health care services they provide.

The Commission should recommend that the Attorney General and/or the Department of Health and Human Services be empowered to review health care transactions, closures, and service and staffing reductions based on factors related to health care access, patient health and mortality, impacts on workers, and the public interest. Health care consolidation has given a few entities outsized power over patients' access to health care and health care workers' access to good jobs with safe working conditions. That power allows health care entities to raise prices, reduce services, and otherwise harm the public interest. To combat the harms of excess market power, MSNA urges the Commission to recommend that Maine adopt what is known in anti-trust law as a "labor impact standard" and "public interest standard" in its health care transaction review. Basically, that means that state agencies are empowered to deny or add conditions to transactions that are likely to give entities excessive power over the labor market or harm the public interest. LD 1972 provides a strong starting point for the Commission to develop this law.

The state should be able to approve, deny, or add conditions for approval of a health care transaction, closure, or service or staffing reduction to reduce the risk that the party in control after the transaction will act in ways that harm health care access, patient health and mortality, workers, or the public interest. Existing certificate of need law does permit conditions for approvals, but it lacks detail and does not extend to all types of change. Examples of conditions to target specific potential risks include requirements that services remain open, requirements that the facility maintain minimum safe staffing ratios, requirements for health impact assessments, or prohibitions on anticompetitive contracting with insurers.

[1] 22 M.R.S.A. § 326 et seq.
[2] 22 M.R.S.A. § 335.
[3] 10 M.R.S.A. § 1101 et seq.
[4] 5 M.R.S.A. § 194-A et seq.

The Commission should recommend that health care transactions legislation include a requirement to provide six months' notice to the public prior to approval of transactions, closures, and service and staffing reductions. It should also require the state and parties to the transaction to host public hearings in the affected communities. Sufficient notice is essential to allow workers and community members to understand the proposed transaction and organize to explain its impacts to policymakers and help develop solutions to prevent closures or avoid potential harms from transactions. Without giving the public sufficient time and opportunity to participate in the process, the state will not be able to perform an accurate review based on public interest factors.

When a few health systems control large portions of the health care market, as they do in Maine as well as most states nationally, they have the power to engage in behavior that hurts workers or patients and increases their market power even further. The Commission should explore potential improvements to Maine's antitrust law, for health care or in general, to more clearly establish a "single firm conduct" standard that gives Maine enforcement agencies' authority to take enforcement action against large health care corporations that abuse their market power in ways that harm health care workers or patients, like closing services and raising health care prices, or engages in conduct that harms health care workers or patients in order to gain market power, like outsourcing care or hiring private equity firms to restructure health care services. While Maine's existing law does bar single firms from monopolizing or attempting to monopolize trade, a more detailed standard may improve the Attorney General's ability to successfully handle this type of case.

For more detail on this concept, see the California Antimonopoly Coalition Report on Antitrust Reform introduced in the Appendix.[5]

III. Additional legislative elements to prevent and reverse hospital and unit closures.

a. Include a legislative mandate for a minimum set of services for a hospital.

The Commission should recommend legislation that stops the rash of hospital and hospital unit closures in the short term by requiring acute care hospitals to provide a minimum set of basic services as a condition of licensure, including obstetrics, birthing, pediatrics, and surgical services in addition to services required by 10-144 C.M.R. Ch. 112. This concept is not new for Maine hospitals. Maine hospital licensing regulations already require a list of basic services, including medical staff, nursing services, emergency services, food and dietetic services, medical records, imaging services, pathology or laboratory services, and pharmacy services. Expanding the list to include obstetrics, birthing, pediatrics, and surgical services would demonstrate that the

[5] "Updating California's Antitrust Law to Promote a Vibrant, Inclusive, and Competitive State Economy," https://economicsecurityproject.org/news/new-report-proposes-updated-antitrust-framework-ca/.

Commission recognizes the importance of providing a full complement of essential hospital services to our rural communities.

The recent hospital closures of obstetrics and related services increasingly threaten the health of pregnant women and newborns in Maine. Hospitals are the backbone of comprehensive perinatal services in our communities, providing specialized expertise, staffing, and resources to manage high-risk pregnancies and to handle complications during the birthing process. Yet, there are no guardrails to ensure all communities have access to basic and essential maternity services, particularly acute care that can only be safely provided in a hospital. In the past decade, Maine has seen eleven birthing units close. Four of those units closed in the past year.[6] Our nurses see patients who must travel long distances to access obstetrics and birthing services, leading them to miss important prenatal services and putting their health at risk from delays during complicated labor.

We recognize that significant numbers of Maine hospitals do not currently provide these services. While hospitals that do provide birthing services now would be required to maintain them, hospitals that do not currently provide these services should be required to submit a service compliance plan to bring them online over time, with support from the state. Thus, the state could recognize that birthing services are essential to a hospital while considering, on a case-by-case basis, the barriers to quickly reopening units when relevant.

b. Create a program to help keep hospital units open and reopen closed units.

To facilitate transactional review of closures and keeping all basic services open in every hospital, the Commission should recommend the creation of a program to help hospitals that can demonstrate financial need to receive support to reopen closed units, such as obstetrical and birthing units.

DHHS could establish a program to examine the underlying causes of closures and provide monetary and non-monetary support for reopening. For hospitals in financial need, the program could provide targeted, conditional funding to these hospitals, requiring review of how hospital and health systems manage their finances and examination of non-operating revenue and balance sheets to ensure genuine need. For example, the Commission could look into the critical access hospital staff enhancement payments that recently ended as an example of one way to support safe staffing in critical access hospitals.[7]

[6] Rose Lundy. Maine Monitor. Sept. 28, 2025. "Mount Desert Island Hospital announced the closure of its birthing unit in July, citing sharply declining birth rates." https://www.newscentermaine.com/article/news/regional/the-maine-monitor/where-maine-delivery-wards-nursing-homes-closed-last-decade/97-17594c6f-40c5-4d0f-841a-6dae71011ea8.

[7] *See* P.L. 2023, ch 643, Sec. LL-1, amended 22 M.R.S. Sec. 1714-C.

The program could also provide support to resolve other challenges leading to unit closures. For example, the department could identify specific ways to support health care professionals working in rural areas, such as expanded student loan repayment or housing support. It could also support training programs for doctors and nurses to maintain competency in specialty care areas, such as state supported programs to ensure OB/GYNs and labor and delivery nurses can maintain competencies in perinatal services when they work in a hospital with relatively few births.

c. The Commission should explore revenue sources to fund these programs and recommend that they be included in legislation.

The Commission has a mandate to study what is necessary to improve certificate of need laws and health care transactions. While there are many improvements that could be made to the transaction review process that can be funded with fees to transacting parties, a program to help hospitals and units remain open would benefit from a larger budget. The Commission should use its resources to explore revenue sources that could help support such a program.

IV. Specific bills

a. LD 1972, An Act to Enhance Transparency and Value in Substantial Health Care Transactions by Changing the Review and Approval Process for Those Transactions

LD 1972 bill would be a strong starting point for the Commission's work. Particularly important aspects include the six months' notice to public before transactions and the empowerment of the Department of Health and Human Services to perform a comprehensive review of both mergers and health care facility and unit closures with consideration of health care access, impacts on workers, and the public interest.

If the Commission includes a version of this bill in its recommendations, it should include the health services currently required by Maine's hospital licensing regulations at 10-144 C.M.R. Ch. 112 (medical staff, nursing services, emergency services, food and dietetic services, medical records, imaging services, pathology or laboratory services, and pharmacy services) and add obstetrics, birthing, pediatrics, and surgical services for acute care hospitals.

b. LD 1578, An Act to Require the Department of Health and Human Services to Review Disruption to or Removal of Health Services

The original version of LD 1578 extended the look-back period after a certificate of need is approved, allowing the Department of Health and Human Services to review some disruptions and removals of health services. This change would be welcome, but it is not broad enough to address many of the problems facing Maine's health care sector. LD 1972 is a stronger starting point on certificate of need changes.

c. LD 1890, An Act to Facilitate the Development of Ambulatory Surgical Facilities by Exempting Certain Facilities from the Requirement to Obtain a Certificate of Need

The Commission should not support this bill or other efforts to remove Certificate of Need requirements for ambulatory surgical centers. Ambulatory surgical centers do not provide the full range of services that a hospital does, increasing the risks of surgery. In addition, ambulatory surgical centers often strip profitable services from hospitals making local hospitals less financially viable and leaving communities without the full range of hospital services that they need. Excluding ambulatory surgical centers from Certificate of Need requirements would exacerbate health care access and other problems Maine faces.

d. LD 985, An Act to Impose a Moratorium on the Ownership or Operation of Hospitals in the State by Private Equity Companies or Real Estate Investment Trusts

An extended or permanent moratorium on ownership or operation of hospitals in the state by private equity or real estate investment trusts would help protect Maine health care from their predatory practices. Banning private equity is not sufficient to fulfil the Commission's mandate, but it is one valuable method to prevent corporate raids from shutting down Maine hospitals.

Sincerely,

Carmen Comsti, Director of Government Relations
Maine State Nurses Association/National Nurses Organizing Committee

Appendix:

NNOC and NNU Comments in Other States and to Federal Agencies on Health Care Transactions and Antitrust Reform

National Nurses United, "Fact Sheet: Health Care & Federal Antitrust Labor Market Impact Review," June 4, 2024 (See attached)

California Nurses Association/National Nurses United's comments on health care transactions to the California Law Revision Commission (June 2024): Our union in California, CNA/NNOC, submitted several comments to the California Law Revision Commission which is studying comprehensive antitrust reform, including on expanding pre-merger notice requirements, expanding Attorney General authority to challenge health care entity and other transactions, expanding Attorney General and other agency authority to review vertical and cross-market mergers under labor market and consumer impact/public interest theories of harm, among other things.

- See https://clrc.ca.gov/pub/2024/MM24-24s7.pdf (Pages 13-178)
- See also coalition letter at https://clrc.ca.gov/pub/2024/MM24-24s7.pdf (Pages 9-12)

California Antimonopoly Coalition Report on Antitrust Reform (May 2025): Our California union, CNA/NNOC, drafted parts of a coalition report on antitrust reform to California's Law Revision Commission. The report includes recommendations related to antitrust reform that would protect workers (See pages 46-52) and that would create stronger enforcement mechanisms against abusive and harmful impacts of corporate consolidation through a "single-firm conduct" standard (See 12-24).

- "Updating California's Antitrust Law to Promote a Vibrant, Inclusive, and Competitive State Economy," https://economicsecurityproject.org/news/new-report-proposes-updated-antitrust-framework-ca/

National Nurses United, Comments to the Federal Trade Commission on "Draft Merger Guidelines, Docket FTC-2023-0043," *Federal Register*, Document # FTC-2023-0043-0001, September 18, 2023, https://www.regulations.gov/comment/FTC-2023-0043-1485.

California Nurses Association, Comments to the Office of Health Care Affordability on "Proposed Emergency Regulatory Action – Promotion of Competitive Health Care Markets; Health Care Affordability (Cost and Market Impact Review)," August 31, 2023, https://hcai.ca.gov/wp-content/uploads/2023/10/Merged-Regs-Public-Comment.pdf, (Pages 70-85).

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FACT SHEET: Health Care & Federal Antitrust Labor Market Impact Review
June 4, 2024
National Nurses United

I. Introduction

This fact sheet addresses recent developments and evolving legal analysis for antitrust regulators regarding labor markets in the health care sector. Unions and workers have long engaged with antitrust review processes and other legal tools to respond to employer consolidation and anticompetitive practices that harm workers and the labor market. Specifically, this fact sheet discusses recent developments with respect to the Federal Trade Commission's and the U.S. Department of Justice's merger guidelines and other antitrust law to include worker impact analysis, prohibitions on noncompete and *de facto* noncompete agreements, labor market and labor welfare standards, and the role of unions in anticompetition law investigation and enforcement.

II. Monopsony, Worker Harm, and Merger Guideline 10

While labor market impacts of mergers and other single-firm conduct related to monopsony power have historically been ignored by federal regulators, the federal antitrust and consumer protection regulators, including the Federal Trade Commission (FTC) and the U.S. Department of Justice (DOJ), have in the past few years began to concertedly develop regulation and guidance that would explicitly extend antitrust law enforcement to examine labor market power concentration and curbing its negative impacts on workers. Key to the monopsonist labor market analysis is the analysis of harm to workers as sellers in a labor market. Section 7 of the Clayton Act's framework to examine the effects of a merger of sellers can be used to provide a framework to examine the effects of horizontal combinations of buyers (or monopsony power), which includes the consolidation of employer power as buyers in a labor market.[1]

In July 2021, President Joe Biden issued an Executive Order, Executive Order 14036, asking antitrust agencies to both broaden enforcement efforts and to combat abuses of labor market concentration as well as concentration in healthcare markets, stating:

> [I]t is the policy of my Administration to enforce the antitrust laws to combat excessive concentration of industry, the abuses of market power, and the harmful effects of

[1] See Federal Trade Commission and U.S. Department of Justice, "Merger Guidelines" (Dec. 18, 2023), pp. 26-27, https://www.ftc.gov/system/files/ftc_gov/pdf/2023_merger_guidelines_final_12.18.2023.pdf.

> monopoly and monopsony – especially as the issues arise in labor markets, […] healthcare markets (including insurance, hospital, and prescription drug markets) […][2]

Executive Order 14036 was shortly followed by proposed updates to the FTC and DOJ merger guidelines and to Hart-Scott-Rodino Act merger filings. In January 2022, the FTC and DOJ issued a Request for Information on its Merger Guidelines, asking for public comment, in part, on the questions related to monopsony power analysis and labor markets, including metrics to be considered for markets involving labor.[3] The agencies stated that they "are particularly interested in aspects of competition the guidelines may underemphasize or neglect, such as labor market effects and non-price elements of competition like innovation, quality, potential competition, or any 'trend toward concentration.'"[4] In December 2023, the FTC and DOJ finalized its updated merger guidelines, making it explicit in Merger Guideline 10 that the agencies would look at labor market competition and the potential harm to workers as part of its antitrust enforcement practices.[5]

Additionally, in July 2023, the FTC noticed proposed updates to Hart-Scott-Rodino Act merger filings, which as proposed would require companies to provide information about their employees "to aid the agencies' evaluation of the impact of proposed transactions on competition for workers in labor markets."[6] The proposed rule would require the companies to detail employee job classifications, post-merger geographical information about workers, and worker and worker safety information, including a firm's history of labor law violations during a 5-year period before the filing. Past labor law violations would include penalties or findings filed by the U.S. Department of Labor, the National Labor Relations Board, and the Occupational Health and Safety Administration.

a. Employer Concentration and Worker Harms in Healthcare

An important aspect of federal regulator's explicit enforcement practices related to labor market concentration is that the agencies recognize that lessening competition for workers not only may result in lower wages for workers but also lower job quality for workers. The inclusion of reduced job quality as a factor in merger review is a recognition that employer concentration in a

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[2] Executive Order 14036, "Executive Order on Promoting Competition in the American Economy," The White House (July 9, 2021), https://www.whitehouse.gov/briefing-room/presidential-actions/2021/07/09/executive-order-on-promoting-competition-in-the-american-economy/.

[3] Federal Trade Commission; Antitrust Division of the U.S. Department of Justice, "Request for Information on Merger Enforcement," *Regulations.gov*, Docket No. FTC-2022-0003 (Jan. 17, 2022), https://www.regulations.gov/docket/FTC-2022-0003.

[4] *Id*. at 2.

[5] *Supra,* note 2.

[6] Federal Trade Commission, "Notice of Proposed Rule, Premerger Notification; Reporting and Waiting Period Requirements," Federal Register, 88 Fed. Reg. 42,178-218 (Aug. 29, 2023), https://www.ftc.gov/legal-library/browse/federal-register-notices/16-cfr-parts-801-803-premerger-notification-reporting-waiting-period-requirements.

labor market may negatively impact the bargaining power of workers over terms and conditions of employment. In short, the FTC and DOJ's updated merger guidelines establish a framework to analyze how decreased worker bargaining power *vis-à-vis* their employer has a negative impact on wages and other working conditions.

The agencies describe in Merger Guideline 10 that "worsen[ing] benefits or working conditions" or "in other degradations of workplace quality" may result from substantially lessening competition for workers.[7] The agencies further explain in a footnote to Merger Guideline 10 what may constitute labor market harm or reduced job quality:

> A decrease in wages is understood as relative to what would have occurred in the absence of the transaction; in many cases, a transaction will not reduce wage levels, but rather slow wage growth. Wages encompass all aspects of pecuniary compensation, including benefits. Job quality encompasses non-pecuniary aspects that workers value, such as working conditions and terms of employment.[8]

Merger Guideline 10 is consistent with the research literature on labor market concentration. A 2021 study by David Arnold on the effects of mergers and acquisitions on worker wages in the U.S. found that local concentration depresses wages by 4 to 5% relative to a fully competitive benchmark.[9] Arnold found that, after mergers and acquisitions that cause significant increases in local labor market concentration, earnings fall by over 2% for workers at the firms involved in the merger or acquisition. The study found the largest effects in already concentrated markets. Mergers generating large concentration changes also reduced wages at other firms in the labor market.

The effects of monopsony power on wages found by Arnold extend to the health care sector, and monopsony power arising from labor market consolidation in the health care sector can led to industry-driven staffing reductions, expansion of restrictive employment covenants, diluted union density, and, among other negative impacts on workers, unsafe working conditions. Generally, market concentration results in lower staffing levels and reduced hiring. A 2021 study by Marinescu et al. observing labor markets in France found a 10% increase in labor concentration is associated with 3.2% fewer new hires.[10] For hospitals, increased market

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[7] *Supra,* note 2, at 26-27.

[8] *Ibid*.

[9] Arnold, David, "Mergers and Acquisitions, Local Labor Market Concentration, and Worker Outcomes," working paper (Oct. 2021). *See also* Arnold, David, "Mergers and Acquisitions, Local Labor Market Concentration, and Worker Outcomes," (2019), doi: 10.2139/ssrn.3476369.

[10] Marinescu I et al, "Wages, Hires, and Labor Market Concentration," *J Econ Behav & Org.* (2021), 184(C), 506-605. *See also* Wasser D, "Literature Review: Monopsony, Employer Consolidation, and Health Care Labor Markets." *Cent for Econ and Pol'y Res* (Jan. 2022). https://www.cepr.net/report/literature-review-monopsony-employer-consolidation-and-health-care-labor-markets/.

competition is associated with increased registered nurse staffing levels.[11] Employer monopsony power in health care settings has a two-fold impact with respect to nurse and health care worker staffing—monopsony in the labor market can lead to both reduction in employment rates within a labor market and it can enable employers to engage in practice that result in understaffing or unsafe staffing in particular worksites.

The new merger guidelines recognize that the impact of labor market monopsony power go beyond the impact on labor market prices—i.e., wages—in that concentration of employer power through market consolidation can result in employer abuse or exploitation of workers and employer power to violate labor and employment law. With respect to job quality, the health care labor market supply is increasingly elastic—when working conditions are poor, nurses and other workers tend to leave bedside care jobs or their professions altogether; and when employers fail to protect health care workers on the job, these workers experience career ending occupational injuries and illnesses at high rates.[12] Similarly, as the Covid-19 pandemic demonstrated, without optimal infectious disease control measures on the job, nurses and other health care workers can also become infected and die from deadly infectious diseases, including Covid-19.[13] These kinds of non-price factors in the labor market—including staffing and other working conditions—can be impacted by concentration of employer power and could fall under the rubric of job quality in addition to wages.

b. Union Density and Worker Bargaining Power

Diluted union density and loss of worker bargaining power in a highly monopsonist labor market may negatively impact not only wages but other working conditions and job quality for nurses and other healthcare workers. Unionization has material benefit to economic benefits for health care workers such as paid sick leave and vacations, retirement benefits, disability benefits, and health insurance as well as improvements to their working conditions such as job security, safe staffing, and safe patient care practices.

In the health care sector, union density and labor market competition among employers play a significant role in improving wages and working conditions for both union and nonunion registered nurses. Unionization and union density impact the power of workers to bargain for improved wages and working conditions against a monopsonist employer. Employer concentration in a labor market post-merger or acquisition may dilute the union density within a

[11] *See* Shin DY et al. 2020. "The Impact of Market Conditions on RN Staffing in Hospitals: Using Resource Dependence Theory and Information Uncertainty Perspective." *Risk Manag Healthcare Pol'y.* 13, 2103-14. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7568637/.

[12] *See* National Nurses United, "Deadly Shame: Redressing the Devaluation of Registered Nurse Labor Through Pandemic Equity," National Nurses United (Dec. 2020), https://www.nationalnursesunited.org/sites/default/files/nnu/graphics/documents/1220_Covid19_DeadlyShame_PandemicEquity_WhitePaper_FINAL.pdf.

[13] *See ibid.*

more concentrated health system, diminishing the bargaining power of health care workers within highly concentrated health system within a labor market. However, mergers of union and nonunion facilities may diminish union density within a labor market and may dilute the bargaining power of health care workers *vis-à-vis* a monopsonist employer and, thus, diminish the net positive effect on wages and working conditions that unions have on nonunion health care workers. In a competitive labor market where union density is high, there is what is called a "union threat effect" where nonunion employers within a market may raise wages to avoid the threat of increased unionization. For example, with respect to nurses, high union density may result in a union threat effect on wages.[14]

Recent research by Prager and Schmitt shows that an increase in health care labor market concentration is associated with lower wages and less bargaining power for workers.[15] In markets with a labor market concentration of 2,500 points or higher on the Herfindahl-Hirschman index (HHI) of hospital full-time employee concentration within a commuting zone, wages are 1 to 4% lower than in perfectly competitive labor markets. Prager and Schmitt also found that large hospital transactions that significantly increase concentration may result in a 6.3% decrease in wages for nurses. Importantly, they also found that a strong labor union presence "meaningfully attenuate[s]" post-merger wage depression but does not eliminate it.

Dilution of union density within a health system post-merger of a union and nonunion facility may impact those workers ability to maintain the wage premium union workers receive compared to their nonunion counterparts. For example, studies of nurse wages controlling for various variables, including type of health facility, geographic region, age, experience, position, and education, concluded that being in a union increases nurse wages, with estimated union wage premiums ranging between almost 8% to over 13%.[16] Importantly, unionization can significantly diminish gender and racial wage gaps for nurses and other workers. The results of one study, applying several control variables, demonstrated that in the nonunion setting Black registered nurses earned almost 8% less in average hourly wage than white RNs but, for unionized Black registered nurses, this racial wage penalty was minimal (0.85%) or, in other words, being in a union reduced the racial wage gap for Black nurses by almost 89%.[17] Additionally, union membership shrinks the wage gap for nonunion professional women, who earn 73 cents for each dollar earned by their male counterparts, while professional women in unions earn 83 cents for each dollar earned by their male counterparts.[18]

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[14] Coombs C et al., "The Bargaining Power of Health Care Unions and Union Wage Premiums for Registered Nurses," *J Lab Res* (Jun 4, 2015), 36(4), 442–61, doi:10.1007/s12122- 015-9214-z.

[15] Prager E, Schmitt M, "Employer Consolidation and Wages: Evidence from Hospitals," *American Economic Review* (Feb. 2021)*,* 111: 397-427. https://www.jstor.org/stable/27027692.

[16] Coombs C, *supra*, note 15; McGregory R, "An Analysis of Black–White Wage Differences in Nursing: Wage Gap or Wage Premium?" *Rev Black Pol Econ* (Mar. 2011), 40(1), 31–37, doi:10.1007/s12114-011-9097-z.

[17] McGregory, *supra,* note 15.

[18] Gould E, McNicholas C, "Unions Help Narrow the Gender Wage Gap," *Working Economics Blog.* Economic Policy Institute (2017), https://www.epi.org/blog/unions-helpnarrow-the-gender-wage-gap.

III. Merger Enforcement Actions & Labor Market Harm

While the U.S. Supreme Court has confirmed that antitrust law applies to buyer anticompetitive behavior and harmful effects of monopsony as it does to seller anticompetitive behavior and monopolies[19], theories of monopsony harm have rarely involved an analysis of labor market competition and harm to workers. Enforcement actions related to buyers have revolved around pricing-related anticompetitive behavior among buyers or cartel markets for goods and services. In the labor market context, antitrust challenges, albeit uncommon, typically arise as challenges under Section 1 of the Sherman Act as prohibited contracts "in restraint of trade"[20] or under Section 5 of the Federal Trade Commission Act as unfair or deceptive acts or practices that affect commerce.[21] However, until the Biden Administration's 2021 instruction to antitrust agencies to pursue enforcement against on the basis of labor market harms, the FTC and DOJ have never blocked or challenged a merger on the basis of its monopsonist labor market effects.

Importantly, antitrust law recognizes that worker consolidation of power is different than employer consolidation of labor market buying power. Section 6 of the Clayton Act creates an exception to antitrust law for workers and labor – unions – and activities for the purposes of "mutual help" of members of labor organizations – workers – from "lawfully carrying out the legitimate objects thereof."[22] This section of the Clayton Act further states that "nor shall such organizations, or the members thereof, be held or construed to be illegal combinations or conspiracies in restraint of trade, under the antitrust laws."[23]

a. Penguin Random House/Simon & Schuster Merger

In November 2021, shortly after the Biden Administration issued Executive Order 14036 directing antitrust agencies to take enforcement action related to labor market harm, the DOJ for the first time sued to block a merger, the acquisition of publisher Simon & Schuster by publisher Penguin Random House, on the basis of monopsony harm to a set of workers as sellers of labor as a result of buyer consolidation. The DOJ argued that the merger of Penguin Random House and Simon & Schuster, two of the largest publishers in the United States, would result in "substantial harm to authors of anticipated top-selling books and ultimately, consumers."[24] In its press release on the blocking litigation, the DOJ explained that "this merger will cause harm to

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[19] See *Weyerhaeuser Co. v. Ross-Simmons Hardwood Lunder Co.*, 549 U.S. 312, 317-18 (2007) (holding that "general theoretical similarities of monopoly and monopsony combined with the theoretical and practical similarities of predatory pricing and predatory bidding convince us that our two-pronged [Sherman Act test] should apply to predatory-bidding claims").

[20] 15 U.S.C. § 1.

[21] 15 U.S.C. § 45.

[22] 15 U.S.C. § 17.

[23] *Id.*

[24] Complaint, *U.S. v. Bertelsmann SE & CO. KGaA, et al*., No. 21-2886-FYP (D.D.C.) (Nov. 2, 2021), https://www.justice.gov/opa/press-release/file/1445916/dl.

American workers, in this case authors, through consolidation among buyers – a fact pattern referred to as 'monopsony.'"[25] The DOJ alleged that the proposed merger would eliminate buyer competition in the market for authors, resulting in lower advances, worse services, and less favorable contract terms for authors and ultimately fewer and less variety in books published for customers.

In October 2022, the DOJ obtained a permanent injunction blocking Penguin Random House's acquisition of Simon & Schuster.[26] Notably, the publishers argued that the definition of the analyzed market was inappropriately focused on a submarket of targeted sellers – the authors of anticipated top-selling books – and the anticompetitive harm to this submarket. The court's analysis centered on whether the market was appropriately defined and whether the merger would allow publishing companies to pay this submarket of authors less money for the rights to publish their work as well as the vulnerabilities of this submarket of authors to anticompetitive behavior, their unique needs, and preferences. The deal was scrapped by November 2022.

b. Kroger/Albertsons Companies, Inc. Merger

In February 2024, filing an administrative complaint and authorizing suit to block the acquisition of Kroger Company and Albertsons Companies, Inc., the FTC made its first challenge to a merger since the adoption of the updated guidance on the basis, in major part, of a labor market harm theory.[27] With eight states, the FTC also sued in the U.S. District Court in Oregon to block the merger.[28] The lawsuit and complaint allege that the merger would substantially lessen competition not only for grocery markets, negatively impacting consumers and raising grocery prices, but also allege that labor market competition would be eliminated, negative impacting Kroger and Albertsons workers and their ability to collectively bargain for stronger union contracts with improved wages, benefits, and working conditions.[29] Recognizing that Kroger and

[25] U.S. Department of Justice, "Justice Department Sues to Block Penguin Random House's Acquisition of Rival Publisher Simon & Schuster," Press Release, Office of Public Affairs (Nov. 2, 2021), https://www.justice.gov/opa/pr/justice-department-sues-block-penguin-random-house-s-acquisition-rival-publisher-simon.

[26] U.S. Department of Justice, "Justice Department Obtains Permanent Injunction Blocking Penguin Random House's Proposed Acquisition of Simon & Schuster," Press Release, Office of Public Affairs (Oct. 31, 2022), https://www.justice.gov/opa/pr/justice-department-obtains-permanent-injunction-blocking-penguin-random-house-s-proposed; Memorandum Opinion, *U.S. v. Bertselsmann SE & CO. KGaA, et al.*, No. 21-2886-FYP (D.D.C.) (Oct. 31, 2022), https://www.justice.gov/atr/case-document/file/1549941/dl .

[27] Complaint ¶ 7, *The Kroger Company and Albertsons Companies, Inc.* (*Kroger/Albertsons*), FTC No. D-9428 (Feb. 26, 2024), https://www.ftc.gov/system/files/ftc_gov/pdf/d9428_2310004krogeralbertsonsp3complaintpublic.pdf; Federal Trade Commission, "FTC Challenges Kroger's Acquisition of Albertsons," Press Release, Office of Public Affairs (Feb. 26, 2024), https://www.ftc.gov/news-events/news/press-releases/2024/02/ftc-challenges-krogers-acquisition-albertsons.

[28] Complaint for Temporary Restraining Order and Injunctive Relief, *FTC et al. v. Kroger et al.,* No. 3:24-cv-00347 (D. Or. Feb. 26, 2024).

[29] See Complaint, *Kroger/Albertsons,* at ¶¶ 7, 57-82; Complaint, *FTC et al. v. Kroger et al.*, at ¶¶ 7, 101.

Albertsons are, respectively, the first and second largest traditional supermarket chain and largest employer of unionized grocery workers in the United States, the Kroger/Albertsons case is the first enforcement action by the FTC to analyze the impact of a merger on union workers and their collective bargaining power in relation to a monopsonist employer.[30]

An important aspect to the FTC and state challenges to the Kroger/Albertsons merger is that in many markets across the country both Kroger and Albertsons operate stores that employe union grocery workers, the vast majority of the workers who are represented by United Food and Commercial Workers (UFCW).[31] FTC argues that the relevant labor market to analyze the probable effects of the merger is defined by union grocery labor with the local collective bargaining agreement area as the relevant geographic market.[32]

The consolidation of Kroger and Albertsons would, the FTC argues, allow the new combined employer to gain increased bargaining leverage over workers and their unions to the workers' detriment, resulting in subpar terms of employment, slower wage growth, worse benefits, and potential degradation of working conditions.[33] The FTC's complaints highlights that workers and the union representatives play Kroger and Albertsons against each other, obtaining a favorable deal from one employer and then leveraging that deal against the other respondent to demand similar or better terms, but that this kind of leveraging is only possible because of the risk to the employers from losing either customers or workers to their competitor.[34] The complaints contrast situations where lack of alignment between Kroger and Albertsons during collective bargaining negotiations with union workers resulted in union contracts with more favorable salaries and benefits for workers with situations where the two employers had successfully coordinated.[35]

The FTC and states' complaints additionally analyze the potential negative effect the merger would have on union workers' ability to credibly leverage the threat of a strike or boycott to negotiate better contract terms.[36] The complaints explain how the merger would result in some geographical areas, including Denver, in Kroger/Albertsons being the only employer of union grocery labor. The FTC provides examples in Denver where UFCW Local 7 members who worked at Kroger's King Soopers supermarkets engaged in a strike, encouraging both customers and workers to transfer prescriptions to and shop at Albertsons stores. The Denver strike of King Soopers resulted in Kroger losing sales and profits, with Kroger agreeing to improvements to wages and safety protections in its workers' collective bargaining agreement. UFCW Local 7

[30] Complaint, *Kroger/Albertsons,* at ¶¶ 7, 57-82; Complaint, *FTC et al. v. Kroger et al.*, at ¶¶ 7, 76-101.
[31] Complaint, *Kroger/Albertsons,* at ¶¶ 61-62; Complaint, *FTC et al. v. Kroger et al.*, at ¶¶ 80-81.
[32] Complaint, *Kroger/Albertsons,* at ¶¶ 63-67; Complaint, *FTC et al. v. Kroger et al.*, at ¶¶ 82-86.
[33] Complaint, *Kroger/Albertsons,* at ¶¶ 69-82; Complaint, *FTC et al. v. Kroger et al.*, at ¶¶ 88-101.
[34] Complaint, *Kroger/Albertsons,* at ¶¶ 71-72; Complaint, *FTC et al. v. Kroger et al.*, at ¶¶ 90-91.
[35] Complaint, *Kroger/Albertsons,* at ¶¶ 78-81; Complaint, *FTC et al. v. Kroger et al.*, at ¶¶ 97-100.
[36] Complaint, *Kroger/Albertsons,* at ¶¶ 73-77; Complaint, *FTC et al. v. Kroger et al.*, at ¶¶ 92-96.

later was able to leverage the improved contract terms with Kroger into the same improvements in its contracts with Albertsons.

The FTC's administrative complaint and litigation are still in early stages with a hearing on the motion for preliminary injunction set to be heard before the U.S. District Judge in the District of Oregon on August 26, 2024.

a. Tapestry/Capri Merger

Most recently, the FTC sued to block Tapestry, Inc's acquisition of Capri Holdings Limited, which would combine three competitors in the "accessible luxury" brand market, in part for the deal's negative impact on the workers' wages, benefits, and working conditions.[37] Applying a different analysis of labor market impacts than the Kroger/Albertsons merger, the FTC complaint indicates that the companies employ thousands of non-union retail workers and that the companies follow the others' labor practices closes and that public disclosure of their employment policies prompts the companies to improve workplaces and worker benefits to attract and retain employees.[38] The FTC's blocking suit was filed in the U.S. District Court for the Southern District of New York.[39]

IV. FTC's Noncompete Rule

Federal regulators have also begun to expand their application of antitrust law to labor market conduct outside of the merger context. These challenges largely have involved wage fixing, noncompete provisions, or no-poach agreements among competitor employers as contracts in restraint of trade under Section 1 of the Sherman Act. Health care firm conduct has been subject to some leading cases on Section 1 enforcement against wage fixing and unlawful coordination of pay scales for doctors and nurses.[40]

More recently, federal antitrust agencies have also been looking to reign in the use of other restrictive covenants in employment contracts like provisions of a worker not to compete with a competitor firm, commonly referred to as non-competes. On January 5, 2023, the FTC issued a Notice of Proposed Rulemaking that seeks to ban most non-competes.[41] Issuing its Final Rule just in April 23, 2024, the FTC would eliminate most non-competes entirely, based on the FTC's authority under Section 5 of the Federal Trade Commission Act to restrict unfair methods of

[37] Complaint ¶ 8, *Tapestry, Inc. and Capri Holdings Limited*, FTC No. 9429 (Apr. 22, 2024).
[38] *Id*. at ¶¶ 9, 43-44, 55-57.
[39] *FTC v. Tapestry, Inc. et al*., No. 1:2024-cv-03109 (S.D.N.Y. Apr. 23, 2024).
[40] *See, e.g*., *Kartell v. Blue Shield of Mass*., 749 F.2d 922 (1st Cir. 1984).
[41] FTC, "Notice of Proposed Rulemaking, Non-Compete Clause Rule," 88 Fed. Reg. 3,482 (Jan. 5, 2023), https://www.federalregister.gov/documents/2023/01/19/2023-00414/non-compete-clause-rule.

competition.[42] The Final Rule importantly includes independent contractors as well as statutory employees in the definition of "workers" to which the Rule applies. In order to streamline compliance, the FTC eliminated a proposed provision that would have required employers to legally modify existing non-competes and formally rescind them. Instead, the FTC requires employers to provide workers subject to an existing non-compete, with the exception of senior executives, with notice that the non-compete agreement will not be enforced against them in the future.

Notably, the FTC's Final Rule bans not just express non-compete provisions, but also agreements that "function to prevent" workers from seeking or accepting other work or starting a business after their employment."[43] The Proposed Rule had suggested that certain *de facto* non-competes, such as non-disclosure agreements (NDAs), non-solicitation agreements, or training repayment agreement provisions (TRAPs) could be considered a prohibited non-competes.[44] The preamble to the Final Rule, the FTC addresses the request by commenters to categorically ban NDAs, TRAPs, and non-solicitation agreements, instead explaining that the agency adopts a functional test:

> [T]he term "functions to prevent" clarifies that, if an employer adopts a term or condition that is so broad or onerous that it has the same functional effect as a term or condition prohibiting or penalizing a worker from seeking or accepting other work or starting a business after their employment ends, such a term is a non-compete clause under the final rule.[45]

Similar to non-compete provisions in employment contracts, TRAPs and other *de facto* non-competes can limit worker freedom within the labor market. Many employers mandate as a condition of employment or coerce employees to sign agreements that force them to pay the employers money if they quit before a prescribed period of time. Regulators and researchers have begun attempts to quantify the use of these contracts. The Consumer Financial Protection Bureau (CFPB) issued a report on "employer-driven debt" arrangements, including TRAPs and other "stay or pay" contracts, in 2023.[46] The CFPB found that employers began the use of TRAPs in the 1990s, predominantly for higher-skilled, higher wage workers but found TRAPs today being used for health care workers, transportation workers, and the retail industry. Similarly, in 2022, a National Nurses United survey of registered nurses (RNs) across the

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[42] In November 2022, the FTC also adopted a statement of enforcement policy on unfair methods of competition under Section 5 of the FTC Act. FTC, "Statement of Chair Lina M. Khan, Section 5 Policy Statement," (Nov. 10, 2022), https://www.ftc.gov/system/files/ftc_gov/pdf/Section5PolicyStmtKhanSlaughterBedoyaStmt.pdf

[43] *See supra*, note 41, at 38,362 (describing Section 910.1(a) of the Final Rule).

[44] *Id.* at 38,362-66.

[45] *Id.* at 38,364.

[46] Consumer Financial Protection Bureau, "Consumer risks posed by employer-driven debt," CFPB Office of Consumer Populations, Issue Spotlight (Jul. 20, 2023), https://www.consumerfinance.gov/data-research/research-reports/issue-spotlight-consumer-risks-posed-by-employer-driven-debt/full-report/.

country found that almost 40% of RNs who started their careers within the past decade were subject to a TRAP.[47] In March 2023, a number of legal and business academics published new research finding that up to 1 in 12 workers in the United States are subject to a TRAP.[48]

For example, the preamble to the Final Rule cites examples of TRAPs that can "function" as a non-compete provided by a commenter. The FTC highlights as potential provisions that function as non-competes both a TRAP "that required entry-level workers at an IT staffing agency who were earning minimum wage or nothing at all during their training periods to pay over $20,000 if they failed to complete a certain number of billable hours" and a TRAP "requiring nurses to work for three years or else repay all they have earned, plus paying the company's 'future profits,' attorney's fees, and arbitration costs."[49] The FTC goes on to state that these kinds of TRAPs "may be functional non-competes because when faced with significant out-of-pocket costs for leaving their employment—dependent on the context of the facts and circumstances—workers may be forced to remain in their current jobs, effectively prevented from seeking or accepting other work or starting a business."[50]

While the FTC expressly declined to categorically prohibit all TRAPs, its discussion in the Proposed Rule regarding the need for a categorical ban on non-completes is helpful in understanding the harmful impact of these types of employment contracts on labor market competition:

> The Commission is proposing a categorical ban on non-compete clauses because, fundamentally, non-compete clauses obstruct labor market competition through a similar mechanism for all workers. Non-compete clauses block workers in a labor market from switching to jobs in which they would be better paid and more productive. This harms workers who are subject to non-compete clauses. This also harms other workers in the labor market, since jobs that may be better matches for those workers are filled by workers who are unable to leave their jobs due to non-compete.[51]

While some employer assert that employer financial investment into an employee's training may justify restrictions on labor market mobility, this may serve merely as a pretense to justify the restrictive covenant to work a minimum period of time with the employer. Indeed, some health

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[47] Berger R, "Caught in a TRAP," *National Nurse Magazine* (Dec. 2022), https://nnumagazine.uberflip.com/i/1489186-national-nurse-magazine-october-november-december-2022/15.

[48] Prescott J, Schwab S, Starr E, "First Evidence on the Use of Training Repayment Agreements in the US Labor Force," *Promarket* (Mar. 27, 2024), https://www.promarket.org/2024/03/27/first-evidence-on-the-use-of-training-repayment-agreements-in-the-us-labor-force/.

[49] *Id.* at 38,365.

[50] *Ibid.*

[51] FTC, "Notice of Proposed Rulemaking, Non-Compete Clause Rule," Federal Register, 88 Fed. Reg. 3,482 (January 19, 2023), https://www.federalregister.gov/documents/2023/01/19/2023-00414/non-compete-clause-rule.

care employers, which have come under scrutiny for their use of TRAPs, assert that they will stop using TRAPs but will still use other "stay or pay" hiring or signing "bonuses."[52]

Finally, as further indication of the FTC's renewed scrutiny on anti-competitive activity in the employment context by a single firm outside of mergers, the FTC recently entered into a memorandum of understanding with the U.S. Department of Labor, agreeing to share information about potential labor and competition law violations, including "non-compete and nondisclosure provisions."[53]

[52] *See, e.g.*, Betancourt M, "Health Care Companies Are Using Debt to Trap Nurses on the Job," *Mother Jones* (Sept. – Oct. 2023), https://www.motherjones.com/politics/2023/08/nurse-debt-trap-training-repayment-agreement/.

[53]" Memorandum of Understanding Between the U.S. Department of Labor and the Federal Trade Commission," at 2 (Aug. 30, 2023), https://www.ftc.gov/system/files/ftc_gov/pdf/23-mou-146_oasp_and_ftc_mou_final_signed.pdf.

McCarthyReid, Colleen

From: Emily Wright <emilyjanewright75@gmail.com>
Sent: Monday, October 6, 2025 10:01 AM
To: McCarthyReid, Colleen
Subject: in support of state oversight for closure of hospital services and specifically OB closures

Hello,

My name is Emily Wright and I am a Registered Nurse with over a decade of experience in acute care, the past few years being in Obstetric Care.

I am writing to you today to express my deep concerns that there currently exists no state oversight for closures of Obstetric (OB) units in the state of Maine.

As you are aware we have a crisis of care as more and more rural OB units are closing across the state and women and families are left in health care deserts having to travel hours to seek the care they need and deserve, or forgo that care all together. Access to proper healthcare, in all stages of the life cycle, is a human right, not a privilege, one that is being denied to birthing women and families.

As a result of these mass closures we have already begun to see patients unable to obtain essential diagnostic testing they need until late in their third trimester. Thus, withholding care that could be life changing for the unborn child and family. We have seen paramedics get their "stork" wings, due to babies being born in the back of ambulances, despite babies arriving at care facilities needing resuscitation or worse. All in the name of saving health care facilities money?! It is unethical and just plain wrong. It can not continue and the decision can not rest on the shoulders of those whose primary goal is to make and save the hospitals money. It must be determined by the state, by those who see the needs of the communities.

I implore you to take these examples and the needs of those most vulnerable, the birthing people and their families into consideration, when making your decision.

Thank you,
Emily Wright RN

--
Emily J Wright RN
she/her/hers
207 801 1012

You are not a drop in the ocean, you are the entire ocean in a drop.

McCarthyReid, Colleen

From: anne marie wilberg <mientje4663@gmail.com>
Sent: Tuesday, October 7, 2025 11:21 AM
To: McCarthyReid, Colleen
Subject: Testimony for Commission to Evaluate the Scope of Regulatory Review and Oversight over Health Care Transactions
Attachments: LD1578 Testimony.pdf

I am excited to see that this commission has been established and will be addressing this complex issue. While I recognize that the Committee's charge encompasses a broad range of concerns, I hope that significant attention will be given to the very real and urgent challenges created by the escalating number of birthing unit closures across our state.

During the last legislative session, I submitted testimony in support of LD 1578. Although that bill did not pass as a stand-alone measure, its intent and key provisions were incorporated into other related proposals, ultimately leading to the creation of this Commission.

While I understand the need to keep the Committee's membership manageable, I am concerned that there is a lack of specific expertise or direct experience in providing or coordinating perinatal care outside of the C suite. Such insight is essential to ensure that the Commission's recommendations address the unique and pressing realities of maternal health care access in Maine.

As I noted in my earlier testimony—which I have attached—the process that allows hospitals to close their birthing units with extremely limited notice to the community is unacceptable. It directly contradicts existing DHHS recommendations for sufficient advance notice, yet there are no consequences when hospitals disregard these guidelines. If closures truly cannot be avoided, there are far better ways to approach the process—through early communication, community engagement, and thoughtful transition planning—to minimize harm to patients, providers, and communities.

--
sincerely.

Anne Marie van Hengel. MD. FACOG
Secretary/Treasurer-elect Maine Section ACOG

207 939 1815

Testimony in Support of LD 1578

Anne Marie van Hengel, MD, FACOG
Portland , Maine

May 9 2025

Introduction

My name is Anne Marie van Hengel. I have over 30 years of experience providing obstetrical care to families across Maine, and I am now actively involved in statewide efforts to improve perinatal outcomes.

Through this work, I have seen firsthand the serious and growing challenges that Maine—and the rest of the nation—is facing when it comes to access to maternity care, particularly in rural areas.

The reasons behind the closure of rural birthing units are multifactorial and complex. There are legitimate concerns—workforce shortages, financial pressures, and regulatory hurdles—that contribute to the strain on hospitals and providers. But complexity is no excuse for silence, secrecy, or inaction. We must ensure that transparent communication, strategic planning, and community input are at the center of any decisions that affect how and where people can give birth.

Full Testimony

I am writing today in strong support of LD 1578.

While I listened carefully to the heartfelt testimony about the impact of birthing unit closures—stories that are both moving and deeply troubling—for me, the most compelling rationale to support this bill lies in the lack of process, transparency, and accountability that has accompanied many of these closures.

As you have heard, we have seen an alarming acceleration in birthing unit closures in Maine: four already this year, and several more last year. Although a few were thoughtfully planned with viable alternatives considered, most have occurred with little or no notice. The Department of Health and Human Services has recommended a 120-day notice period, yet this has been repeatedly ignored. Some hospitals have closed their birthing units with as little as 30 days' notice.

It is inconceivable to me that hospital leadership was unaware of the financial pressures that made continued operation unfeasible. Hospital budgets are developed well in advance. These challenges would have been recognized months—if not years—before the decision to close was made.

Decisions of this magnitude should not be made without input from the providers and staff who deliver care, and without engaging the communities that will be affected. When decisions are made behind closed doors, it undermines public trust and places patients and

providers in increasingly difficult positions.

This bill will not, in and of itself, prevent hospitals from closing birthing units. The underlying issues—workforce shortages, declining reimbursement, and the financial fragility of rural health care—still need to be addressed. But what this bill does do is ensure that if closures must happen, they occur in a way that allows for thoughtful planning, community involvement, and mitigation of harm.

With Maine having received a TMAH (Transforming Maternal Health Access) grant, there are significant efforts underway to develop and implement a comprehensive strategy to address the rural maternity health care access crisis. This work is crucial, but it is not an acute solution. These systems-level changes will take time to build and enact. Meanwhile, several more hospitals are currently struggling with the same issues—financial instability, workforce challenges, and difficult decisions about whether they can continue offering obstetric services. We cannot afford to wait for longer-term solutions to come to fruition while communities continue to lose access to essential maternity care.

LD 1578 seeks to establish a clear and reasonable process. When a hospital recognizes that its birthing unit is in jeopardy, it should be required to communicate early with DHHS, explore potential solutions to avoid closure, and, if closure is truly unavoidable, provide adequate time—not just for administrative transitions, but for:

- Patients to arrange alternative care,
- Communities to prepare and adjust, and
- Emergency departments to receive appropriate training to handle OB-related emergencies safely.

This is not simply about logistics. It is about respect for patients, providers, and rural communities, and about protecting the health and safety of pregnant individuals and their newborns.

LD 1578 offers a step toward ensuring that future birthing unit closures are managed with greater transparency, foresight, and responsibility. I urge you to vote in favor of this bill.

Sincerely,

Anne Marie van Hengel, MD, FACOG

McCarthyReid, Colleen

From: shenders@maine.rr.com
Sent: Tuesday, October 7, 2025 5:38 PM
To: McCarthyReid, Colleen
Subject: testimony for 10/8

I am a retired nurse educator. The American Nurses Association defines health care as a basic human right (ANA,1989). Compassion has been foundational to the development of the professional nursing and professional practice is based on a ANA Code of Ethics (2025). Nurses have been at the patient's side on the battle field, in rural homes, in urban communities, in hospitals, and office practices. Nurses know that health care is not a business like any other business; it is a professional service providing care to vulnerable individuals, families and groups.

We have a moral, ethical obligation to look at profit margins and how money is spent when the health and well-being of our population is at stake. Unfettered capitalism does not provide an answer. Business is not required to behave in socially responsible ways and when the owners have no ties to a community, there is no stopping the damage that can be done.

Resources are finite and as former Governor Brennon said, "Health care is but one social concern". Social concerns need be administered with justice and mercy. The market place of unfettered capitalism has neither justice nor mercy. We have homeless, housing insecure and sick citizens who fear for their survival. A roof, food and basic health care are not something working people who do not earn a lot of money can count on. An economist, Rashi Fein, said that "people live in a society not an economy". Our task is to shape the economy to create the society we want and need.

Susan Henderson
shenders@maine.rr.com
9 E Street, South Portland, Me

MSNA Maine State Nurses Association
National Nurses Organizing Committee
National Nurses United
OUR PATIENTS. OUR UNION. OUR VOICE.

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Comments from Brynne O'Neal
Regulatory Policy Specialist, Maine State Nurses Association/National Nurses Organizing Committee

Commission to Evaluate the Scope of Regulatory Review and Oversight Over Health Care Transactions that Impact the Delivery of Health Care Services in the State

October 8, 2025

Hello. I am Brynne O'Neal, a Regulatory Policy Specialist with Maine State Nurses Association/ National Nurses Organizing Committee, a labor union representing over 4,000 registered nurses and other health care workers in Maine. We thank the Chair and Commissioners for considering this important topic. We are submitting written comments with more detail on our recommendations on the agenda items discussed today.

Given the urgency of the situation in Maine, we appreciate the tight statutory timeline. It is crucial that Maine's hospitals remain open and offer needed services, including obstetrical services. Our patients depend on their community hospitals.

LD 1972, from this past session, is a good place to start expanding health care transaction review authority of Maine enforcement agencies. The Commission should also consider expanding regulatory review authority to vertical integration as well as horizontal integration of health care entities and, importantly, to include review of hospital and unit closures. There are increasing numbers of hospitals and large health care corporations acquiring physician practices. And many Maine hospitals are part of large health systems that can close units and hospitals knowing that patients will have to drive to other hospitals owned by the same system. We also support a permanent private equity moratorium, following the example of Chair Tipping's bill from this year.

Importantly, the Commission should consider expanding enforcement agencies' ability to place conditions on health care transactions and closures, including requirements that services remain open, that the facility maintain minimum safe staffing ratios, required health impact assessments, or prohibitions on anticompetitive contracting with insurers.

In the short term, the Commission can develop strong legislation to immediately stop hospital closures and reductions in services and staffing. The Commission can also identify long-term solutions to help hospitals that are in genuine financial need to support safe staffing and reopening of closed services, such as obstetrics units. Additionally, the Commission can explore ways to recapture some of the federal tax cuts that benefit rich corporations at the state level and reallocate those funds to meet the needs of patients.

Our national union, National Nurses United, is working to combat the threat of hospital closures across the country. But if the federal political situation does not change, funding cuts are coming. That threat makes your work on this Commission all the more urgent. The time is now for the legislature to set up oversight and funding programs to keep hospitals open. Patients' lives depend on it.

Maine State Nurses Association has broad expertise, particularly in health care antitrust law reform, in our research and policy departments. We are happy to serve as a resource for the Commission as you develop your recommendations.

MSNA Maine State Nurses Association
National Nurses Organizing Committee
National Nurses United
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Comments from Erin Oberson, RN

Commission to Evaluate the Scope of Regulatory Review and Oversight Over Health Care Transactions that Impact the Delivery of Health Care Services in the State

October 8, 2025

My name is Erin Oberson and I've been a registered nurse for 24 years. I'm a proud member of the Maine State Nurses Association. I currently work in obstetrics at the Northern Light Eastern Maine Medical Center and previously worked in the obstetrics unit at Mount Desert Island Hospital, before the unit closed.

Recent OB closures in northern rural Maine have put patients in danger and crowded care into larger hospitals like EMMC. We've seen OB closures in Calais, Waldo county, Fort Kent, and recently Mount Desert Island and Houlton.

These closures hurt my patients. After the closure of Houlton's OB, they send OB patients to us, over an hour and a half away. These delays are dangerous. One patient went to Houlton with signs of preterm labor and was set to transfer to EMMC, but after waiting for hours for transport, they left against medical advice and her partner drove her to us.

Babies will be born regardless of whether their local hospital has an OB unit or not, placing mother and baby in grave danger. For example, I know of another patient with labor complications who went to Houlton after their OB closed, and a non-obstetrical team had to perform an emergency c-section.

When OB units close, other area hospitals must absorb those patients without additional resources to care for them. This happened at EMMC one weekend recently when both Maine Coast Ellsworth—where Mount Desert Island residents go now—and Machias OB units were diverting patients to other hospitals, so women had no access to care between our facility in Bangor and Presque Isle, 2 and a half hours away. We have only 7 labor rooms but had 12 patients in labor with no additional staff. That is not safe for patients or nurses.

I also see more patients who missed important routine prenatal screenings because it takes so much time and money to get to a facility that still provides these services. Predictably, this often results in longer hospital stays, after a baby is born.

Labor doesn't always go according to plan. A healthy pregnancy can turn into a medical emergency in minutes. When this happens, we need a hospital, trained staff, surgical teams, neonatal intensive care units ready 24/7.

I ask the Commission to prioritize legislation that can be introduced this session requiring hospitals to maintain their OB units and to authorize the state to review closure decisions. Hospital and unit closures disrupt our communities and could cost our patients their lives.

Finally, I ask that you identify programs that can serve as long-term solutions to help hospitals reopen OB and other services that they have closed.

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Comments from Portia Judson, RN
Commission to Evaluate the Scope of Regulatory Review and Oversight Over Health Care Transactions that Impact the Delivery of Health Care Services in the State

October 8, 2025

My name is Portia Judson and I have been a registered nurse for 10 years. I currently work at Mount Desert Island Hospital as an ER nurse and I'm a member of the Maine State Nurses Association.

Mount Desert Island Hospital closed its obstetrics department earlier this year. Our hospital cannot serve the needs of our patients without an OB. Recently, I saw a patient come into the hospital 23 weeks pregnant with a history of complications in prior pregnancies. She was having horrible abdominal pain and was terrified. When we did not hook her up to a fetal heart monitor, because we had no one to use it, she asked about our OB coverage. We told her we no longer had the department. She asked for her husband and immediately insisted they leave and go to a hospital with an OB department.

This woman's terror was stark and real. I couldn't honestly tell her that if she, or her baby, needed it, transport would be available, much less whether it would arrive in time to save them. It was exactly the type of thing nurses all worry about. —especially on an island. Thankfully it turned out alright, this time. I don't know about next time.

Patients like these are why specialist OB care in hospitals is so important to the entire community. And the community needs to be involved in decisions about unit closures.

When Mount Desert Island Hospital closed its obstetrics unit, the community got about three months advance notice. My union held a town hall to share our concerns and speak with our community members, because the state required no process to hear from the community. We strongly urge the Commission to ensure public participation in future decisions about hospital transactions by recommending the state require 6 months' notice and public hearings before closures, mergers, or other significant transactions.

In that same spirit, I encourage the Commission itself to host community meetings to inform its work, particularly in areas where hospitals have closed or reduced services and staffing, for example, in obstetric units.

7 October 2025

To the members of the Commission to Evaluate Regulatory Review and Oversight of Healthcare Transactions:

We at the Maine Academy of Family Physicians are concerned about the worsening crisis of access to maternity and obstetric care throughout our state. To that end, we have developed a task force to work to address this issue—one that affects many of our patients and our members especially in rural Maine. We are working with various community stakeholders statewide and are actively pursuing state policy that will help to address the problem. We are committed to the safe and accessible care of our pregnant patients and their families, no matter where they live. We will strongly support efforts by the Commission that will maintain birthing units in rural Maine, and offer our partnership in the endeavor.

Sincerely,

Marya R. Goettsche Spurling, MD, FAAFP

On behalf of the Board of Directors, Maine Academy of Family Physicians

Commission to Evaluate the Scope of Regulatory Review and Oversight over Health Care Transactions That Impact the Delivery of Health Care Services in the State

Additional Written Comments

Submitted to Commission on October 8, 2025 after 8:00 am

PACIFIC LEGAL FOUNDATION

October 8, 2025

Statement of Support for Certificate of Need Reform

To the Members of the Commission to Evaluate the Scope of Regulatory Review and Oversight over Health Care Transactions that Impact the Delivery of Health Care Services in Maine:

My name is Jaimie Cavanaugh, and I am State Policy Counsel at Pacific Legal Foundation (PLF). PLF is a nonprofit, public interest law firm dedicated to defending Americans' liberties when threatened by government overreach and abuse. Since its founding more than 50 years ago, PLF has been helping Americans preserve their constitutional rights in courthouses and legislatures across the country.

PLF has secured 18 victories at the United States Supreme Court, and helped enact more than 50 laws in legislatures across the country. As part of this work, PLF represents health care providers around the country who want to provide high-quality, safe care, but are unable to do so because of overly burdensome laws or regulations.

Over the past several years, I have become a national certificate of need (CON) policy expert. In 2020, I was the lead author of a survey of CON laws around the country[1] and in 2023, I published a review of every academic-quality study of CON[2] with co-author economist Matthew D. Mitchell (Ph.D). We found that 89% of tests of CON laws show that CON laws result in a negative or neutral result. The results overwhelmingly show that CON laws fail to provide any benefits to the public such as decreasing healthcare costs, increasing access to care, or increasing healthcare quality.

This Commission should consider robust CON reform

This is an initial letter in support of CON reform in Maine. More thorough testimony will follow. As this Commission decides the scope of its review, it should be aware that Maine is becoming an outlier in the region by *not* reforming its CON laws.

In 2025, D.C.,[3] New York,[4] and Vermont[5] significantly reformed their CON laws. These jurisdictions raised the capitol spending triggers, meaning facilities that cost less than a set minimum can now open without going through the arduous CON application process. Specifically, Vermont increased its threshold for healthcare facilities from

[1] *See* https://ij.org/report/conning-the-competition/
[2] *See* https://ij.org/report/striving-for-better-care/
[3] https://lims.dccouncil.gov/Legislation/B26-0025
[4] https://www.jdsupra.com/legalnews/new-york-adopts-certificate-of-need-4172648/
[5] https://legislature.vermont.gov/bill/status/2026/H.96

$1.5 million to $10 million and D.C. increased its threshold for healthcare facilities from $6 million to $15 million.

Connecticut[6] and Vermont[7] also took positive steps to increase access to maternal healthcare by repealing CON for birth centers. In 2024, Massachusetts[8] streamlined application procedures, but left its substantive restrictions in place. And in 2025, Rhode Island Governor McKee promoted CON reform in his budget, but those reforms have not been adopted by the legislature yet.

Additionally, Maine's only border state, New Hampshire repealed CON in 1996 and its residents are reaping the benefits of shorter wait times for medical appointments and lower costs. A recent article featured on yahoo explained that Massachusetts doctors are sending patients to the Granite State for imaging services because New Hampshire facilities offer fast appointments at lower prices.[9]

If this Commission is serious about increasing access to healthcare in Maine and decreasing healthcare costs, it must recommend large-scale CON reforms or full repeal. Montana (2021),[10] South Carolina (2023),[11] and Oklahoma (2024)[12] all recently repealed CON for everything except long-term care. Today, 40% of the nation's population live in a state with zero or very limited CON laws. Maine should join their ranks.

I am looking forward to participating in future meetings and providing more testimony to this Commission. Thank you for your consideration and please feel free to reach out with any questions.

Respectfully,

JCA

Jaimie Cavanaugh
Legal Policy Counsel
jcavanaugh@pacificlegal.org
cell: 248-895-1555

[6] https://www.cga.ct.gov/2023/act/pa/pdf/2023PA-00147-R00SB-00986-PA.pdf
[7] https://legislature.vermont.gov/bill/status/2026/S.18
[8] https://malegislature.gov/Bills/193/H4653
[9] https://www.yahoo.com/news/articles/massachusetts-doctors-sending-patients-hampshire-090054537.html?guccounter=1&guce_referrer=aHR0cHM6Ly93d3cuZ29vZ2xlLmNvbS8&guce_referrer_sig=AQAAACFi-R8adya-vG2ERkPdVmRCPYLsZWq46YSiji-MbBnhRiGH3DByUKu-pgGWGVvhpeSgyOxqyFEEyJYGs1-WUg0bas1Lw2eoKs68R-GeJEhGHzuvTKeAm7PX9EVbfKPL5mG4Zgr8HU2UfsRYIELmVAZkK11TYaTF8T5zwFeHAR_W
[10] https://archive.legmt.gov/bills/2021/billpdf/HB0231.pdf
[11] https://www.scstatehouse.gov/sess125_2023-2024/prever/164_20230503.htm
[12] https://www.oklegislature.gov/BillInfo.aspx?Bill=HB2330&Session=2400

PACIFIC LEGAL FOUNDATION

October 8, 2025

Supplement to Statement of Support for Certificate of Need Reform

To the Members of the Commission to Evaluate the Scope of Regulatory Review and Oversight over Health Care Transactions that Impact the Delivery of Health Care Services in Maine:

This is a follow up in response to Representative Foley's question. Here are two literature surveys that review all known certificate of need (CON) studies. Both contain appendices that summarize the findings of each academic study:

1. Mitchell, Matthew D. "Certificate-of-Need laws in healthcare: A comprehensive review of the literature." *Southern Economic Journal* 92.1 (2025): 6-43. Attached.[1]

2. Cavanaugh, Jaimie and Matthew D, Mitchell. "Striving for Better Care: A Review of Kentucky's Certificate of Need Laws." *Institute for Justice*. (August 2023).[2]
    a. Note that although the title mentions Kentucky, the second half of the publication is a general literature review and is not specific to Kentucky.

Here is another recently published piece that contains a more thorough discussion of the historical basis for CON laws.

3. Mitchell, Matthew D. "Certificate of need laws in health care: Past, present, and future." *INQUIRY: The Journal of Health Care Organization, Provision, and Financing* 61 (2024).[3]

Finally, here is a recent journal article showing that rural areas benefitted *most* from CON repeal for ambulatory surgical centers with no negative effects for existing rural hospitals.

4. Stratmann, Thomas, Markus Bjoerkheim, and Christopher Koopman. "The causal effect of repealing Certificate-of-Need laws for ambulatory surgical centers: Does access to medical services increase?." *Southern Economic Journal* 92.1 (2025): 63-86. Attached.[4]

[1] https://doi.org/10.1002/soej.12698
[2] https://ij.org/report/striving-for-better-care
[3] https://doi.org/10.1177/00469580241251937
[4] https://doi.org/10.1002/soej.12710

I am looking forward to participating in future meetings and providing more testimony to this Commission. Thank you for your consideration and please feel free to reach out with further questions.

Respectfully,

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SYMPOSIUM ARTICLE

Southern Economic Journal WILEY

Certificate-of-Need laws in healthcare: A comprehensive review of the literature

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Abstract

Certificate-of-Need (CON) laws limit the supply of healthcare services in about two-thirds of U.S. states. The regulations require those who wish to open or expand their facilities to first prove that their services are needed. Once encouraged by the federal government, Congress eliminated the inducement in the 1980s and since then several states have either pared their CON programs back or eliminated them altogether. To date, there have been 128 academic assessments of CON laws and together these papers contain over 450 tests. In this paper, I review this literature, organizing the results around the most common rationales for CON laws. The accumulated evidence is overwhelming that CON laws do not achieve their purpose. Instead, the balance of evidence suggests that these regulations increase spending, reduce access to care, undermine quality, and fail to ensure care for underserved populations.

KEYWORDS

Certificate of Need, healthcare, regulation

JEL CLASSIFICATION

I11, I18, H75

1 | INTRODUCTION

A Certificate-of-Need (CON) law requires anyone hoping to open a new facility, expand an existing facility, or acquire certain equipment to first prove to a regulator that the new capacity is

needed. Though the laws date back to the first decades of the 20th century and have been applied to various markets, New York was the first state to adopt a CON law in healthcare in 1964 (McGinley, 1995). A decade later, the federal government enacted the National Health Planning and Resources Development Act (NHPRDA), which encouraged states to adopt CON regulations by threatening to withhold federal funds from any state without such a program (NHPRDA, 1975). The threat never materialized as Congress repeatedly postponed the financial penalty (Conover & Bailey, 2020, p. 2). But the Act achieved its goal of encouraging state CON programs: By the 1980s, nearly every state in the country had instituted a CON program in healthcare (Mitchell et al., 2021).

The intellectual origins of healthcare CONs date to 1959, when UCLA health researcher Milton Roemer published a coauthored study reporting a positive correlation between the number of hospital beds available per capita and the number of used hospital days per capita (Shain & Roemer, 1959). The finding became known as "Roemer's Law" and was shortened to the pithy characterization that "in an insured population, a hospital bed built is a hospital bed filled (Page, 2001)." The phenomenon can be characterized as an example of supplier-induced demand, in which physicians use their informational advantage to encourage unneeded care. Auster and Oaxaca (1981) have argued that in the absence of supplier-induced demand, the "only purpose [of CON] is to prevent competition through which the efficient may take business away from the nonefficient" (Auster & Oaxaca, 1981, p. 340).

In encouraging CON, lawmakers hoped hospitals would acquire fewer beds, fill them with fewer patients, and spend less money. The main purpose of CON, therefore, was to reduce healthcare expenditures by rationing care. The authors of the NHPRDA also apparently believed that CON would restrain spending by encouraging "the use of appropriate alternative levels of healthcare, and for the substitution of ambulatory and intermediate care" which, presumably, would be less-costly than other modes of care (NHPRDA, 1975, 88:2). Beyond costs and expenditures, the authors of the NHPRDA also hoped to ensure an adequate supply of care, especially for "underserved populations," including "those which are located in rural or economically depressed areas" (NHPRDA, 1975, 88:3). Finally, they hoped to "achieve needed improvements in the quality of health services" (NHPRDA, 1975, 88:4). These goals—cost containment, greater access (especially for underserved populations), and quality improvement—continue to be widely-shared aims of health policy. They also constitute convenient buckets into which the empirical CON research can be sorted.

If the NHPRDA had been Congress's last word on CON, then research on the regulation's effects might have come to an end once CON was universally adopted. By the mid-1980s, however, Congress had concluded that CON laws were not achieving their goals and so the federal CON mandate was repealed in 1986 (Pub. L. 99-660, § 701, 100 Stat. 3799, 1986). Almost immediately, 12 states eliminated their CON programs and, in time, others followed suite. Over time, the trend has been for states to gradually pare their programs back either by eliminating CON requirements for certain categories of medical equipment, by raising the dollar threshold at which a CON is required, or by exempting certain areas, such as rural counties, from the requirement. This history has yielded wide variation in CON regulation across time and states (Mitchell et al., 2021). And this, in part, explains why CON laws have been so widely studied.

2 | CON TODAY

Today, 39 states and the District of Columbia require a CON for at least one healthcare service or technology.[1] In many of these states, however, the CON regime is quite limited. For example, Arizona, Minnesota, and New Mexico only require CONs for ambulance services. Indiana, Montana, Ohio (and soon, South Carolina) only require CONs for nursing homes.[2] Hawaii, which requires a CON for 28 services and technologies, regulates more activities than any other state.

The most-common CON requirement is for nursing home beds, found in 34 states (including DC). The next-most-common requirements are for psychiatric services (31 states), new hospitals (29 states), and intermediate care facilities for those with intellectual disabilities (28 states). The least-common CONs are for ultrasounds (required in 2 states) and subacute services (only regulated by Illinois).

In about half of CON states, the decision to grant a CON is made by a board whose members are appointed by the governor; in the rest, the decision is made by governor-appointed officials. Employees of incumbent providers are typically allowed to serve on this board, earning the regulation the moniker "competitor's vetoes" (Ohlhausen & Luib, 2015; Sandefur, 2015). In all but six CON states, incumbent providers are allowed to participate in the CON process and object to the application of a would-be competitor.[3] Even when competitors do not object, statutes and regulations typically require regulators to deny CONs if they believe the applicant's services will duplicate an existing service, virtually guaranteeing a local monopoly.

We lack systematic data on application costs, the length of review, or approval rates. And all of these factors would be good candidates for future study. Anecdotal evidence suggests, however, that the CON process is typically long and expensive. It can take years and can cost providers tens or even hundreds of thousands of dollars in opportunity costs (Hoover, 2012). One analysis found that the approval in Virginia was 51%, in Georgia it was 57%, and in Michigan it was 77% (Stratmann & Monaghan, 2017). Another found that when Georgia competitors object to an application it adds about 520 days to the wait time for a final decision, while each additional party who objects adds another 129 days (Denson & Mitchell, 2023).

3 | METHODS

The goal of this study is to identify and classify every peer-reviewed original empirical analysis of healthcare CON laws. To identify relevant papers, I relied on previous overviews,[4] internet

[1]Some states, such as Wisconsin, cap the total number of pieces of equipment. For example, they may cap the total number of beds in the state at 20,000. If the cap is set low enough it will be *more* restrictive than a CON regulation because there is no way for a provider to request to exceed the cap. If, on the other hand, the cap is set high enough (as is currently the case in Wisconsin), then the cap will be non-binding. Some researchers treat caps as equivalent to CONs. But given the fact that most caps are currently non-binding, I will ignore these regulations for the remainder of this piece.

[2]On October 3, 2023, South Carolina Governor Henry McMaster signed Senate Bill 164. It immediately eliminated the CON requirement for all services except for hospitals and nursing homes. The requirement for hospitals will be phased out over 3 years, though it will not be enforced in counties that currently lack hospitals.

[3]These are Indiana, Louisiana, Michigan, Nebraska, New Jersey, and New York. For more details, see Cavanaugh et al. (2020, 4, 61, 75, 89, 117, 131).

[4]Conover and Bailey's (2020) review was especially helpful.

and library search engines, and helpful suggestions from others.[5] I primarily focused on academic publications, but I also included a handful of academic-quality analyses by government agencies such as the Federal Trade Commission that appeared to have gone through a peer-review process. I only focused on original empirical analyses; I ignored literature reviews or studies that employed previous estimates to illustrate the effects of CON. I made no judgments about the quality of the empirical tests, though by only including peer reviewed material, I believe my approach ensured a minimal threshold for quality.

Most studies included more than one test of CON and so my unit of observation is each empirical test, rather than each paper. This allows me to characterize the literature in more detail and to avoid using the vague catch-all "mixed results" if a paper has multiple regressions, some positive and some negative. I do often code results as "negligible or insignificant," however. In these cases, I rely on the authors' assessments to make these judgments about economic and statistical significance. In some cases, it was not always clear how one can define a distinct "test" and I did have to use some discretion. My general approach was to define a test as a unique dependent and independent variable combination, without regard to mathematical transformation. For example, if a paper reported a regression of the form $Y = a + b$*CON and another regression of the form $\ln(Y) = a + b$*CON, then I just considered this as one test since the underlying variables were identical in both tests.

As the analysis proceeded, it became clear that there were certain patterns to the literature and the patterns that emerged helped inform the organization of this review. Occasionally, some tests fit a pattern without the author's knowing or emphasizing it. For example, some papers assess the effect of CON on efficiency by looking at output/input. In these tests, a higher output/input is generally interpreted as a "good" result because it implies greater technical efficiency. In my own test of bed shortages during COVID, coauthored with Thomas Stratmann, we found that there were higher bed utilization rates in CON states than in non-CON states (Mitchell & Stratmann, 2022). At the time, we did not view this as a "good" result, focusing instead on the fact that hospitals were more likely to run out of beds in CON states than in non-CON states. Nevertheless, since several other authors interpret higher output/input to be a good result, I feel compelled to categorize our finding as such to be consistent.

Finally, I should note that this approach does lead to some double counting. For example, one way that authors assess quality is to see if CON is associated with a costly or unwarranted treatment. If a paper finds that CON encourages an unwarranted treatment then I will code it as being associated with greater utilization of a procedure (good) *and* lower quality (bad), even though there was only one empirical test involved.

4 | RESULTS

My approach identifies 128 papers that together contain 458 tests.[6] The bulk of these tests focus on the four aims of CON identified in the NHPRDA: reducing spending, increasing access,

[5]Angela Erickson of the Pacific Legal Foundation generously shared a quite helpful spreadsheet with many references. If you are aware of any articles that I have missed, please share them with me: matthew.mitchell1@mail.wvu.edu.

[6]For full coding see: https://docs.google.com/spreadsheets/d/1-xZKWcEzqnptxPtkS7h6_EwapMfwub_o/edit?usp=sharing&ouid=102779922122058875161&rtpof=true&sd=true.

enhancing quality, and encouraging care for underserved populations. My summary begins with those four categories. To these we can add one other area of the literature with an obvious normative interpretation: The effects of CON on competition. Then I turn to several sets of tests with less obvious (but still interesting) normative implications. These tests focus on provider volume, provider profits, and the political economy of CON. For the sake of brevity, I will not detail the results of each test in the body of this paper but I do report them in the Table A1.

Before digging into the specific subcategories of the literature, however, let me briefly summarize the broad results of those tests that have relatively obvious normative implications.[7] Figure 1 summarizes these tests. It shows that among 433 tests with an obvious normative implication, a slight majority (212) associate CON with a "bad" outcome. These bad outcomes include higher spending, less access, lower quality, diminished care for underserved populations, or less competition. The next-most-common result, found in 157 tests (36%) was a neutral or insignificant result. Finally, 54 tests (12%) associate CON with a "good" outcome such as less spending or higher quality. Tests associating CON with a bad outcome are four times more common than tests associating CON with a good outcome. With these broad patterns established, I now turn to more specific findings, starting with spending.

4.1 | CON and spending

Do CON laws restrain spending? The first stated aim of CON was to reduce spending. In total, 107 tests assess the effect of CON on spending. But authors approach question in three different ways: spending per service, which I will denote by the shorthand $/Q; spending per person, or $/capita; and efficiency, as measured by output/input. I will take each in turn.

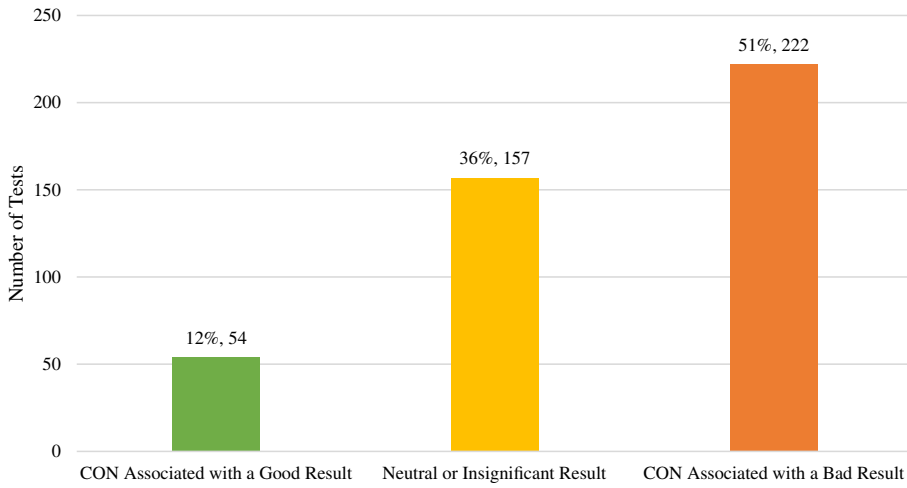

FIGURE 1 Summary of tests with an obvious normative implication. [Color figure can be viewed at wileyonlinelibrary.com]

[7]As will become clear, I don't always agree with the normative interpretations here. But enough researchers evidently do that it is relatively straightforward to categorize results as "good," "bad," or "neutral."

4.1.1 | CON and spending per service rendered ($/Q)

Forty-five tests assess the effect of CON on charges, reimbursements, prices, or per-unit costs. What sets these tests apart from others is that they look at spending *per service rendered*, or $/Q. This is an intuitive way to think about spending because it is analogous to a market price, which is expressed in per-unit or per-service terms. It is also a normatively appealing way to assess the regulation because we typically want to know the financial sacrifice per service rendered.

Standard economic theory offers two reasons to suppose that CON regulation might increase spending per service. First, CON is a supply restriction. As Ford and Kasserman explained nearly three decades ago, "the economic effect [of CON] is to shift the supply curve of the affected service back to the left," and "the effect of such supply shifts is to raise... [the] equilibrium price" (Ford & Kaserman, 1993, pp. 783–784). Second, because of its anticompetitive properties, CON seems likely to permit some degree of pricing power. The empirical literature on spending per service, summarized in Figure 2, is consistent with these expectations.

Among the 45 tests that assess the effects of CON on spending per service, 27 of them—60%—find CON is associated with higher spending per service. Just three tests (7%) associate CON with lower spending per service. Fifteen tests (33%) find insignificant or negligible results. For every test associating CON with lower spending per service, there are nine associating it with higher spending per service.

4.1.2 | CON and spending per capita ($/capita)

Fifty-two tests assess the effect of CON on spending per patient or per person ($/capita). If $/Q is analogous to a market price, then $/capita is analogous to total expenditures, adjusted for the population.[8] That is, it indicates the total amount spent, irrespective of the quantity of services rendered. The $/capita metric seems to align with the initial goals of CON advocates. And in

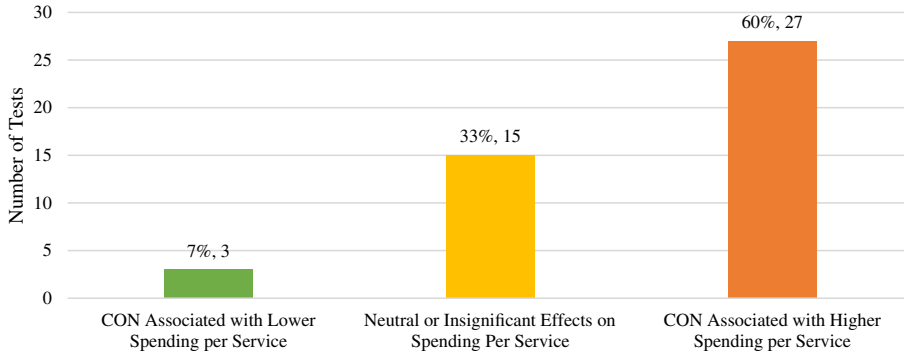

FIGURE 2 Tests assessing the effect of CON on spending per service ($/Q). [Color figure can be viewed at wileyonlinelibrary.com]

[8]In some cases, the line between $/Q and $/capita is not obvious. This is especially true in the case of home health agencies, where the quantity of services rendered is often measured in patient days. In these cases, I coded these as $/capita studies, though others might as easily consider them $/Q studies.

contrast with $/Q, it is more plausible that CON might reduce $/capita. After all, an extremely restrictive CON that did not permit *any* healthcare resources, would result in $0/capita. Under less extreme regimes, we can expect CON to reduce $/capita in cases where the service in question is elastically demanded. In this case, the Q-reducing effect of CON will dominate the $/Q-increasing effect of CON (Bailey, 2018a; Bailey & Hamami, 2019; Ford & Kaserman, 1993; Mitchell, 2016). Most healthcare services, however, are thought to be inelastically demanded (Ringel et al., 2002). So even this theoretically possible effect of CON seems unlikely.

In contrast with the $/Q metric, the $/capita metric has a weaker connection to welfare. A reduction in expenditures per capita is only desirable in cases where marginal services are unwarranted or not cost-effective. As we will see when we consider the quality literature below, this is sometimes the case. However, CON is often applied to procedures and technologies that are thought to be desirable on the margin such as burn care, psychiatric care, substance abuse services, neo-natal intensive care, and hospice care. In short, while less spending per *service* is clearly desirable, it is not always the case that less spending per *person* is desirable. With these caveats in mind, let's turn to the data.

Figure 3 summarizes this subset of the literature. Among the 52 tests, the most-common finding, obtained in 23 tests (44%), associated CON with greater spending per capita. The next-most-common finding is a negligible or insignificant result (21 tests, 40%). Finally, eight tests, representing 15% of the sample, associate CON with lower spending per capita. For each test associating CON with less spending per person there are about three that associate it with more spending per person.

4.1.3 | CON and efficiency (output/input)

Ten tests assess the effect of CON on efficiency as measured by output/input. These tests look at whether inputs such as labor or capital are more intensely used in the presence of the regulation. Theory offers no clear prediction with these tests. On one hand, by limiting the number of healthcare resources, CON might result in greater utilization of each resource, permitting providers to realize economies of scale. On the other, by undermining competition, CON might make providers inattentive to cost containment, resulting in greater x-inefficiency (Leibenstein, 1966; Robinson, 2011; Stensland et al., 2010). Like spending per capita, this metric

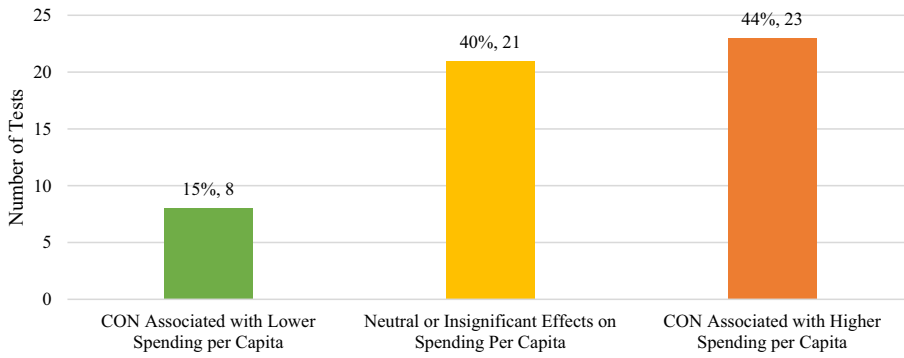

FIGURE 3 Tests assessing the effect of CON on spending per capita ($/Capita). [Color figure can be viewed at wileyonlinelibrary.com]

is also not an especially useful gauge of welfare, but it does give us a sense of how CON affects technical (if not economic) efficiency. The empirical literature, shown in Figure 4, reflects this ambiguity. Four tests associate CON with greater output/input. Four associated it with lower output/input, and two tests find negligible or insignificant results.

4.1.4 | Summary of CON and spending

Overall, the results cast doubt on the main rationale for CON. Most tests associate CON with either more spending or less efficiency and for every one test that associates CON with better spending outcomes, there are nearly four that associate it with worse outcomes. What's more, the results are more mixed in the $/capita and output/input tests where the normative interpretation is weakest but more consistently bad in the $/Q tests where the normative implications are clearest.

4.2 | CON and access

Do CON laws improve access to care? This is the most-studied effect of CON. In total, 190 tests examine whether CON laws impede or enhance access to care. The literature takes two distinct approaches to this question, however: "availability tests" and "utilization tests."

4.2.1 | CON and availability of services

Eighty-three tests measure access by looking at the availability of healthcare services. Some count the number of service providers or units of medical technology per capita. Some measure how far patients must travel to obtain care or how long patients must wait until they can be served. The important distinction with these tests is that they look at the availability of healthcare services, not at whether these services are used.

The theoretical expectation here is *relatively* straightforward. As a supply restriction, one would expect CON to reduce the overall availability of healthcare resources. It is possible,

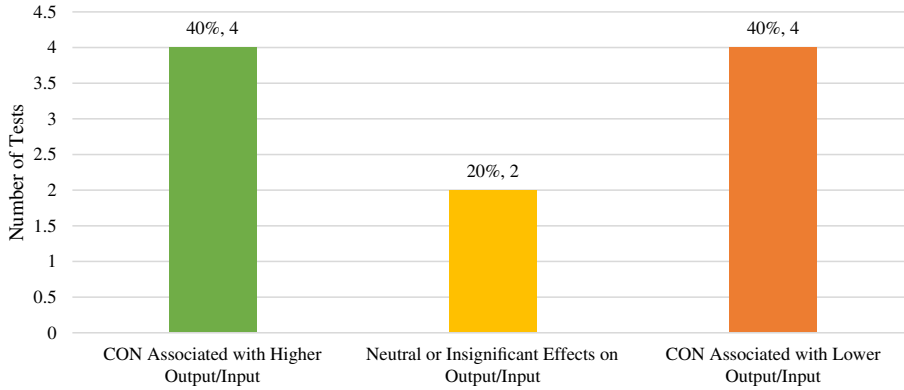

FIGURE 4 Tests assessing the effect of CON on output/input. [Color figure can be viewed at wileyonlinelibrary.com]

however, to imagine scenarios in which CON might increase the availability of *some* specific resources. For example, if CON applies to certain technologies or capital expenditures and not to others, or if regulators are more restrictive with some investments than others, then we might expect to see the latter become more available.

Note that this possibility is consistent with both the public interest theory and the special interest theories of regulation. On the one hand, publicly spirited regulators might throttle costly or ineffective care in hopes of encouraging more efficient or effective modes. On the other, special interests might seek to restrict their competition or raise their rivals' costs and this might make the special interest's services relatively more abundant (Salop & Scheffman, 1983; Tullock, 1967).

As shown in Figure 5, the empirical literature on CON and availability of care is lopsided. Of the 83 tests, 65 (78%) associate CON with diminished availability of services. Twelve tests (14%) find negligible or inconclusive results. And just six tests (7%) associate CON with greater availability of resources.

4.2.2 | CON and the utilization of services

The other common way to assess access is to see if CON correlates with the utilization of services. Here, too, it is reasonable to expect CON will tend to reduce the utilization of services by restraining supply. As with availability, though, it is possible that CON may increase the utilization of some services if it restrains the use of substitutes. Moreover, because healthcare is inelastically demanded, patients may still seek care even if it is costly or difficult to obtain. The results, shown in Figure 6, are consistent with this ambiguity. In total, 107 tests assess the effect of CON on utilization of services, and 60 (56%) find negligible or statistically insignificant effects of CON on utilization. Thirty-four tests (32%) associate CON with diminished utilization of services. And 13 tests (12) associate CON with increased utilization of services.

4.3 | CON and quality

Do CON laws improve the quality of care? CON advocates often make the case that CON ensures quality. How? The most-common rationale relates to the quality-volume relationship.

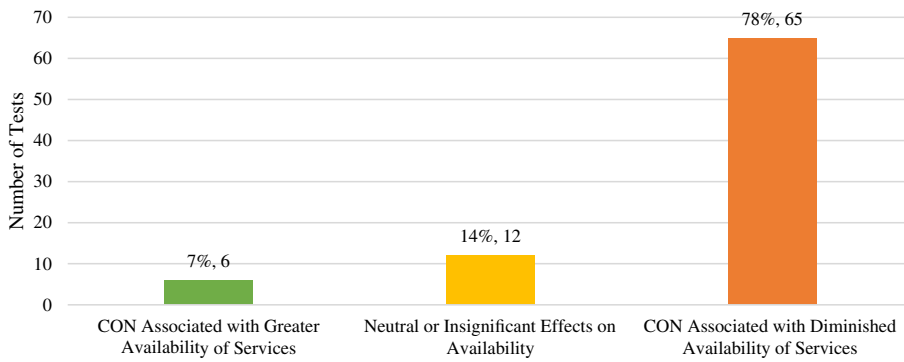

FIGURE 5 Tests assessing the effect of CON on availability of services. [Color figure can be viewed at wileyonlinelibrary.com]

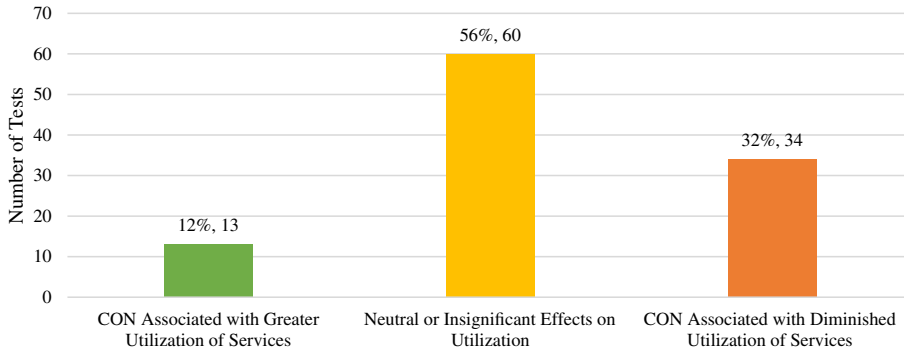

FIGURE 6 Tests assessing the effect of CON on utilization of services. [Color figure can be viewed at wileyonlinelibrary.com]

It is well documented that providers who frequently perform a procedure tend to get better at it (it is possible, of course, that causality could run in the opposite direction; especially competent providers may be in especially high demand). If CON results in fewer providers, and if each provider ends up doing more procedures, then it is possible that it might indirectly enhance quality. On the other hand, competition tends to enhance quality as well. And so it is possible that by undermining competition, CON will undermine quality. What do the data say?

One-hundred-and-fourteen tests assess the effect of CON on quality. One common technique is to see if CON correlates with outcome measures such as mortality rates, readmission rates, or infection rates. Another is to see if CON discourages the use of unwarranted procedures (in this case, what will be coded here as a "good" quality outcome will be coded above as a bad "volume" outcome). Figure 7 summarizes this literature. Of 114 tests, 52 (46%) associate CON with diminished quality of care. Fort-four (39%) find either neutral or insignificant effects of CON on quality. And 18 tests, (16%) associate CON with better quality.

Nearly three times as many tests associate CON with lower quality outcomes as with higher quality.

4.4 | CON and underserved populations

Do CON laws improve the provision of care for underserved populations? Though CON is a supply restriction, CON advocates believe that the regulation diverts healthcare resources from overserved populations to underserved populations. So far, there is no evidence for this.

Figure 8 summarizes the literature on CON and underserved populations. These tests look at whether CON has undermined the financing or provision of care to rural or otherwise underserved populations. There have been 17 tests in this category and of these, 14 (82%) associate CON with weaker provision of care to underserved populations while 3 (18%) find no significant effects. No tests associate CON with enhanced provision of care for underserved populations.

4.5 | CON and competition

The final set of tests with normatively clear implications address the effect of CON on competition. These tests usually measure the degree of competition with the Herfindahl–Hirschman

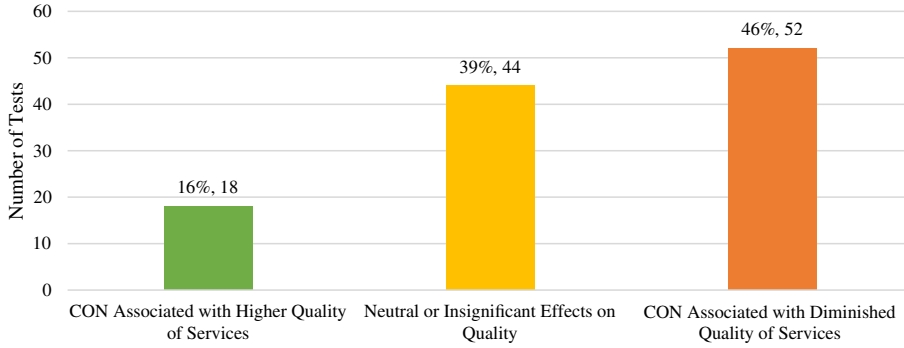

FIGURE 7 Tests assessing the effect of CON on quality of care. [Color figure can be viewed at wileyonlinelibrary.com]

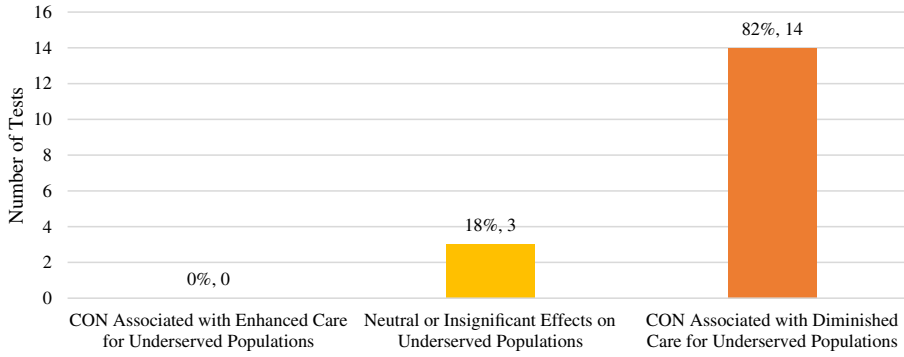

FIGURE 8 Tests assessing the effect of CON on underserved populations. [Color figure can be viewed at wileyonlinelibrary.com]

Index. Among five tests, three associate CON with less competition and two associate it with more competition.

4.6 | CON and provider volume

So far it has been relatively easy to characterize results as "good," "neutral," or "bad." Now I turn to a set of tests that are not so easily characterized. The first of these is provider volume. These tests assess whether CON increases or decreases the average provider's volume of services. By limiting the number of providers, we would expect CON to lead to higher volumes by provider. Some scholars *infer* that this is a good result because it might allow providers to achieve economies of scale or to improve their quality through repetition. These outcomes, however, are better measured directly through the tests summarized above.

Among 20 tests, 17 (85%) associate the regulation with greater provider volume. Two tests find neutral or negligible results and another associates CON with diminished provider volume.

4.7 | CON and provider profits

Are CON laws profitable? As a barrier to entry, one would expect CON laws to lead to higher profits among incumbent providers in the short run. These incumbent providers vigorously lobby against any proposals to repeal CON, and this, too, suggests that the laws are profitable (or at least that providers believe them to be so). Political economists, however, have long noted that contrived privileges only offer above-normal returns in the short run (Tullock, 1975). Competition can occur along multiple margins and barriers to entry rarely succeed in covering all of these margins. Over longer periods, providers may expend costly resources seeking CONs, opposing the CONs of their competitors, and maintaining the CON process itself. These costs may erode the extra-normal profits conferred by CON (Tullock, 1967, 1980).

This is a relatively understudied phenomenon. There have only been three papers assessing the effect of CON on profitability and together they contain four tests. Among the four tests, three associate CON with diminished profitability while one associates it with enhanced profitability. Together, the results suggest that, if anything, CON depresses rather than enhances hospital profitability. But we should be cautious with these results given how limited this subcategory of the literature is.

4.8 | The political economy of CON

A small but interesting subset of tests examine the political economy of CON laws. These tests are idiosyncratic and their results are not easy to aggregate. Teske and Chard (2004) study the factors that make a state likely to retain its CON law, making this paper one of the few that study CON as a dependent variable.[9] They find that CON laws were more likely to be retained in states with more Democrats in the upper and lower houses, higher hospital costs, more affluent and better-educated citizens, fewer physicians, and stronger hospital interests. Eichmann and Santerre (2011) study the degree to which hospital executives capture the rents generated by CON laws, finding that urban CEOs earn $91,000 more in CON than in non-CON states. Finally, Stratmann and Monaghan (2017) study whether political action committee (PAC) contributions affect CON approval rates in three states. They find that a 1% increase in PAC contributions from an applicant firm is associated with 6.7% greater odds of approval in Georgia, 1.8% greater odds of approval in Michigan, and 3.6% greater odds of approval in Virginia.

5 | DISCUSSION AND CONCLUSION

The state experiment with CONs in healthcare began in New York in 1964. A decade later, federal legislators encouraged the regulation through the National Health Planning and Resources Development Act of 1974. The federal inducement was eliminated in the mid-1980s, however, and since then about a third of states have repealed their health care CON laws and others have pared their programs back.

[9]Note that because they find that CON is positively related to hospital costs and negatively related to the number of physicians, I have included this paper in the previous sections and coded it as indicating CON is associated with higher $/Q and lower availability of healthcare.

Few state policy experiments have been as thoroughly examined as CON laws in healthcare. I have identified and coded 128 papers that together contain over 450 tests. The bulk of these address the stated goals of the regulation, assessing the effect of CON on spending, access, quality, and underserved populations. Other tests assess the effect of CON laws on competition, provider volume, and profits. And others assess the political economy of CON laws.

The balance of research suggests that CON laws do not achieve their stated goals. There is little evidence that they restrain spending, increase access, enhance quality, or improve the provision of care to underserved populations. In fact, the most-common finding is that CON laws undermine each of these goals. For every test associating CON with a "good" outcome, there are more than 4 that associate it with a "bad" outcome.

These findings are consistent with standard economic theory. They suggest that CON laws are barriers to entry that enhance the business of incumbent providers, increase costs, and limit access to care. These barriers likely enhance the profits of incumbent providers in the short run but not necessarily in the long run.

Though CON laws have been exhaustively studied, there are some understudied aspects of the regulation. First, CON law data is fragmentary and inaccessible. Though there have been hundreds of tests assessing the effect of CON laws, the data that these researchers have collected largely remains private. Future researchers would make a mighty contribution to the public good simply by collecting and posting their panel data on CON laws.

Second, while there have been some attempts to measure the stringency of CON laws, these tests have been relatively rare. Here again, it would be helpful if future researchers collected and disseminated data on approval rates, thresholds, and wait times. Though more difficult, it would be especially helpful to know the compliance and opportunity costs involved in seeking a CON. How much revenue is forgone in the CON process? How many patients are not served while providers navigate the process? And how many providers are discouraged by these costs and fail to even apply? In some cases, qualitative case studies may be better at answering these questions than large cross section time series data analyses.

Third, little is known about the political economy of CON laws. To my knowledge, no one has studied whether the institutional environment affects CON decisions. For example, are CON applications more likely to be granted in states where the decisionmaker is a board rather than an administrator? Does the composition of the board make a difference? Do regulatory guidelines make a difference? We have some data that suggests that politically active applicants are more likely to be successful in seeking CONs (Stratmann & Monaghan, 2017). Does the applicant's size, profitability, employment, nonprofit status, location, or political connections matter? Though one study (Teske & Chard, 2004) has examined why states retain their CON laws, it is now nearly two decades old and it may be time to revisit this question. This area is especially ripe for investigation given several high-profile proposals to eliminate or pare back CON programs in several states in recent years.

Finally, while the "public interest" theory of CON has been well studied (and found lacking), the "special interest" theory of CON has been relatively understudied. Which interests benefit from CON laws? And which interests benefit from their repeal? How do CON laws affect employment and compensation in different health sectors? In many states, boutique consulting firms profit by shepherding providers through the CON process. To my knowledge, these entities have been entirely unstudied.

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APPENDIX

TABLE A1 Summary of all direct tests of CON.

Paper	Summary
Hellinger (1976)	CON legislation induced hospitals to increase investments before CON took effect. He interprets this as a bad result. I code it as increasing access (in the short run).
Salkever and Bice (1976)	CON does not decrease investment but does change its composition.
Salkever and Bice (1979)	They assess the effect of CON on a cross section, time series data set cover all states from 1968 to 1972. They find that CON is associated with: (1) At best, a modest reduction in total spending per capita, (2) A small increase in average inpatient cost per inpatient day, (3) Reduced inpatient days per capita.
Sloan and Steinwald (1980)	Comprehensive CON programs have no effect on hospital expenditures per patient day, while noncomprehensive programs increase hospital expenditures by 5% per patient day.
Joskow (1980)	CON reduces bed supply by about 6% and makes it more likely that a hospital will turn away patients.
Coelen and Sullivan (1981)	Though their primary interest is in prospective reimbursement programs, they also included CON as a covariate. They find no evidence that CON reduces spending per patient day, per admission, or per capita, and some evidence that it increases expenditures. In about half the states they find evidence that it is associated with higher spending per patient day, per admission, and per capita.
Sloan (1981)	He studies the effects of both mature and new CON regulations on hospital costs and profits. He finds: (1) Total expense per admission was lower in the years after CON was implemented for part of the period studied, (2) Expense per adjusted admission was not statistically significantly different after CON was implemented, (3) Expense per patient day was not statistically significantly different after CON was implemented, (4) Expense per adjusted patient day was not statistically significantly different after CON was implemented, and (5) Profits were lower after CON was implemented.
Eastaugh (1982)	He finds CON has: (1) A marginally significant, positive effect on change in plant assets (percentage and log), which he interprets as a negative result, (2) No statistically significant effect on change in beds (percentage and log), which he interprets as a negative result, and (3) A significant, positive effect on change in plant assets per bed (percentage and log), which he interprets as a negative result.
Cromwell and Kanak (1982)	Their primary focus is on prospective reimbursement programs and their effect on the diffusion of services, but they use CON as a control variable and find that it has no effect on the diffusion of services.

TABLE A1 (Continued)

Paper	Summary
Lee et al. (1983)	The paper assesses the effect of various policies on nursing home behavior using the 1973 National Nursing Home Survey. Of relevance here, they find that CON is associated with: (1) Higher operating costs per patient day, and (2) Higher average annual occupancy.
Sloan (1983)	His primary interest is the effect of rate regulation on hospital costs, but he includes CON as a control. His measures of spending are total hospital expense per admission, per "adjusted" admission (adjusted for hospital outpatient activity), per patient day, per adjusted patient day, and per length of stay. He finds no evidence that CON reduces spending per patient.
Ashby (1984)	He assesses the effect of CON and other regulatory programs on five outcomes. His unit of analysis is each state in each year from 1971 to 1977. He finds that: (1) CON is associated with statistically significant positive growth in hospital costs per capita, (2) CON has no statistically significant effect on percentage change in average length of stay, (3) CON has no statistically significant effect on percentage change in total admissions per capita, and (4) CON has no statistically significant effect on percentage change in plant assets.
Gertler (1985)	He finds that under a binding CON capacity constraint, increases in Medicaid rates are associated with lower quality in New York state nursing home facilities.
Anderson and Kass (1986)	They examined the effect of CON on economies of scale and cost in the home healthcare industry. They find: (1) Costs are 2% higher in CON states relative to non-CON states, (2) No substantial economies of scale in the home health industry overall, and (3) No difference in economies of scale in CON and non-CON states.
Noether (1988)	CON increases the average price and expense for several disease categories including: (1) Diabetes mellitus, (2) Cataract surgery, (3) Acute myocardial infarction, (4) Congestive heart failure, (5) Acute, cerebrovascular disease, (6) Pneumonia, (7) Respiratory system disease, other, (8) Inguinal hernia, (9) Diverticula of intestine, (10) Hyperplasia of prostate, and (11) Fracture of neck and femur.
Sherman (1988)	He estimates the effects of CON on cost functions using a sample of 3708 hospitals using data from 1983 to 1984. Though he uses the term costs, he is actually measuring operating expenditures. He finds that spending would fall by 1.4% if states relaxed CON by raising the thresholds at which it is applied.

(Continues)

TABLE A1 (Continued)

Paper	Summary
Shortell and Hughes (1988)	They examined the effect of CON (among other factors) on hospital quality, finding that the ratio of actual to predicted mortality rates among Medicare patients is 5%–6% higher in states with stringent CON regulation.
Mayo and McFarland (1989)	They study the effect of variation in CON approval in different service areas of Tennessee on the number of beds, finding it is associated with fewer beds. They also find that larger hospital size is associated with more spending and infer that CON is associated with lower average spending per patient day, though they do not directly measure it.
Swan and Harrington (1990)	They assess the effect of nursing home CONs on nursing home bed stock using cross-section, time-series data from 1981 to 1984. They find that: (1) Nursing home CONs constrain the bed stock, and (2) The greater the dollar amount of CON approvals per aged population (a measure of CON stringency), the greater the bed stock.
Eakin (1991)	CON hospitals are less efficient than non-CON hospitals.
Anderson (1991)	A reply to Mayo and McFarland's (1989) paper, he estimates the effects of CON (and the number of years it has been in effect) on average variable costs among 2069 general acute hospitals with 100 or more beds. He uses CON age as a measure of CON stringency under the theory that "the effect should increase the longer the regulation has been around." It enters the equation linearly and multiplied by the number of beds to see if CON has a different effect on large hospitals. He finds: (1) CON is associated with 10% higher variable costs, and (2) CON is associated with greater probability of a hospital having 100 or fewer beds.
Lanning et al. (1991)	They measure the effect of CON on hospital expenditures, finding that it is associated with 20.6% higher spending per capita.
Mayo and McFarland (1991)	This is a reply to Anderson's (1991) critique of their 1989 paper. Anderson worried CON might constrain hospitals on one dimension (say beds), but then cause them to substitute into other areas of spending (say labor). They tested this possibility and found mixed results. In a larger panel data set, they found support for Anderson's concern (CON increases spending) while in a 1984 cross-section they found support for their initial (implied) conclusion (CON decreases spending).
Ford and Kaserman (1993)	They assess the effect of CON on the number of dialysis clinics and stations, finding that it has limited new firm entry and total capacity.
Zinn (1994)	She examined the determinants of nursing home quality. One of her explanatory variables is nursing home construction moratoria. She finds these to be associated with lower RN staffing ratios and greater use of physical restraint.
Caudill et al. (1995)	They examine the effect of CON on the diffusion of hemodialysis, an effective and practical treatment for chronic renal failure. Their data span 50 states and 14 years. They find that CON regulation slows the spread of hemodialysis.
Antel et al. (1995)	They find that CON increases per-day and per-admission hospital expenditures but has no relationship to per capita hospital expenditures.

TABLE A1 (Continued)

Paper	Summary
Harrington et al. (1997)	In a two-stage least squares regression, they assess the effect of CON, and/or moratoria on the growth of nursing home beds and Medicaid nursing home reimbursement rates. They find: (1) CON has no effect on Medicaid nursing home reimbursement rates, and (2) CON reduces growth of beds.
Conover and Sloan (1998)	CON has no effect on total per capita health expenditures; there is no evidence of a surge in spending after repeal.
D'Aunno et al. (2000)	They study the market and institutional determinants of radical organizational change in rural hospitals. In particular, they study the factors that make a rural hospital likely to change to provide other types of services. They find that stronger CON regulation makes a rural hospital 8% less likely to change.
Robinson et al. (2001)	They examine the effect of CON elimination in PA (comparing it with NJ, which maintained CON), finding: (1) Open-heart surgery programs increased 25% following elimination of CON, (2) The total volume of CABG surgeries were unchanged following repeal, (3) Provider volume shifted from programs that had been established before CON repeal to programs that were established after CON repeal, and (4) The mortality rate was unchanged following repeal.
Miller et al. (2002)	They find that CON increases per capita Medicaid community-based care expenditures.
Vaughan-Sarrazin et al. (2002)	They assess the effect of CON on coronary artery bypass graft (CABG) surgery, finding: (1) Mean annual hospital volume is lower in states without CON, (2) More patients undergo CABG surgery in low-volume hospitals in states without CON, and (3) Mortality following CABG is higher in states without CON.
Grabowski et al. (2003)	CON repeal: (1) Has no statistically significant effect on per diem Medicaid nursing home charges, (2) No effect on per diem Medicaid long-term-care charges, (3) No effect on days.
Gulley and Santerre (2003)	They look at the effects of several public policies on nursing home residents and nursing home beds per persons 65 years old and older. Their data are from a cross section of counties in 1991. Their measure of CON is the number of years in which a CON law has been in effect. They find that in states where CON has been in effect for longer: (1) There are fewer nursing home beds per persons 65 years old and older, but the effect is not statistically significant, and (2) There are fewer nursing home patients per persons 65 and older, but this effect is also statistically insignificant.
Conover and Sloan (2003)	Dropping CON has 0% effect on all expenditures.
Teske and Chard (2004)	This study examines several political factors to determine the likelihood of a state retaining CON regulation. They find that the following factors are associated with CON regulation:

(Continues)

TABLE A1 (Continued)

Paper	Summary
	(1) Democrats in upper and lower houses, (2) Higher hospital costs, (3) More affluent and better-educated citizens, (4) Fewer physicians (which implies CON may reduce the number of physicians), and (5) A variable measuring hospital interests: the number of hospital industry-related interest groups active in a particular state multiplied by their average political action committee spending. This was found to be significantly associated with retention of CON, but legislative party makeup is more important.
Ho (2004)	She compares Florida, where there is a CON for percutaneous transluminal coronary angioplasty (PTCA) with California, where there is no such CON. She finds: (1) CON is associated with higher in-hospital volume for PTCA, and (2) There is a positive relationship between PTCA volume and mortality outcomes (though note that she does not directly study the relationship between CON and PTCA mortality outcomes).
Chen (2005)	Nursing home CONs are associated with greater cost efficiency, but diminished technical efficiency.
DiSesa et al. (2006)	They study CON, volume, and mortality in coronary artery bypass grafting (CABG). They find: (1) CON is positively associated with CABG volume within hospitals, and (2) There is no direct relationship between CON and mortality.
Bates et al. (2006)	CON hospitals are not any less efficient than non-CON hospitals.
Custer et al. (2006)	They use a cross-border design to study the effect of CON in hospital markets. This allows them to control for unobservable factors. They also used interviews and public information to develop an index measuring CON rigor based on fees, administrative requirements, reviewability, appeals, and administrative complexity. They assess the effects of CON on acute care, long term care, and home health markets. They find: (1) CON is associated with higher private inpatient acute care costs, (2) Acute care costs rise with the rigor of the CON program for the most resource-intensive acute care diagnoses, (3) Some evidence that CON is associated with higher Medicaid costs for home health services, (4) There is weak evidence that CON is associated with higher private long term care costs, (5) There is weak evidence that CON is associated higher Medicaid long term care costs, (6) Some evidence that CON is associated with higher per-capita costs for home health services, (7) CON is associated with fewer hospitals, (8) CON is associated with fewer hospital beds, (9) CON is associated with fewer home health agencies per 1000 residents, (10) CON is associated with fewer Medicare beneficiaries receiving home health services, (11) There is no significant relationship between the percent of hospital admissions that are self-pay, though when controlling for the number of

TABLE A1 (Continued)

Paper	Summary
	uninsured and family income, CON is positively related to self-pay admission per uninsured, (12) There is no apparent difference in acute care quality in CON and non-CON markets, (13) In long-term care, CON is associated with better quality on two measures but worse quality on six measures, (14) In home health markets, they find no evidence that CON affects any of 10 outcome measures of quality, (15) They find that acute care markets are less competitive when CON is rigorous, (16) CON is associated with lower levels of competition in home health agency markets.
Popescu et al. (2006)	They studied access and quality outcomes in revascularization. They found that patients in CON states: (1) Were less likely to be admitted to hospitals offering revascularization, (2) Were less likely to undergo revascularization, and (3) Had no difference in 30-day mortality rates relative to patients in non-CON states.
Dobson et al. (2007)	They find that safety-net hospitals in non-CON states had higher margins than those in CON states.
Ho (2007)	They study the association between cardiac CON regulations, availability of revascularization facilities, and revascularization rates, focusing on differences between the general population and the elderly and on differences between procedures (coronary artery bypass graft surgery [CABG] or a percutaneous coronary intervention [PCI]). They find that: (1) CON is associated with fewer hospitals offering CABG and PCI, (2) CON has no effect on overall CABG utilization, and (3) CON is associated with 19.2% fewer PCIs per 1000 elderly.
Ho et al. (2007)	The study assesses the effect of CON on cardiac costs and outcomes. She finds: (1) While CON is associated with lower average costs per patient, it also seems to be associated with more procedures and this is enough to offset the savings from lower average costs, (2) CON is associated with greater volume within hospitals, and (3) CON does not seem to be related to inpatient mortality.
Rivers et al. (2007)	They find CON laws increase hospital expenditures per adjusted admission.
Ross et al. (2007)	They examine the effect of CON on the volume of cardiac catheterization after admission for acute myocardial infarction. While CON did not seem to decrease the volume of strongly-indicated catheterization, it did reduce the volume of equivocally and weakly indicated catheterization. Because their interest is both overall volume and rates of catheterization when it is not warranted, I categorize in both the volume and the quality sections.
Short et al. (2008)	They studied Medicare data on beneficiaries treated with one of six cancer resections and an associated cancer diagnosis from 1989 to 2002. They find: (1) CON is associated with fewer hospitals per cancer incident for colectomy, rectal resection, and pulmonary lobectomy, (2) CON has no effect on the number of procedures per cancer incident, and

(Continues)

TABLE A1 (Continued)

Paper	Summary
	(3) CON is associated with greater hospital volume.
Zhang (2008)	He examined the effect of three regulatory policies—CON laws, uncompensated care pools, and community benefit requirement laws. CON is associated with small increases in uninsured admissions, though the results were small (0.07%) and not statistically significant when he attempted to control for endogeneity. Furthermore, he found that in the presence of all three policies, the number of uninsured admissions by nonprofit hospitals fell.
Cantor et al. (2009)	The authors studied a 1996 New Jersey reform that created a pilot program to license additional hospitals to perform coronary angiography. They find that the number of angiography facilities doubled following reform and a large black-white disparity disappeared after the reform.
DeLia et al. (2009)	This builds off of the authors' previous study, confirming the result (the reforms eliminated the black-white disparity) using additional techniques (weighting zip codes by the number of black and white residents). They also study the mechanism by which the disparity was eliminated, finding that incumbent hospitals served more black patients as new entrants cut into their market share for white patients.
Ho et al. (2009)	They use difference-in-difference regression analysis to compare states that dropped CON during the sample period with states that kept the regulation. They find that in states that dropped CON: (1) The number of hospitals in the state performing CABG and PCI went up following repeal, (2) Statewide procedural volume for CABG and PCI were unchanged, (3) Mean hospital volume declined for both procedures, and (4) Procedural CABG mortality declined after repeal, though the difference was not permanent.
Kolstad (2009)	He examined how the 1996 repeal of CON legislation in Pennsylvania affected the market for CABG surgery in the state, finding: (1) The number of CABG facilities increased 46%, and (2) Surgeries were more likely to be performed by high quality surgeons.
Hellinger (2009)	CON is associated with fewer hospital beds, which in turn are associated with slower growth in aggregate health expenditures per capita. But there is no direct relationship between CON and health expenditures per capita.
Ferrier et al. (2010)	CON hospitals are more efficient than non-CON hospitals.
Carlson et al. (2010)	This is a cross-sectional study of geographic access to U.S. hospices using multivariate logistic regression to identify gaps in hospice availability (measured by distance to hospice facilities) by community characteristics. CON was associated with longer travel distance to hospice care.
Cutler et al. (2010)	They assess the 1996 repeal of CON in Pennsylvania on CABG. They find: (1) Repeal of CON reduced travel distanced by 9%, (2) There was no statistically significant effect on total volume following CON repeal, (3) There were mixed results on scale; following CON repeal, fewer surgeries were performed by high-volume hospitals, but more were performed by high-volume surgeons,

TABLE A1 (Continued)

Paper	Summary
	(4) CON repeal led to a shift from standard quality to high quality surgeons, and (5) Incumbent hospital margins initially fell following repeal but these hospitals had regained profitability and were the most profitable by 2002.
Vaughan et al. (2010)	In a study design that exploits the fact that some markets cross boundaries between CON and non-CON states, they find: (1) A greater increase in coronary artery bypass graft surgery programs in states that reduced CON regulation, and (2) No change in percutaneous coronary intervention programs in states that reduced CON.
Rivers et al. (2010)	They find that stringent CON programs increase hospital expenditures per admission.
Fric-Shamji and Shamji (2010)	They evaluate the mean per capita rates of 26 diverse surgical procedures in 21 CON and 5 non-CON states between 2004 and 2006. The proportion of procedures performed in teaching facilities was also assessed. They find no significant difference in procedural rates between CON and non-CON states.
Silveira et al. (2011)	They study the number of hospice programs per county. Among other things, they find that CON regulations is associated with fewer hospice programs.
Cosby (2011)	She studies the effect of solid organ transplant CON regulations, finding: (1) CON is associated with fewer transplant centers, (2) CON has no statistically significant effect on provider volume, (3) CON has no statistically significant effect on graft failures or deaths.
Granderson (2011)	He studies the effect of hospital alliance membership, alliance size, and CON on hospital cost efficiency among 144 urban Midwest hospitals from 1996 to 1999. He finds that repeal of CON resulted in greater hospital efficiency, as measured by a stochastic cost frontier.
Eichmann and Santerre (2011)	They study the effects of CON on access and rents. They find CON is associated with: (1) 12% fewer beds per capita, (2) 48% fewer hospitals per capita, and (3) $91,000 more in urban hospital CEO pay.
Kahn et al. (2012)	They examine factors affecting utilization of long-term acute care (LTAC) hospitals. Among other things, they find that utilization is lower in the presence in CON laws.
Jacobs, Zhang, and Hollenbeck (2012)	They study the effect of CON on utilization of intensity-modulated radiotherapy (IMRT), an expensive procedure with unproven benefits. They find that CON does not reduce utilization of the procedure, which they interpret as a negative quality result.
Jacobs et al. (2012)	They examine whether CON reduces the use of a questionably warranted procedure, radiotherapy, for prostate cancer. They find no difference in use of the procedure in CON and non-CON health service areas. In fact, in HSAs with high-stringency CONs, they find greater use of the procedure.
Lorch et al. (2012)	They studied NICU CONs. They found: (1) CON is associated with fewer units; (2) CON is associated with fewer beds;

(Continues)

TABLE A1 (Continued)

Paper	Summary
	(3) CON is unrelated to very low birth weight (VLBW) infant mortality and low birth weight (LBW) infant mortality. (4) CON is associated with lower rates of all-infant mortality in states with a large metropolitan area.
Nelson et al. (2012)	They examine whether CON reduces the use of a questionably warranted procedure, definitive intensity modulated radiation therapy (IMRT), among 155,379 men between 2004 and 2007. They find no evidence that CON limits the use of the procedure.
Ho and Ku-Goto (2013)	Removing CON decreases the cost of coronary artery bypass grafts, but not for percutaneous coronary intervention. In Ohio, reimbursements fell 2.8% following repeal of CON and in Pennsylvania, they fell 8.8% following repeal.
Khanna et al. (2013)	The authors focus on intensity modulated radiation therapy. They find that: (1) CON is not associated with any difference in cost growth (2) CON is associated with greater growth in intensity modulated radiation therapy which is an expensive and no more effective treatment, so they interpret this as a negative quality result.
Jacobs et al. (2013)	They study whether CON restrains the use of a questionable procedure—robotic prostatectomy. They find that CON stringency had no effect on the use of the procedure.
Lu-Yao et al. (2013)	They study whether CON limits the use of IMRT in a population that would likely benefit from it the least: older or debilitated men with low-risk prostate cancer. They find that CON laws actually encourage the procedure.
Rosko and Mutter (2014)	CON hospitals are more efficient than non-CON hospitals.
Polsky et al. (2014)	They assess the effect of CON on home health agencies, using a research design that focuses on markets that straddle CON and non-CON states. They find that: (1) Medicare expenditures are not statistically significantly different between CON and non-CON states, (2) Non-CON states have roughly twice as many home health agencies per Medicare beneficiary, (3) CON states have 13.7% fewer home health admissions from hospitals, (4) 60 day (total) readmission rates are 5% higher in CON states than in non-CON states, though the effect is not sustained, (5) 60 day preventable readmission rates are 13% higher in CON states than in non-CON states, though the effect is not sustained. (6) In CON states there are fewer home health visits, fewer visits per week, and a lower proportion of visits by skilled nurses, but the effects are small and not statistically significant, (7) The Herfindahl Index in the home health market is approximately 1000 points lower in non-CON states.
Stratmann and Russ (2014)	They study the effects of CON on the supply and provision of services to indigent populations. They find: (1) CON programs are associated with 99 fewer hospital beds per 100,000 people, (2) Bed-specific CONs are associated with 131 fewer beds per 100,000 people,

TABLE A1 (Continued)

Paper	Summary
	(3) There are 4.7 fewer beds per 100,000 persons for each additional service covered by CON, (4) CON programs reduce the number of hospitals with MRI machines by 1–2 hospitals per 500,000 people, (5) CON programs that require charitable care are uncorrelated with uncompensated care.
Paul et al. (2014)	They assess the effect of CON and CON stringency on emergency department length of stay. They find that CON laws are associated with shorter stays, which they interpret as an indication of higher quality, but the effect diminishes with the stringency of CON laws (as measured by expenditure thresholds).
Chui et al. (2015)	To see if CON limits the use of inappropriate percutaneous coronary interventions, they looked at the share of procedures considered appropriate, uncertain, or inappropriate in CON and non-CON states. They found that states with CON have a lower proportion of inappropriate PCIs, but the differences were small.
Falchook and Chen (2015)	They examined utilization of radiation therapy when it is not warranted in CON and non-CON states, concluding that in CON states there is greater use of this treatment on elderly patients who may not need it.
Horwitz and Polsky (2015)	They use a cross-border design to estimate the effect of CON on MRI machines. They find that in a CON county that borders a non-CON county there are 6.4 fewer MRIs per million people.
Li and Dor (2015)	Removal of CON was associated with: (1) A substantial increase in the number of hospitals performing cardiac revascularization procedures, (2) An overall downward trend in CABG and an overall upward trend in the alternative procedure, PCI, (3) Entry led to a significant increase in the likelihood of CABG, relative to trend, but it did not contribute to the increase in PCI after adjusting for patient traits, market characteristics, and area-specific trends, (4) The probability of receiving PCI specifically at incumbent hospitals decreased with market entry, suggesting a volume shift from incumbents to entrants, (5) Entry shifted a disproportionate volume of low-severity patients from incumbent hospitals to entrants, and (6) Entry by new cardiac surgery centers tended to sort high-severity patients into the more invasive CABG procedure and low-severity patients into the less invasive PCI procedures, potentially improving quality of care.
Gutierrez et al. (2016)	They study the effect of CON on freestanding emergency departments, finding that those states that require a CON for EDs have fewer EDs per capita.
Bailey (2016)	Removing CON reduces hospital charges by 5.5% 5 years after repeal.
Kim et al. (2016)	They study the effect of CON laws on the use of intensity modulated radiation therapy when it is not warranted. They find that the therapy was actually used more often in CON states than in non-CON states, concluding that it failed to achieve its goal.
Stratmann and Koopman (2016)	They study the effect of CON on overall supply of services as well as rural supply of services. In particular, they find:

(Continues)

TABLE A1 (Continued)

Paper	Summary
	(1) CON programs are associated with 30% fewer hospitals per 100,000 residents across the entire state, (2) ASC-specific CONs are correlated with 14% fewer total ASCs per 100,000 residents, (3) CON programs are associated with 30% fewer rural hospitals per 100,000 rural residents, and (4) ASC-specific CONs are correlated with 13% fewer rural ASCs per 100,000 rural residents.
Rahman et al. (2016)	CON increases the growth in Medicare and Medicaid expenditures on nursing home care but decreases growth in home healthcare expenditures.
Bailey et al. (2017)	They find that prices are higher in CON states relative to non-CON states, but the difference isn't statistically significant.
Ni et al. (2017)	They assess the effect of CON on market concentration (as measured by the Herfindahl–Hirschman Index [HHI]) in emergency departments. They measure CON two ways—using a simple binary measure and a stringency measure based on the dollar threshold at which investments are subject to review. They use 2SLS to address concerns of endogeneity. Their (somewhat dubious) IVs in the binary tests are an index of science and technology and the unemployment rate, and in the stringency model, they are the CPI and the unemployment rate. They find that CON laws are associated with greater competition in emergency departments, concluding that they serve as a sort of anti-trust tool.
Perry (2017)	Service areas in NC are allocated a new machine when the number of MRI procedures performed in the area crosses a predetermined threshold. He compares service areas that are just below the threshold to areas just above the threshold to see the effect of a binding CON constraint. He finds: (1) By limiting the use of scanners, CON laws reduce spending on patients with low back pain by about $400 in the first month of diagnosis, (2) CON limits the number of MRI scanners in an area. When an area is allowed to obtain a scanner, they almost always do, (3) Providers get around this constraint, to some degree, by utilizing unregulated mobile scanners, (4) Patients in a region constrained by CON receive 34% fewer scans in the first month after diagnosis, (5) Medicare patients are disproportionately crowded out by CON; their fraction of MRIs performed jumps 10 percentage points after CON approval, and (6) CON seems to limit cancer patient access to scans, but not musculoskeletal disorder patient access to scans.
Bailey (2018b)	He uses fixed- and random-effects regressions to test how the effect of CON on all-cause mortality within US counties. Though he finds a positive relationship between CON laws and all-cause mortality, the results are not statistically significant.
Browne et al. (2018)	They examine the effect of CON on total knee arthroplasty (TKA) by comparing states with and without CON. They find: (1) Average Medicare reimbursements were 5%–10% lower in non-CON states,

TABLE A1 (Continued)

Paper	Summary
	(2) CON is associated with lower TKA utilization per capita, but faster growth in utilization per capita, (3) CON is associated with TKA in higher-volume hospitals, and (4) Examination of adverse event rates did not reveal any strong associations between adverse outcome and CON.
Ohsfeldt and Li (2018)	They examine the effect of CON on home health agency quality ratings from the Centers for Medicare and Medicaid Services (CMS). They find that: (1) HHAs in CON states were about 58% less likely to be rated as "High" quality ($p < .01$), (2) HHAs in CON states were about 30% more likely to be rated as "Medium" quality compared to HHAs in states without CON for HHAs.
Noh and Brown (2018)	The study the effects of CON on substance abuse facilities, finding: (1) CON laws are negatively associated with the number of nonprofit substance abuse facilities, but (2) In states with both CON laws and Medicaid expansion, the number of nonprofit substance abuse facilities tended to increase.
Casp et al. (2019)	They study the effect of CON on total hip arthroplasty. They find: (1) CON is associated with a lower volume of total hip arthroplasty, (2) CON is associated with more care in high-volume hospitals, and (3) No difference in postoperative complications between CON and non-CON states.
Chui et al. (2019)	Like their 2015 paper, this one assesses whether CON limits inappropriate percutaneous coronary interventions. And as with the other paper, they find a small but economically insignificant effect.
Averett et al. (2019)	They analyzed the effects of the expiration of Pennsylvania's CON law on hip and knee replacement surgeries. They assessed the effect of deregulation on one measure of cost per service (charges) and four measures of quality. They found that deregulation had: (1) No effect on total charges, (2) Increased the length of stay, (3) No effect on hospital acquired infections, and (4) Decreased mortality.
Paul et al. (2019a)	States with CON laws have lower bed occupancy rates. The authors speculate that while CON reduces the number of beds, it may also shorten the length of patient stay and the net effect is to reduce the occupancy rate. Note that this is the opposite of the intention (which was to reduce unused capacity).
Paul et al. (2019b)	They study the effect of CON on market concentration in the inpatient care market, as measured by a normalized Herfindahl–Hirschman Index (HHI) built using inpatient volume data of acute care hospitals in each health referral region (HRR). They find that CON is associated with less market concentration.
Malik et al. (2019)	The examined the effect of CON on elective posterior lumbar fusions (PLFs) from 2005 to 2014, finding: (1) Average 90-day reimbursements were slightly higher (1.4% higher) in non-CON states ($22,115 vs. $21,802), (2) CON laws are associated with lower per capita utilization of PLFs, (3) CON laws are associated with more high-volume facilities,

(Continues)

TABLE A1 (Continued)

Paper	Summary
	(4) CON laws are not associated with significant reduction in 90-day readmissions, and (5) CON laws are not associated with significant reduction in 90-day complications.
Bailey (2019)	States that eliminate CON experience 4% reductions in real per capita healthcare spending.
Wu et al. (2019)	They assess the effect of CON regulation on several measures of quality in home healthcare, using a cross-border design to control for endogeneity. They find that CON is uniformly associated with worse outcomes including: (1) Patients perform worse on functional improvement measures (bathing, ambulating, transferring to bed, managing oral medication, and less pain interfering with activity), (2) They are more likely to be admitted to the ER, and (3) More likely to be admitted to an acute care hospital.
Sridharan et al. (2020)	They study the effect of CON on elective posterior lumbar fusions. They find: (1) CON is associated with reduced utilization of the procedures, (2) CON has no statistically significant effect on reimbursements, (3) CON is associated with more high-volume facilities, and (4) CON has economically insignificant effects on readmissions or complications.
Fayissa et al. (2020)	In an IV study, they find that CON is associated with: (1) 18%–24% lower nursing home survey scores computed by healthcare professionals, and (2) The substitution of lower-quality certified nursing assistance care for higher-quality licensed practical nurse care.
Mitchell et al. (2020)	They studied the relationship between CON and projected ICU bed shortages over the course of the COVID-19 pandemic. They found that compared with non-CON states, in CON states, expected shortages were more than twice as likely and the shortages were about nine times greater in per capita terms.
Myers and Sheehan (2020)	They examine the effect of CON laws on wait times. They find CON programs: (1) Increase median wait times for medical examinations, (2) Increase wait times for pain medication administration, (3) Increase wait times for hospital admittance and (4) Increase wait times for hospital discharge.
Cancienne et al. (2020)	They examine the effect of CON on knee arthroscopy, assessing its effect on: (1) Charges and reimbursements: in t-tests without controls they found that charges (which are the prices set before any negotiation) were lower in CON states, while reimbursements (which are actual payments) were not statistically significantly different, (2) Total volume: total volume and growth in total volume was lower in CON states than in non-CON states, (3) Volume within facilities: CON is associated with the presence of more high-volume facilities, and (4) Quality: There were more ER visits within 30 days of operation and more infections within 6 months of operation in CON than in non-CON states;

TABLE A1 (Continued)

Paper	Summary
	there were no differences in in-hospital deaths or readmissions within 30 days of the operation between CON and non-CON states.
Ettner et al. (2020)	They examine the effects of home health agency CONs and nursing home CONs on home health agencies. They find that in states with home health agency CONs there are: (1) Lower per patient expenditures (they don't know if this is due to skimping or to economies of scale), (2) Higher expenditures per agency, (3) Higher expenditures per resident, (4) Slightly fewer home health agencies per capita, and (5) Higher caseloads (volume) within agencies (this is what drives the higher expenditures per agency).
Stratmann and Baker (2020)	They examine the effect of CON on two measures of spending and two measures of quality (all four are indicators of "overutilization or waste"): (1) Medicare spending per rural beneficiary (they found this was $295 higher in CON states than in non-CON states), (2) Ambulance spending per beneficiary ($2.54 higher in CON states), (3) Hospital readmission rates (1.2 percentage points higher in CON states), and (4) Emergency room visits per 1000 beneficiaries (35.1 more emergency department visits per 1000 beneficiaries in CON states).
Ziino et al. (2020b)	The paper looks at reimbursements for spinal surgery in CON and non-CON states, finding that reimbursements fell the most in non-CON outpatient settings (−11% compound annual growth) in non-CON states.
Yuce et al. (2020)	The assess the effect of CON on measures of volume and of quality. They find: (1) No significant difference between CON and non-CON states in county-level procedures per 10,000 persons, (2) No significant difference between CON and non-CON states for hospital procedural volume, (3) No difference in hospital market share, (4) No difference in risk-adjusted 30-day postoperative mortality, (5) No difference in surgical cite infection, and (6) No difference in readmission
Ziino et al. (2020a)	They examined the effect of CON in lumbar micro decompressions in both in-patient and out-patient settings, focusing on growth in utilization of the procedure over time and changes in reimbursement over time. These were simple comparisons, not regressions with controls. They found: (1) CON status did not affect overall reimbursement rates ("The ability of outpatient surgery to lower costs may, in fact, be more powerful than CON programs.") (2) Utilization of the procedure increased more in CON states than in non-CON states.
Denduluri et al. (2021)	They study the effect of CON on open and endoscopic carpal tunnel release finding that the regulation has no effect on utilization or spending on the procedures.

(Continues)

TABLE A1 (Continued)

Paper	Summary
Chiu (2021)	He uses a cross-border discontinuity design to study the effect of CON on heart attack mortality. He finds that it is associated with 6 to 10% higher mortality 3 years after enactment.
Kosar and Rahman (2021)	They study the effect of CON regulation on the size of nursing homes, positing that larger nursing homes may facilitate the spread of COVID. They find that counties with CON laws had more COVID cases.
Bailey and Lewin (2021)	They examine the effect of psychiatric service CONs. They find that psychiatric service CONs: (1) Reduce the number of psychiatric hospitals by 20%, (2) Reduce the likelihood that a hospital will accept Medicare by 5.35 percentage points, and (3) Reduce the number of psychiatric clients per capita by 56%.
Baker and Stratmann (2021)	They examine the effect of medical imaging CONs on medical imaging providers. They find: (1) CON laws are associated with 20%–33% fewer providers, (2) Residents of CON states are 3.4–5.3 percentage points more likely to travel out of state to obtain these services, (3) CON laws are associated with 27%–53% fewer scans by nonhospital providers per beneficiary, 23%–70% fewer scans by new hospitals, and 6 to 21% more scans by older hospitals.
Herb et al. (2021)	They measure the effect of CON on travel time to radiation oncology facilities, breaking down the effect by region. They find CON: (1) Has no association with prolonged travel in the West, (2) Is associated with lower odds of prolonged travel in both urban and rural tracts in the South, and (3) Is associated with increased odds of prolonged travel in both urban and rural tracts in the Midwest and Northeast.
Schultz et al. (2021)	They examined the effect of CON on total knee (TKA), hip (THA), and shoulder arthroplasty (TSA), finding: (1) TKA and TSA costs were higher in CON states than in non-CON states (and these results were statistically significant), THA costs were lower in CON states but these results were not statistically significant, (2) CON is associated with a lower volume of TKA and TSA procedures, though it was not statistically significant in the case of hip arthroplasty, and (3) CON has no statistically significant effect on complications (deep vein thrombosis and pulmonary embolism).
Ziino et al. (2021)	They studied inpatient cervical discectomy in CON and non-CON states in inpatient and outpatient setting. It appears that they did not use any controls, however. Regarding reimbursements, they find: (1) In the inpatient setting, reimbursement was lower in non-CON states ($1128.40) than in the CON states ($1223.56). But reimbursements in the CON states were falling faster over time. (2) In the outpatient setting reimbursement was higher in Non-CON states ($4237.01) than in CON states ($3859.31) and reimbursements were growing in the non-CON states but falling in the CON states. Regarding access:

TABLE A1 (Continued)

Paper	Summary
	(3) In the inpatient setting, there were more patients in the CON setting than in the non-CON setting (657 compared with 231) and utilization of the procedure was growing faster in CON than in non-CON states but this does not appear to control for the larger population of CON states than non-CON states. (4) Similarly, in the outpatient setting, there were more patients in the CON setting than in the non-CON setting (435 compared with 257) and utilization of the procedure was growing faster in CON than in non-CON states but again this does not appear to control for the larger population of CON states than non-CON states.
Roy et al. (2022)	They examined the relationship between CON and mortality associated with illnesses that require similar medical equipment as COVID. They find that: (1) There are higher mortality rates in CON states than in non-CON states, and (2) States with high healthcare utilization that reformed their CON laws during the pandemic saw lower mortality rates resulting from natural death, septicemia, diabetes, chronic lower respiratory disease, influenza or pneumonia, Alzheimer's, and COVID.
Stratmann (2022)	He studies the effect of CON on 9 measures of hospital quality: (1) Death among surgical inpatients with serious treatable complications, (2) Postoperative pulmonary embolism or deep vein thrombosis, (3) Percent of patients giving their hospital a 9 or 10 overall rating, (4) Pneumonia readmission rate, (5) Pneumonia mortality rate, (6) Heart failure readmission rate, (7) Heart failure mortality rate, (8) Heart attack readmission rate, (9) Heart attack mortality rate, Hospitals in CON states performed worse than those in non-CON states in 8 of the 9 categories, the exception being postoperative pulmonary embolism.
Bailey et al. (2022)	They measure how CON affects the number of substance abuse facilities and beds per capita in a state, and the effect of CON on the forms of payment that treatment facilities accept. They find that CON reduces the acceptance of private insurance but has no statistically significant effect on the number of facilities, beds, or clients and no significant effect on the acceptance of Medicare or Medicaid.
Mitchell and Stratmann (2022)	They examine the effect of bed CON on statewide bed utilization rates and on individual hospital shortages. They find: (1) States that require CONs for beds had 12% higher bed utilization rates, (2) States that require CONs for beds had 58% more days with more than 70% of their beds in use, (3) Hospitals in these states were 27% more likely to run out of beds, and (4) States that relaxed these rules for COVID saw no difference in utilization rates or shortages.
Gaines and Cagle (2023)	They study the effects of CON laws in a cross-sectional analysis of hospice quality outcomes using the hospice item set metric (HIS) developed by CMS. Controlling for ownership and size, they found hospice CON states had higher HIS ratings than those from Non-CON states along four dimensions:

(Continues)

TABLE A1 (Continued)

Paper	Summary
	(1) Beliefs and values addressed ($\beta = .05$, $p = .009$), (2) Pain assessment ($\beta = .05$, $p = .009$), (3) Dyspnea treatment ($\beta = .08$, $p < .001$), and (4) The composite measure ($\beta = .09$, $p < .001$). They also found that along four additional measures, the differences were statistically insignificant ($p > .05$): (5) Treatment preferences, (6) Pain screening, (7) Dyspnea screening, and (8) Opioid bowel treatment
Bailey and Hamami (2023)	CON causes spending on those with less than excellent health to be as much as 20% higher, though it has no statistically significant effect on spending on those in good health.
Horwitz et al. (2024)	They use a border discontinuity design to study the effect of CON on availability and utilization of CT and MRI imaging in both low-value and high-value settings. They find: (1) Moving across the border from a non-CON state to a CON state reduces the odds that the Census tract will have an MRI by 14%, (2) Moving across the border from a non-CON state to a CON state has no effect on the availability of CT scanners, (3) There is a 20%–26% reduction in seven measures of low-value imagining utilization, which they interpret as a potentially positive result, (4) There is no difference in high-value MRI utilization across the border, and (5) There is a 6% difference in high-value CT utilization across the border.

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SYMPOSIUM ARTICLE

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The causal effect of repealing Certificate-of-Need laws for ambulatory surgical centers: Does access to medical services increase?

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Abstract

In many states, Certificate-of-Need (CON) laws prevent ambulatory surgical centers (ASCs) from entering the market or expanding their services. This paper estimates the causal effects of state ASC-CON law repeal on the accessibility of medical services statewide, as well as for rural areas. Our findings show that CON law repeals increase ASCs per capita by 44%–47% statewide and 92%–112% in rural areas. Repealing ASC-CON laws causes a continuous increase in ASCs per capita, an effect which levels off 10 years after repeal. Contrary to the "cream-skimming" hypothesis, we find no evidence that CON repeal is associated with hospital closures in rural areas. Rather, some regression models show that repeal is associated with fewer medical service reductions.

KEYWORDS

ambulatory surgical centers, barriers to entry, Certificate of Need, Certificate-of-Need laws, community hospitals, entry barrier, healthcare, regulation, rural healthcare

JEL CLASSIFICATION

I11, I18, L51, R51, K23

1 | INTRODUCTION

Certificate-of-Need (CON) laws restrict entry and/or expansion of healthcare facilities in 35 states (National Conference of State Legislatures, 2024). These laws require hospitals, nursing homes,

ambulatory surgical centers, and other healthcare providers to obtain regulatory approval before opening a new practice, expanding, or making certain capital investments. Thus, CON laws effectively create barriers to entry that limit competition among medical providers.

A substantial body of research has investigated whether CON laws successfully provide greater access to medical care, lower healthcare costs, and improve the quality of services.[1] In a literature review, Mitchell (2024, p. 1) finds overwhelming evidence that people in states with CON laws have less access to medical care compared to those in states without CON laws. Further, the medical care available in CON states is of higher cost and lower quality than in states without CON laws. However, much of the current CON literature is limited by the use of empirical designs that can only speak to correlations between CON laws and the stated goals, without addressing causality. Exceptions include work by Cutler et al. (2010), Perry (2018), and Yu (2024). However, these studies analyze how CON repeals impact access to specific services in single states (Pennsylvania, North Carolina, and Missouri, respectively).[2]

This paper overcomes limitations in the previous CON literature by exploiting the staggered repeals of CON laws for Ambulatory Surgical Centers in six states on access to medical care, using an empirical design and estimation methods that allow for causal inference. We focus on ambulatory surgery centers due to their growing importance: In 1980, 16% of surgeries were performed on an outpatient basis. Hospitals provided most of these surgeries, as only a few hundred ambulatory surgical centers (ASCs) operated nationwide. Today, 80% of surgeries occur in outpatient settings, and the number of surgical centers has grown to almost 6000, fueled by advancements in anesthesia and non-and minimally invasive surgical procedures (Hall et al., 2017; Kozak., 1999; Munnich & Parente, 2018).

Ensuring access to healthcare in rural communities has remained a central justification of state CON legislation; however, this aspect has only received modest attention in the CON literature. Exceptions include Yu (2024), showing that the repeal of Missouri's ASC-CON increased ASC presence; Melo et al. (2024) showing that the repeal of CON for hospital beds caused hospital entry in both urban and rural areas, Carlson et al. (2010), showing that CON laws correlate with decreased rural access to hospice care; and Herb et al. (2021), documenting that CON laws are associated with prolonged travel time to radiation oncology facilities in rural areas of the Northeast and Midwest, but not in the South. Our study contributes to the limited work on how CON laws affect access to rural medical services.

Hospitals and ASCs often compete in providing outpatient services (Carey et al., 2011; Plotzke & Courtemanche, 2011). However, ASCs have more control over patient selection, as federal regulations permit surgical centers to selectively offer services based on subjective criteria, including whether a patient can be safely discharged following the procedure.[3] One often-cited rationale for restricting ASCs' entry is "cream-skimming," a catch-all phrase for providers accepting and providing services to only the most profitable patients (Rajan et al., 2021). CON advocates claim that limiting ASC entry reduces cream-skimming,

[1]The literature has studied how CON laws relate to medical costs, expenditures, quality, and provision for indigenous and underserved populations. Examples of this work are Sloan (1981), Joskow (1980), Robinson et al. (2001), Rivers et al. (2010), Stratmann and Russ (2014), Bailey (2016), Bailey (2018), Ohsfeldt and Li (2018), Wu et al. (2019), Stratmann and Baker (2020), Baker and Stratmann (2021), Stratmann (2022). For a comprehensive review of the literature, see Mitchell (2024).

[2]The study closest to our approach is a contemporaneously developed paper by Melo, Sigaud, Neilson, and Bjoerkheim (2024, this issue) that examines the repeal of CON laws for hospital beds in five states. Another example is Chiu (2021), who estimates that the causal effect of CON laws is an increase in heart attack mortality, using a border discontinuity design.

[3]For example, if a patient does not have a responsible adult to transport the patient home and provide post-operative care, the anesthesiologist or surgeon may choose not to offer the surgery.

assuring hospitals' viability and access to hospital medical care. We test the implications of the "cream-skimming" hypothesis, namely, whether repealing ASC-CON laws is associated with hospital closures or reductions in medical services.

We show that repealing ASC-CONs causes a 44%–47% increase in per capita ASC presence statewide and an increase of 92%–112% in rural areas. The findings are robust across several modern difference-in-difference estimators and specifications. Further, our findings do not support the arguments of CON advocates who claim that CON laws reduce cream-skimming by ASCs, and thereby ensures access to hospital services by preventing hospital closures. Rather, the estimates show that states that repeal CON laws do not have more hospital closures, but rather, have fewer hospital service reductions than states with CON laws. These findings suggest that repealing ASC entry restrictions may instead facilitate the survival of rural hospitals.

2 | A BRIEF HISTORY OF CERTIFICATE-OF-NEED, RURAL ACCESS, AND CREAM-SKIMMING

In 1964, New York became the first state to pass CON legislation. The legislation aimed to strengthen regional health planning programs by creating a process for prior approval of certain capital investments (Simpson, 1985). Between 1964 and 1974, 26 other states adopted CON legislation. However, with the passage of the National Health Planning and Resources Development Act of 1974 (NHPRDA), the federal government made the availability of some federal funds contingent on the enactment of state CON legislation. By the end of 1982, every state except Louisiana had passed a CON law regulating hospitals, nursing homes, dialysis facilities, and ambulatory surgical centers (Simpson, 1985).

However, evidence accumulated that CON laws were failing to achieve their goals (Cimasi, 2005). Several states, including Texas, Arizona, and Utah, repealed their CON laws. Federal legislators became increasingly concerned that CON laws had "failed to reduce the nation's aggregate healthcare costs, [and were] beginning to produce a detrimental effect in local communities." (McGinley, 1995; Simpson, 1985). In 1986, Congress repealed the NHPRDA, ending the federal government's subsidization of state CON laws.[4]

After the NHPRDA's repeal, several states repealed their CON laws. We study the repeals of ASC-specific CON laws in six states: Pennsylvania (1996), Ohio (1997), Nebraska (1999), New Jersey (2000), Missouri (2002), and New Hampshire (2016).

CON laws have been justified on the grounds of achieving numerous public policy goals. Policymakers have seen CON laws as a way for governments to control healthcare costs, regulate the level of capital investments, increase charity care, protect the quality of medical services, and protect access to services across geographic locations. Indeed, Congress cited rural access to medical care as one of the primary goals of the NHPRDA. After federal repeal, many states adopted rural access to medical services as a primary rationale for continuing to implement CON laws.[5,6,7]

[4]For an in-depth discussion of the NHPRDA, see Madden (1999).

[5]The NHPRDA included National Health Priorities, which begin with the goal of "the provision of primary care services for medically underserved populations, especially those which are located in rural or economically depressed areas."

[6]See, for example, Arkansas (A.C.A. § 20–8-103(b)-(c)); Florida (Fla. Stat. Ann. § 408.034(3)); Georgia (Ga. Code Ann., § 31–6-1); Kentucky (KRS § 216B.010); North Carolina (N.C. Gen. Stat. Ann. § 131E-175(3a)); Tennessee (Tenn. Code Ann. § 68-11-1625(c)(7)); Virginia (12 Va. Admin. Code 5–230-30(2)), 12 Va. Admin. Code 5–230-30(2) (2015), 35 Pa. Stat. § 448.401c.

[7]To understand the theoretical underpinnings for using CON laws to protect access, see Colon Health Centers of America v. Hazel et al., No. 14–2283, slip op. at 23 (4th Cir. 2016), which notes,

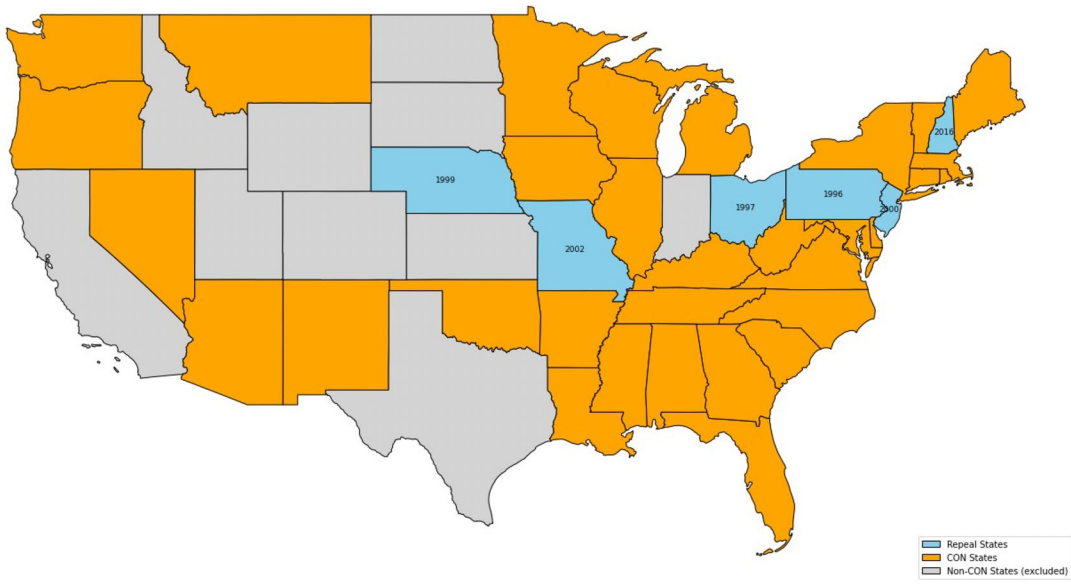

FIGURE 1 Certificate-of-need repeals for ambulatory surgical centers (ASCs). *Sources:* AHPA, HeinOnline's Digital Session Laws Library, and https://www.mercatus.org/conlaws [Color figure can be viewed at wileyonlinelibrary.com]

For example, Pennsylvania's CON laws required the "identification of the clinically related health services necessary to serve the health needs of the population of this Commonwealth, including those medically underserved areas in rural and inner-city locations." The North Carolina CON statute states that "access to healthcare services and healthcare facilities is critical to the welfare of rural North Carolinians, and to the continued viability of rural communities, and that the needs of rural North Carolinians should be considered in the certificate of need review process." A stated goal of Virginia's CON law is to support the "geographical distribution of medical facilities and to promote the availability and accessibility of proven technologies." And one of the justifications for West Virginia's CON laws is that they provide "some protection for small rural hospitals ... by ensuring the availability and accessibility of services and to some extent the financial viability of the facility."[8]

To achieve greater access to medical care in rural communities, many states use CON laws to limit entry and expansion of medical providers, including firms deemed "hospital substitutes," such as ASCs (Cimasi, 2005). ASCs are subject to federal regulations permitting them to treat

A related purpose of the CON law is geographical in nature. For reasons not difficult to discern, medical services tend to gravitate toward more affluent communities. The CON law aims to mitigate that trend by incentivizing healthcare providers willing to set up shop in underserved or disadvantaged areas such as Virginia's Eastern Shore and far Southwest. "In determining whether" to issue a certificate, for example, Virginia considers "the effects that the proposed service or facility will have on access to needed services in areas having distinct and unique geographic, socioeconomic, cultural, transportation, or other barriers to access to care." Va. Code Ann. § 32.1–102.3(B)(1).

A CON law may also aid underserved consumers more indirectly. By reducing competition in highly profitable operations, the program may provide existing hospitals with the revenue they need not only to provide indigents with care but also to support money-losing but important operations like trauma centers and neonatal intensive care units.

[8]West Virginia Health Care Authority, *Annual Report to the Legislature 1998*, http://www.hca.wv.gov/data/Reports/Documents/annualRpt98.pdf.

patients only if the service is not expected to exceed 24 h and does not require subsequent hospitalization.[9] Regulators consider limiting ASC entry beneficial, as these providers allegedly engage in "cream-skimming," meaning that surgery centers treat only the most profitable patients, thereby reducing hospitals' profit centers (Schactman, 2005). Some CON advocates claim that when more profitable patients seek care elsewhere, hospitals' ability to cross-subsidize charity care and provide other essential services is reduced, potentially resulting in hospital closures.

Scholarly work has researched cream-skimming by ASCs (Munnich & Parente, 2018; Plotzke & Courtemanche, 2011), hospitals (Friesner & Rosenman, 2009; Yang et al., 2020), and outside of healthcare settings (Tabarrok, 2013). However, the cream-skimming hypothesis has not been tested in the context of the ASC-CON repeal.

3 | HYPOTHESES

While CON laws can influence healthcare markets along several margins, we first test whether ASC-specific CON laws act as barriers to entry, given that these laws aim to reduce the number of ASCs in a state.[10] If CON laws are barriers to entry, we predict their repeal will lead to increased ASCs per capita operating in the state. Given the explicit rationale for CON laws to provide access to medical care in rural areas, we add the hypothesis that repealing ASC-CONs results in more ASCs in rural areas.

Hypothesis 1. Repealing ASC-CON laws increases ASCs per capita statewide.

Hypothesis 2. Repealing ASC-CON laws increases ASCs per capita in rural areas.

CON advocates claim that limits to ASC entry reduce cream-skimming, which protects the viability of incumbent hospitals in rural areas and prevents them from closing. Similar reasoning predicts that this prevents rural hospitals from reducing the services they offer, what is known as a conversion. Examples include hospitals that close their inpatient units but continue to operate at a reduced capacity, converting to standalone emergency departments, outpatient care centers, or specialized medical facilities.

Hypothesis 3. Repealing an ASC-CON law increases hospital closures or service reductions by hospitals in rural areas.

4 | DATA AND EMPIRICAL STRATEGY

4.1 | Ambulatory surgical centers

Our data source for ASCs is the POS files from the Centers for Medicare and Medicaid Services accessed through the National Bureau of Economic Research (NBER) (2024).[11] We construct two state-level annual measures: the number of operating ASCs per 100,000 state population and the

[9] 42 CFR Part 416, available at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-416.

[10] CON laws are also barriers to expanding existing facilities, not just to the entry of new facilities. In this paper, we do not analyze this aspect of ASC CON laws.

[11] The data in this paper builds on Stratmann and Koopman (2016).

number of operating ASCs per 100,000 rural population from 1991 to 2019. We merge the POS data with the 2013 edition of the Urban–Rural classifications from the National Center for Health Statistics (NCHS) (2017) to determine whether an ASC is in an urban or rural community. We classify providers as rural if they are located in a Micropolitan or Non-Core area.[12]

Data on Certificate-of-Need laws come from HeinOnline's Digital Session Laws Library and the American Health Planning Association (2012). Six states repealed ASC-CON laws from 1991 to 2019: Pennsylvania (1996), Ohio (1997), Nebraska (1999), New Jersey (2000), Missouri (2002), and New Hampshire (2016) (Figure 1).[13]

Our empirical design uses a difference-in-difference approach: the treatment group comprises the six repeal states, and the states with CON laws throughout our sample period comprise the control group.[14] This approach estimates the causal effect of ASC-CON repeals, assuming parallel trends between the treatment and control groups. The difference-in-difference regression model for the Two-Way Fixed Effects model (TWFE) model is

$$ASCs\ per\ 100{,}000_{it} = \gamma\, ASC - CON\ Repeal_{it} + \mu_t + \alpha_i + \varepsilon_{it} \quad (1)$$

and the regression model for the corresponding event study is

$$ASCs\ per\ 100{,}000_{it} = \sum_t \lambda_t\, ASC - CON\ Repeal_{it} + \mu_t + \alpha_i + \eta_{it} \quad (2)$$

In Equation (1), we estimate the average impact of repealing ASC-CON on the number of ASCs per 100,000 population in state i and year t. Here, the CON variable is an indicator variable equal to one starting in the first year a state's CON repeal is in effect and zero otherwise. We include year effects μ_t and state effects α_i. We estimate both equations for ASCs statewide and for ASCs in a state's rural areas. We cluster the standard errors by state throughout.

In Equation (2), we implement an event-study approach. That model interacts with the repeal indicator with year indicators before and after CON repeals, centered around the final year before each repeal's implementation. We plot the estimated coefficients for 10 years before and 20 years after the repeal. This allows us to assess the dynamic effects of repeal and evaluate the plausibility of the assumption of parallel trends.

Recent econometric developments have identified several biases when attempting to estimate treatment effects using Equations (1) and (2) when the timing of treatment differs across treated units and when treatment effects are heterogeneous across time or units (Borusyak

[12]The Urban–Rural classifications change several times during our sample period. We use the 2013 edition to ensure our unit of analysis remained constant over our study period (Ingram & Franco, 2014). This circumvents the possibility that changes to which counties are classified as Urban or Rural in the different editions could introduce compositional changes to our panel. We were able to link all providers to Urban–Rural codes after harmonizing the FIPS codes of a small number of counties using https://seer.cancer.gov/popdata/modifications.html#appendix1 and by using the ZIP codes for a handful of providers with missing FIPS codes in the POS data. No rural counties exist in one of the repeal states (New Jersey) and three of our control states (Delaware, Rhode Island, and the District of Columbia). Rural analyses are, therefore, based on a slightly smaller sample.

[13]Pennsylvania and New Hampshire eliminated their entire CON laws.

[14]We do not include California, Colorado, Idaho, Kansas, North Dakota, Texas, Utah, Wyoming, and South Dakota in the control group, as they did not maintain a CON law throughout our sample period. We include the District of Columbia in the control group for statewide analyses, but not when we analyze rural areas, as described above. We did not include Indiana in the control group as it repealed and implemented CON several times during our sample period. As a robustness test, we present results in the appendix, using all states that did not repeal ASC-specific CON laws as the comparison group.

et al., 2021; Callaway & Sant'Anna, 2021; De Chaisemartin & D'Haultfœuille, 2020; Gardner, 2021; Wooldridge, 2021). To obtain unbiased estimates of Models (1) and (2), we employ the "Extended-TWFE" approach proposed by Wooldridge (2021), the imputation-based approach proposed by Borusyak et al. (2021), estimators developed by Callaway and Sant'Anna (2021), the two-stage approach of Gardner (2021), and the estimator by de Chaisemartin and D'Haultfœuille (2020).

We use a pooled reference period for the Wooldridge estimator, which generates more precise estimates than a fixed reference period.[15] We implement Borusyak's imputation method with a 10^{-6} default tolerance and 100 iterations. The Callaway-Sant'Anna method can be estimated with the control group either being states that never repealed or states that have "not yet" repealed. We present both approaches. Gardner's two-stage procedure first estimates state and year-fixed effects using observations from states that did not or have not yet repealed CON to predict the counterfactual outcomes for all units and periods. The residualized outcome is then regressed on repeal in the second stage to estimate the effect of repeal. We estimate de Chaisemartin and D'Haultfœuille's proposed method with the first-difference option, comparing first-time treated units to placebo's not-yet treated. We draw 100 bootstrap replications to compute the standard errors clustered on the state level.

5 | RESULTS

Table 1, Panel A, shows summary statistics for these variables from 1991 to 2019. Table 1, Panel B shows summary statistics for the states that repealed ASC-CON, as well as for states with CON laws.

TABLE 1 Summary statistics.

Panel A. Summary statistics from state annual data, 1991-2019				
	(1) Mean	**(2) SD**	**(4) Min**	**(5) Max**
ASCs per 100 K state population	1.266	0.966	0.125	6.312
Rural ASCs per 100 K rural population	0.692	0.632	0.000	3.978
Black % state population	0.135	0.120	0.003	0.663
Hispanic % state population	0.081	0.085	0.004	0.495
Elderly (65+) % state population	0.137	0.022	0.041	0.212
Unemployment rate	5.635	1.868	2.100	13.800
N (*N* rural)	1189 (1073)			

Panel B. Summary statistics ASC-CON repeal states and CON states from state annual data, 1991-2019				
	ASC-CON repeal states		**CON states**	
	(1) Mean	**(2) SD**	**(3) Mean**	**(4) SD**
ASCs per 100 K state population	1.454	0.725	1.234	0.977
Rural ASCs per 100 K rural population	0.905	0.632	0.744	0.634

(Continues)

[15]For further discussions see Wooldridge (2021) and Hegland (2023).

TABLE 1 (Continued)

Panel B. Summary statistics ASC-CON repeal states and CON states from state annual data, 1991-2019				
	ASC-CON repeal states		CON states	
	(1) Mean	(2) SD	(3) Mean	(4) SD
Hispanic % state population	0.058	0.051	0.085	0.089
Elderly (65+) % state population	0.143	0.015	0.136	0.023
Unemployment rate	5.115	1.778	5.725	1.870
N (*N* rural)	174 (145)		1015 (928)	

Panel C. Summary statistics rural hospital closures and service reductions, 2005–2019				
	ASC-CON repeal states		CON states	
	(1) Mean	(2) SD	(3) Mean	(4) SD
Hospital closures per 100 K	0.105	0.150	0.156	0.187
Closed hospital beds per 100 K	5.376	8.083	4.646	6.535
Hospital service reductions per 100 K	0.086	0.058	0.177	0.230
Hospital beds lost to service reductions per 100 K	1.520	1.061	8.852	18.083
Rural population, baseline	0.271	0.113	0.253	0.176
Unemployment rate	5.180	1.297	5.916	0.985
Rural population, % change	−0.012	0.026	0.022	0.063
Elderly (65+), % change	0.384	0.130	0.517	0.182
Hispanic, % change	0.725	0.097	0.627	0.189
Black, % change	0.325	0.288	0.340	0.275
Adults diagnosed with diabetes + lung cancer deaths per 100 K (18+, age-adjusted), % change	0.942	0.057	0.913	0.073
N	5		32	

Note: Panel C presents summary statistics for data used to analyze rural hospital closures, service reductions, and control variables. Therefore, New Jersey, Delaware, Rhode Island, and the District of Columbia do not have rural areas and are omitted. The variable Rural Population is the percent of the state population that was rural in 2005. The unemployment rate is averaged over the 2005–2019 period. The percent changes in the rural, Elderly (65+), Black, and Hispanic populations are calculated from 2005 to 2019. The percent change in adults (18+) diagnosed with diabetes and lung cancer is calculated from 2005 to 2016, as these series were discontinued in 2016.

Table 1, Panel C shows descriptive statistics for the measures we use to analyze hospital closures and medical service reductions. These are presented separately for the states that repealed ASC-CONs and states that had CON laws over the sample period. Panel C foreshadows some of our estimation results by documenting that repeal states had fewer hospital closures and service reductions from 2005 to 2019 than did CON states. Panel C also shows that closed hospitals are similar in repeal states and CON states; however, hospitals that reduced services were smaller in repeal states.

5.1 | Ambulatory surgical centers statewide

Figure 2 plots the event-study coefficients from the difference-in-difference estimates from the regression models testing the effect of ASC-CON repeals on the number of ASCs statewide. In

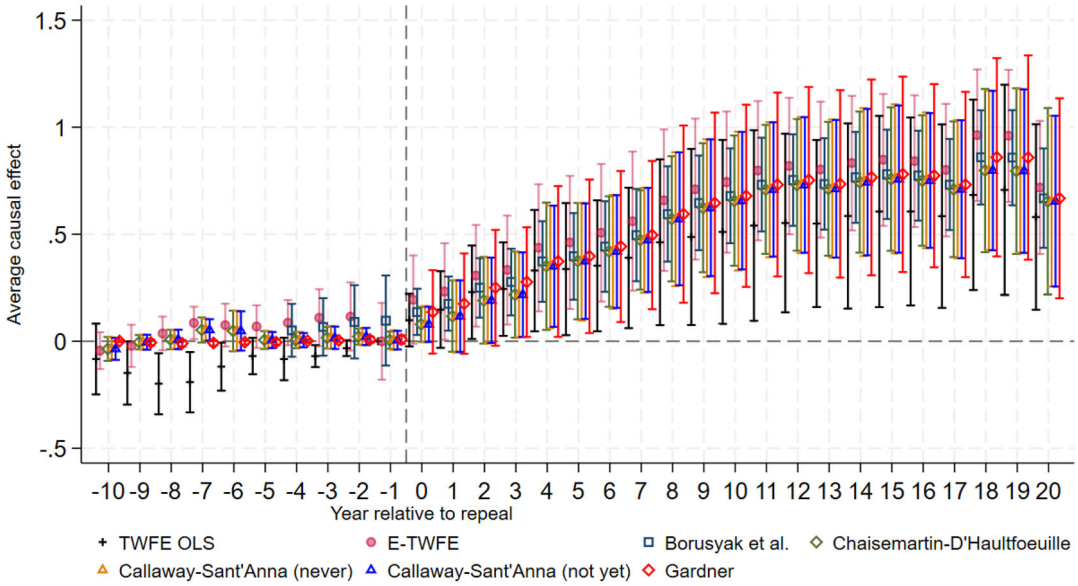

FIGURE 2 Statewide event-study results: estimated effects of ASC-CON repeal on ambulatory surgical centers per 100,000 state population. [Color figure can be viewed at wileyonlinelibrary.com]

TABLE 2 Statewide effect of ASC-CON repeal on ambulatory surgical centers per 100,000 state population.

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	TWFE	Wooldridge E-TWFE	Borusyak	Callaway Sant'Anna (never)	Callaway Sant'Anna (not yet)	Gardner	Chaisemartin and D'Haultfœuille
Estimated treatment effect	0.536** (0.179)	0.553*** (0.106)	0.553*** (0.098)	0.522*** (0.124)	0.523*** (0.122)	0.553** (0.174)	0.523*** (0.137)
R^2	.884	.894					
N	1189	1189	1189	1189	1189	1189	1189

Note: This table presents the estimated effects of the Certificate of Need repeal on the number of ambulatory surgical centers (ASCs) per 100,000 state population. Column (1) is estimated with Ordinary Least Squares and state and year fixed effects (TWFE). Columns (2)–(7) present aggregated Average Treatment Effects on the Treated (ATT's) from the robust difference-in-difference estimators proposed by Wooldridge (2021), Borusyak et al. (2021), Callaway and Sant'Anna (2021), Gardner (2021), and de Chaisemartin and D'Haultfœuille (2020) using data from 1991 to 2019 for 40 states. All regressions are estimated with state and year-fixed effects but without other controls. Standard errors clustered at the state level are in parentheses. R-squared is only available for Columns (1) and (2). *$p < .05$, **$p < .01$, ***$p < .001$.

this figure, the whiskers indicate the 95% confidence intervals corresponding to each point estimate. Leading up to date of the repeals, all point estimates of the unbiased estimation methods are closely centered around zero, supporting the parallel trends assumption. The point estimates are positive after repeal, statistically significant after 3 to 4 years and increase steadily during the first 10 years. These findings indicate that ASC-CON repeals cause ASC entry. About 10 years after the repeal, the increase in ASCs levels off at ∼0.75 additional ASCs per 100,000 state population.

In Figure 2, in contrast to the results documented by the unbiased estimators, the biased TWFE-estimator estimates the presence of pre-trends and somewhat smaller point estimates following repeal. Given that this biased estimator detects pre-trend trends, if one were to

account for these by estimating linear trends before treatment and subtract the estimated trend from observations after treatment, the TWFE-estimator would estimate coefficients that would lead to the erroneous conclusion that CON repeal did not affect ASC entry (Rambachan & Roth, 2023).

Table 2 shows the corresponding estimates of the average treatment effect on the treated (ATT). The ATT estimates are of similar magnitudes, ranging from 0.522 to 0.553, and are statistically significant at the 1% and 0.1% levels. These results imply that the repeal of ASC-CONs caused an increase in the number of ASCs per capita of 44%–47% relative to baseline (1.179) shown in Table A7 (Appendix). Combined with our event-study results, these estimates support our hypothesis that repealing ASC-CONs causes the entry of ASCs statewide.

5.2 | Rural ambulatory surgical centers

Figure 3 shows the event study plots documenting the effect of ASC-CON repeal on the entry of ASCs in rural areas. Pre-repeal and with two exceptions, the point estimates are centered closely around zero, supporting the parallel-trends assumption. The exceptions are the biased TWFE estimator and the Wooldridge extended TWFE estimator. The pre-trends estimates are noisy for the latter estimator, especially for the early pre-treatment years. After repeal, the point estimates for most estimators are positive and statistically significant after about 4 years. The estimated coefficients grow steadily during the first 10 years after ASC-CON repeal and then level off at ∼0.7–0.8 additional ASCs per 100,000 rural population.

Table 3 shows the estimated ATT effects corresponding to Figure 3. For the unbiased estimators, these estimates are positive, ranging from 0.499 to 0.610, and statistically significant. In comparison, the estimated ATT derived from the biased TWFE estimator is not statistically significant.

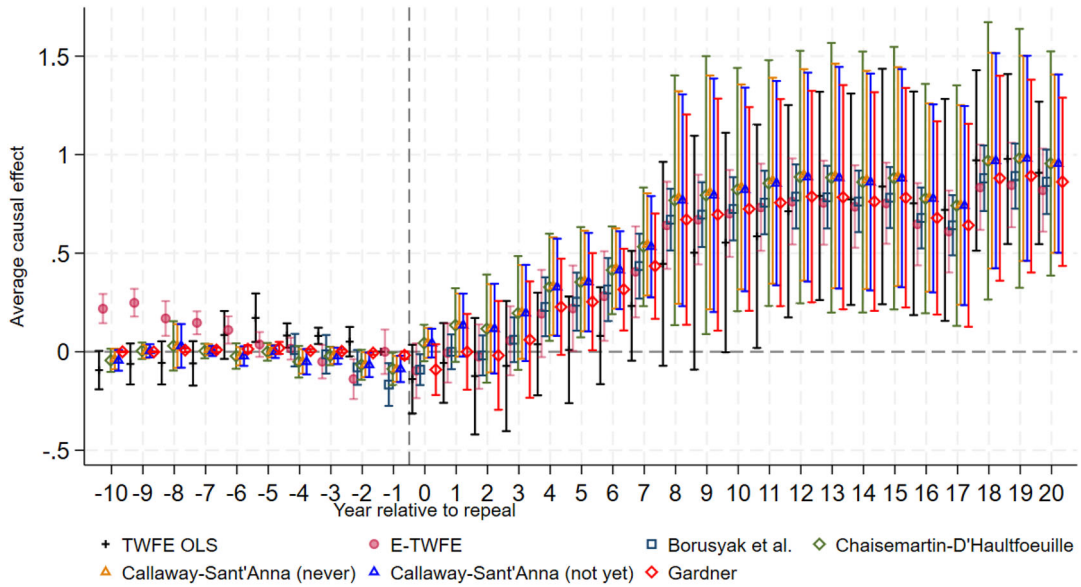

FIGURE 3 Rural event-study results: estimated effects of ASC-CON repeal on ambulatory surgical centers per 100,000 state population. [Color figure can be viewed at wileyonlinelibrary.com]

TABLE 3 Rural Effect of ASC-CON repeal on ambulatory surgical centers per 100,000 state population.

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	TWFE	Wooldridge E-TWFE	Borusyak	Callaway Sant'Anna (never)	Callaway Sant'Anna (not yet)	Gardner	Chaisemartin and D'Haultfœuille
Estimated treatment effect	0.375 (0.228)	0.499*** (0.075)	0.499*** (0.070)	0.610*** (0.177)	0.603*** (0.177)	0.499** (0.182)	0.603** (0.185)
R^2	.807	.842	-	-	-	-	-
N	1073	1073	1073	1073	1073	1073	1073

Note: This table presents the estimated effects of the Certificate of Need repeal on the number of rural ambulatory surgical centers (ASCs) per 100,000 rural population. No rural counties exist in Delaware, New Jersey, Rhode Island, and the District of Columbia. Column (1) is estimated with Ordinary Least Squares and state and year fixed effects (TWFE). Columns (2)–(7) present aggregated Estimated Treatment Effects on the Treated (ATT's) from the robust difference-in-difference estimators proposed by Wooldridge (2021), Borusyak et al. (2021), Callaway and Sant'Anna (2021), Gardner (2021), and de Chaisemartin and D'Haultfœuille (2020) using data from 1991 to 2019 for 36 states. All regressions are estimated with state and year-fixed effects but without other controls. Standard errors clustered at the state level are in parentheses. R-squared is only available for Columns (1) and (2). *$p < .05$, **$p < .01$, ***$p < .001$.

Similar to Table 2, the results for ASC entry in rural areas show that removing an ASC-CON increases the number of Ambulatory Surgical Centers in these areas. These estimates show that the number of ASCs in rural areas increases by 92%–112% relative to the baseline (0.539) shown in Table A7 (Appendix). Together with our event-study results, we find support for our hypothesis that repealing ASC-CONs causes ASCs to enter rural areas.

5.3 | Robustness tests for the analyses of ASC entry: A different control group

As a robustness test, we re-estimate all models with both states that never had a CON and states that had a CON throughout the sample period in the control group. These results are presented in the Appendix, as Figures A1 and A2, and Tables A1 and A2.

The estimates from these robustness tests are similar to those using CON states as the control group. The event studies support the parallel trends assumption, grow over time, and then level off about 10 years after repeal. All estimated ATTs are statistically significant both statewide and in rural areas. As predicted, the magnitudes are slightly smaller when non-CON states are included in the control group, as entry is not restricted in these states.

6 | HOSPITAL CLOSURES AND SERVICE REDUCTIONS

6.1 | Data and empirical strategy

To test the hypotheses regarding rural hospital closures and service reductions, we use the Rural Hospital Closures data from the University of North Carolina (UNC Cecil G. Sheps Center for Health Services Research, 2024). This data set includes measures of reductions in rural healthcare access, overcoming limitations in the POS data (Kaufman et al., 2016). The UNC data classify a hospital as closed if it ceased providing general, short-term, and acute inpatient

care. The data classify a hospital as converted if it closed its inpatient unit but continued to offer some medical services.[16] Converted hospitals are hospitals with service reductions.

The beginning year of the UNC data is 2005. All repeal states other than New Hampshire (2016) removed ASC-CONs from their statutes prior to 2005, making the use of a difference-in-difference empirical design unfeasible. Instead, we compare the repeal states to states with CON laws on four measures of changes in healthcare access, from 2005 to 2019. The measures are rural hospital closures, service reductions, beds closed, and beds lost to service reductions per 100,000 rural population. There are no rural counties in three CON states (Delaware, Rhode Island, and the District of Columbia) and one repeal state (New Jersey). The rural analyses are, therefore, based on this slightly smaller sample. The regression model is:

$$Y_i = \alpha + \gamma\, ASC - CON\, Repeal_i + \boldsymbol{\beta X_i} + \varepsilon_i, \tag{3}$$

where Y_i is one of the outcome measures. The matrix $\mathbf{X}$ includes the control variables: rural population as a percentage of the state in 2005, the average unemployment rate from 2005 to 2019, and the percent change in the rural, Black, Hispanic, and elderly populations between 2005 and 2019. To control for changes to residents' health status, we include the percent change in mortality rates due to lung cancer or diabetes for residents 18 and older between 2005 and 2016 Center for health disease 2015. The construction of these series in 2016; thus, 2016 is the last year of this variable. The Census Bureau is the data source for population size, rural population size, and percentages of black, Hispanic, and elderly populations, defined as those 65 and older. State-level data on unemployment rates come from the Bureau of Labor Statistics.

6.2 | Main results

Table 4 presents the results from estimating Equation (3) with hospital closures per 100,000 rural population as the dependent variable. The estimated coefficient in Table 4, Column (1), is negative, suggesting that ASC growth is not associated with hospital closures. The magnitude of this estimate shows that ASC-CON repeal states exhibit, on average, 0.052 fewer rural hospital closures; however, this estimate is not statistically significant. In Table 4, all coefficients on hospital closures are negative, ranging from −0.052 in Column (1) to −0.007 in Column (3). While these estimates are not statistically significant, they do not support the hypothesis that repeal states lost access to rural hospital services, as measured by hospital closures.

Table 5 presents the results from estimating Equation (3) with closed hospital beds per 100,000 rural population as the dependent variable. In all specifications, the estimated coefficients are positive and range from 0.730 to 2.393; however, none of the point estimates are statistically significant. These results suggest that the rural per capita number of hospital beds closed is similar among repeal states and CON states. The results do not support the hypothesis that repeal states had more closed hospital beds.

[16]These data are only available for rural areas. The data does not consider a hospital to have closed if it merged with another hospital or was sold to another hospital and continued operating. Hospitals that converted to Critical Access Hospitals, Rural Emergency Hospitals, or which closed and reopened within the same calendar year at the same location are also not considered closed, following the methodology developed by the Office of Inspector General (Rehnquist, 2003).

TABLE 4 Effect of ASC-CON repeal on rural hospital closures per 100,000 state population.

	(1) Closures	(2) Closures	(3) Closures	(4) Closures	(5) Closures
ASC-CON repeal	−0.052 (0.070)	−0.047 (0.066)	−0.007 (0.068)	−0.026 (0.084)	−0.042 (0.093)
Rural population, baseline		✓	✓	✓	✓
Unemployment rate			✓	✓	✓
Rural population, % change				✓	✓
Elderly (65+), % change				✓	✓
Hispanic, % change				✓	✓
Black, % change				✓	✓
Adults diagnosed diabetes + lung cancer, % change					✓
R^2	.010	.068	.157	.333	.350
N	37	37	37	37	37

Note: The dependent variable is the number of rural hospital closures from 2005–2019 per 100,000 Rural population in the state. No rural counties exist in Delaware, New Jersey, Rhode Island, and the District of Columbia. Column (2) controls for the percentage of the rural state population in 2005 and the average unemployment rate in the state over the 2005–2019 period. Column (3) also controls for the percent change in the rural population between 2005 and 2019. Column (4) also controls for the percent changes in the Elderly (65+), Hispanic, and Black populations in the state over the 2005–2019 period. Column (5) also controls for the percent change in the age-adjusted rate of adults (18+) diagnosed with diabetes and lung cancer from 2005 to 2016 (these series were discontinued in 2016). Standard errors are clustered by state in parentheses. $^{+}p < .1$, $^{*}p < .05$, $^{**}p < .01$, $^{***}p < .001$.

TABLE 5 Effect of ASC-CON Repeal on closed hospital beds per 100,000 state population in rural areas.

	(1) Closed Beds	(2) Closed Beds	(3) Closed Beds	(4) Closed Beds	(5) Closed Beds
ASC-CON repeal	0.730 (3.524)	0.837 (3.464)	2.393 (3.424)	1.102 (3.984)	0.971 (4.232)
Rural population, baseline		✓	✓	✓	✓
Unemployment rate			✓	✓	✓
Rural population, % change				✓	✓
Elderly (65+), % change				✓	✓
Hispanic, % change				✓	✓
Black, % change				✓	✓
Adults diagnosed diabetes + lung cancer, % change					✓

(Continues)

TABLE 5 (Continued)

	(1) Closed Beds	(2) Closed Beds	(3) Closed Beds	(4) Closed Beds	(5) Closed Beds
R^2	.001	.022	.125	.336	.336
N	37	37	37	37	37

Note: The dependent variable is the number of beds lost to rural hospital closures from 2005–2019 per 100,000 Rural population in the state. No rural counties exist in Delaware, New Jersey, Rhode Island, and the District of Columbia. Column (2) controls for the percentage of the state population that was rural in 2005 and the average unemployment rate in the state over the 2005–2019 period. Column (3) also controls for the percent change in the rural population between 2005 and 2019. Column (4) also controls for the percent changes in the Elderly (65+), Hispanic, and Black populations in the state over the 2005–2019 period. Column (5) also controls for the percent change in the age-adjusted rate of adults (18+) diagnosed with diabetes and lung cancer from 2005 to 2016 (these series were discontinued in 2016). Standard errors are clustered by state in parentheses.
$^{+}p < .1$, $^{*}p < .05$, $^{**}p < .01$, $^{***}p < 0.001$.

TABLE 6 Effect of ASC-CON Repeal on Hospital Service Reductions per 100,000 State Population in Rural Areas.

	(1) Service Reductions	(2) Service Reductions	(3) Service Reductions	(4) Service Reductions	(5) Service Reductions
ASC-CON repeal	-0.091^{+} (0.048)	-0.085^{+} (0.047)	−0.079 (0.061)	−0.070 (0.087)	−0.107 (0.100)
Rural population, baseline		✓	✓	✓	✓
Unemployment rate			✓	✓	✓
Rural population, % change				✓	✓
Elderly (65+), % change				✓	✓
Hispanic, % change				✓	✓
Black, % change				✓	✓
Adults diagnosed diabetes + lung cancer, % change					✓
R2	0.021	0.077	0.079	0.143	0.201
N	37	37	37	37	37

Note: The dependent variable is the number of rural hospital service reductions from 2005–2019 per 100,000 Rural population in the state. No rural counties exist in Delaware, New Jersey, Rhode Island, and the District of Columbia. Column (2) controls for the percentage of the state population that was rural in 2005 and the average unemployment rate in the state over the 2005–2019 period. Column (3) also controls for the percent change in the rural population between 2005 and 2019. Column (4) also controls for the percent changes in the Elderly (65+), Hispanic, and Black populations in the state over the 2005–2019 period. Column (5) also controls for the percent change in the age-adjusted rate of adults (18+) diagnosed with diabetes and lung cancer from 2005 to 2016 (these series were discontinued in 2016). Standard errors are clustered by state in parentheses.
$^{+}p < 0.1$, $^{*}p < 0.05$, $^{**}p < 0.01$, $^{***}p < 0.001$.

Table 6 presents the results from Equation (3), with hospital service reductions per 100,000 rural population as the dependent variable. The point estimate in Table 6, Column (1) shows that repeal states had 0.091 fewer service reductions by rural hospitals. This estimated coefficient is statistically significant at the 10% level. The −0.085 estimate in Table 6, Column (2) is statistically significant at the 10% level. The estimated coefficients on ASC-CON repeals in the

TABLE 7 Effect of ASC-CON repeal number of beds lost to rural hospital service reductions per 100,000 state population in rural areas.

	(1) Closed Beds	(2) Closed Beds	(3) Closed Beds	(4) Closed Beds	(5) Closed Beds
ASC-CON Repeal	−7.332* (3.264)	−6.853* (3.078)	−8.384^{+} (4.775)	−10.360 (6.757)	−12.342^{+} (7.282)
Rural population, baseline		✓	✓	✓	✓
Unemployment rate			✓	✓	✓
Rural population, % change				✓	✓
Elderly (65+), % change				✓	✓
Hispanic, % change				✓	✓
Black, % change				✓	✓
Adults diagnosed diabetes + lung cancer, % change					✓
R^2	.022	.085	.100	.183	.210
N	37	37	37	37	37

Note: The dependent variable is the number of beds lost due to rural hospital service reductions from 2005–2019 per 100,000 Rural population in the state. No rural counties exist in Delaware, New Jersey, Rhode Island, and the District of Columbia. Column (2) controls for the percentage of the state population that was rural in 2005 and the average unemployment rate in the state over the 2005–2019 period. Column (3) also controls for the percent change in the rural population between 2005 and 2019. Column (4) also controls for the percent changes in the Elderly (65+), Hispanic, and Black populations in the state over the 2005–2019 period. Column (5) also controls for the percent change in the age-adjusted rate of adults (18+) diagnosed with diabetes and lung cancer from 2005 to 2016 (these series were discontinued in 2016). Standard errors are clustered by state in parentheses. $^{+}p < .1$, $*p < .05$, $**p < .01$, $***p < .001$.

subsequent columns are also negative and of similar magnitude, ranging from 0.070 to −0.107; however, they are not statistically significant. These results do not support the hypothesis that repeal states lost access to rural hospital services, as measured by hospital conversions. Rather, the evidence points toward ASC-CON repeal states having fewer reductions in hospital services.

Table 7 presents regression results from estimation Equation (3). In these regressions, the dependent variable is hospital beds lost due to hospital service reductions, measured as the number of beds lost per 100,000 rural population. The coefficient in Table 7, Column (1), shows the estimate that when no control variables are included, repeal states lost on average 7.3 fewer beds. This coefficient is statistically significant at the 5% level. In Columns (2)–(5), which add different control variables in each specification, the estimated coefficients range from −12.3 to −6.9. The coefficients in Column (3) and (5) are statistically significant at 10% level. Thus, evidence shows that fewer beds were lost in repeal states than in CON states when hospitals reduce services. These results do not support the hypothesis that repeal states lost access to hospital services, as measured by the size of the hospitals that reduced services. Instead, the evidence shows repeal states had smaller hospitals involved in service reductions.

6.3 | Robustness tests for the analyses on hospital closures/service reductions: A different control group

To evaluate the sensitivity of the results for hospital closures and service reductions we implement the same robustness test as in Section 5.3, by re-estimate all models with both states that

never had a CON and states that had a CON throughout the sample period in the control group. These results are presented in the Appendix, as Tables A3–A6. The results from these robustness tests are qualitatively very similar to those using CON states as the control group. The estimated coefficients are similar throughout, with some minor differences found in the precision of the estimates, specifically in Tables A5 and A6.

The estimated coefficients in Columns (1) and (2) of Table A5 are of similar magnitude as before, but are now statistically significant at the 5% level, rather than the 10% level (in Table 6). The coefficient in Column (3) is statistically significant at the 10% level in Table A5. The finding that repeal states had fewer hospital service reductions (Table 6) is therefore robust to employing this alternative control group.

The estimated coefficients in Table A6 are of similar magnitude but Column (3) is statistically significant at the 5% level (rather than the 10% level in Table 7), and the coefficient in Column (3) is statistically significant at the 5% level (rather than at the 10% level). The finding that repeal states lost fewer hospital beds to service reductions (Table 7) is therefore robust to employing this alternative control group.

7 | CONCLUSIONS

This study estimates the causal effects of repealing ASC-specific CON laws. It shows that ASCs per capita increased by 44%–47% statewide due to repeal. In rural areas, ASC-CON repeal caused ASC's per capita to increase of 92%–112%. Given that CON law repeal is followed by medical provider entry, these findings document that CON laws are effective statewide and rural entry barriers.

According to the cream-skimming hypothesis, unrestricted entry for hospital substitutes, such as ASCs, allows entrants to selectively provide services to the most profitable patients, thereby threatening hospitals' financial prospects. While our models cannot test this claim directly, they test the implications stemming from the cream-skimming hypothesis. Specifically, this hypothesis predicts increased hospital closures and service reductions in states that repeal their CON laws. We test this prediction for rural areas in CON repeal states, as closures of hospitals in rural areas are a major concern of policymakers, who favor CON laws based on the claim that they prevent hospital closures in rural areas. However, the point estimates on CON repeal do not support the prediction that ASC entry results hospital closures or hospital service reductions. Rather, we find suggestive evidence that repealing ASC-CONs improves access to hospital services.

One explanation for this suggestive evidence is that ASCs and hospitals serve complementary roles in healthcare markets. ASC entry allows hospitals to focus on surgeries and medical services that are not feasible in ASC settings. This differentiation could lead hospitals to specialize in more complex—and potentially more profitable—surgeries and make the hospital attractive for medical providers specializing in these services. Another explanation for our finding is that unrestricted ASC entry mitigates one reason hospitals close, for example, the lack of qualified staff. Surgeons tempted to quit their rural hospital jobs are incentivized to continue working at the hospital when they can also form an ASC, 91% of which are surgeon-owned (Munnich & Parente, 2018). This explanation is also consistent with research that shows surgeons are the only physician-specialty that predicts rural hospital closures (Germack et al., 2019).

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APPENDIX

All figures and tables in the Appendix define the control group as including states that never had a CON during the sample period and states that always had a CON during the sample period.

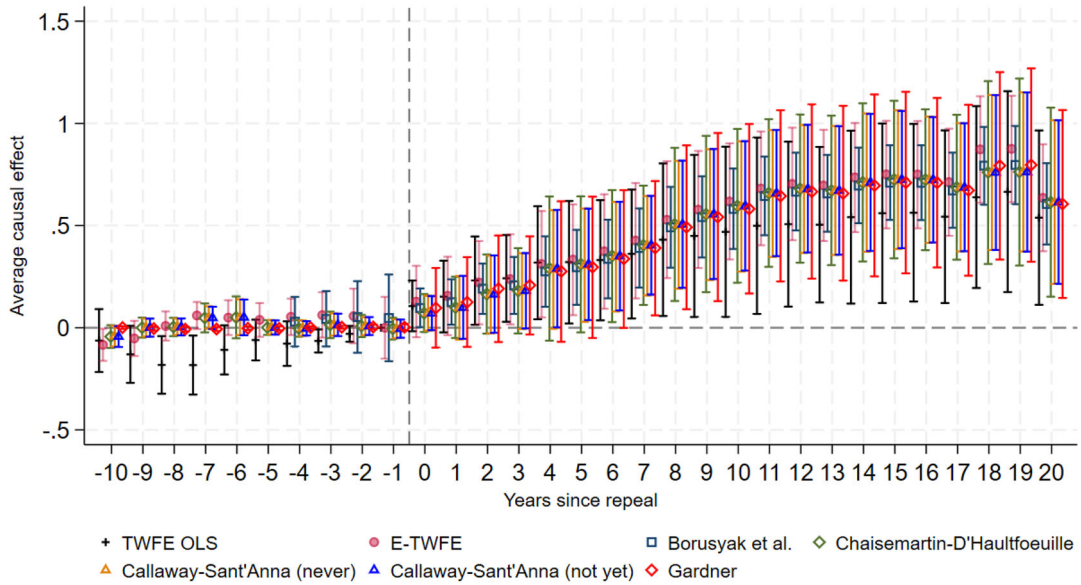

FIGURE A1 Statewide event-study results: estimated effects of ASC-CON repeal on ambulatory surgical centers per 100,000 state population. [Color figure can be viewed at wileyonlinelibrary.com]

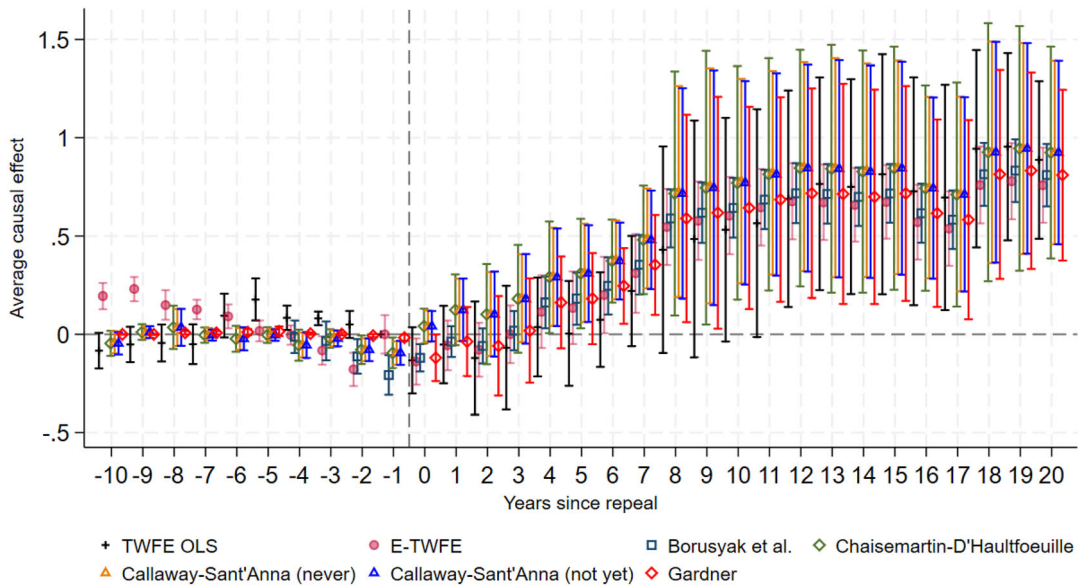

FIGURE A2 Rural event-study results: estimated effects of ASC-CON repeal on ambulatory surgical centers per 100,000 state population. [Color figure can be viewed at wileyonlinelibrary.com]

TABLE A1 Statewide effect of ASC-CON repeal on ambulatory surgical centers per 100,000 state population.

	(1) TWFE	(2) Wooldridge E-TWFE	(3) Borusyaket al.	(4) Callaway Sant'Anna (never)	(5) Callaway Sant'Anna (not yet)	(6) Gardner	(7) Chaisemartin and D'Haultfœuille
Estimated treatment effect	0.471** (0.170)	0.476*** (0.092)	0.476*** (0.086)	0.478*** (0.121)	0.480*** (0.120)	0.476** (0.167)	0.480*** (0.126)
R^2	.877	.885	-	-	-	-	-
N	1479	1479	1479	1479	1479	1479	1479

Note: This table presents the estimated effects of the certificate of need repeal on the number of ambulatory surgical centers (ASCs) per 100,000 state population. Column (1) is estimated with ordinary least squares and state and year fixed effects (TWFE). Columns 2–7 present aggregated average treatment effects on the treated (ATT's) from the robust difference-in-difference estimators proposed by Wooldridge (2021), Borusyak et al. (2021), Callaway and Sant'Anna (2021), Gardner (2021), and de Chaisemartin and D'Haultfœuille (2020) using all available data from 1991 to 2019 for 51 states. All regressions are estimated with state and year-fixed effects but without other controls. R-squared is only available for Columns (1) and (2). Standard errors clustered at the state level in parentheses. R-squared is only available for Columns (1) and (2). $^{+}p < .1$. $^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$.

TABLE A2 Rural Effect of ASC-CON repeal on ambulatory surgical centers per 100,000 State Population.

	(1) TWFE	(2) Wooldridge E-TWFE	(3) Borusyaket al.	(4) Callaway Sant'Anna (never)	(5) Callaway Sant'Anna (not yet)	(6) Gardner	(7) Chaisemartin and D'Haultfœuille
Estimated treatment effect	0.327 (0.220)	0.438*** (0.069)	0.438*** (0.066)	0.573** (0.176)	0.569** (0.176)	0.438* (0.178)	0.569** (0.190)
R^2	.793	.819	-	-	-	-	-
N	1363	1363	1363	1363	1363	1363	1363

Note: This table presents the estimated effects of the certificate of need repeal on the number of rural ambulatory surgical centers (ASCs) per 100,000 rural population. Column (1) is estimated with Ordinary Least Squares and state and year fixed effects (TWFE). Columns (2)–(7) present aggregated Average Treatment Effects on the Treated (ATT's) from the robust difference-in-difference estimators proposed by Wooldridge (2021), Borusyak et al. (2021), Callaway and Sant'Anna (2021), Gardner (2021), and de Chaisemartin and D'Haultfœuille (2020) using all available data from 1991 to 2019 for 47 states. No rural counties exist in Delaware, New Jersey, Rhode Island, and the District of Columbia. All regressions are estimated with state and year-fixed effects but without other controls. Standard errors clustered at the state level are in parentheses. R-squared is only available for Columns (1) and (2). $+p < .1$, $^{*}p < .05$, $^{**}p < .01$, $^{***}p < .001$.

TABLE A3 Effect of ASC-CON repeal on rural hospital closures per 100,000 state population.

	(1) Closures	(2) Closures	(3) Closures	(4) Closures	(5) Closures
ASC-CON repeal	−0.051 (0.069)	−0.049 (0.063)	−0.021 (0.064)	−0.028 (0.075)	−0.013 (0.074)
Rural population, baseline		✓	✓	✓	✓
Unemployment rate			✓	✓	✓
Rural population, % change				✓	✓
Elderly (65+), % change				✓	✓
Hispanic, % change				✓	✓
Black, % change				✓	✓
Adults diagnosed diabetes + lung cancer, % change					✓
R^2	.007	.118	.210	.244	.257
N	47	47	47	47	47

Note: The dependent variable is the number of rural hospital closures from 2005–2019 per 100,000 rural population in the state. No rural counties exist in Delaware, New Jersey, Rhode Island, and the District of Columbia. Column (2) controls for the percentage of the rural state population in 2005 and the average unemployment rate in the state over the 2005–2019 period. Column (3) also controls for the percent change in the rural population between 2005 and 2019. Column (4) also controls for the percent changes in the Elderly (65+), Hispanic, and Black populations in the state over the 2005–2019 period. Column (5) also controls for the percent change in the age-adjusted rate of adults (18+) diagnosed with diabetes and lung cancer from 2005 to 2016 (these series were discontinued in 2016). Standard errors are clustered by state in parentheses. $+p < .1$, $*p < .05$, $**p < .01$, $***p < .001$.

TABLE A4 Effect of ASC-CON repeal on closed hospital beds per 100,000 state population in rural areas.

	(1) Closed Beds	(2) Closed Beds	(3) Closed Beds	(4) Closed Beds	(5) Closed Beds
ASC-CON repeal	0.432 (3.511)	0.489 (3.359)	1.650 (3.266)	0.862 (3.678)	1.784 (3.643)
Rural population, baseline		✓	✓	✓	✓
Unemployment rate			✓	✓	✓
Rural population, % change				✓	✓
Elderly (65+), % change				✓	✓
Hispanic, % change				✓	✓
Black, % change				✓	✓
Adults diagnosed diabetes + lung cancer, % change					✓
R^2	0.000	0.080	0.181	0.227	0.259
N	47	47	47	47	47

Note: The dependent variable is the number of beds lost to rural hospital closures from 2005–2019 per 100,000 rural population in the state. No rural counties exist in Delaware, New Jersey, Rhode Island, and the District of Columbia. Column (2) controls for the percentage of the rural state population in 2005 and the average unemployment rate in the state over the 2005–2019 period. Column (3) also controls for the percent change in the rural population between 2005 and 2019. Column (4) also controls for the percent changes in the Elderly (65+), Hispanic, and Black populations in the state over the 2005–2019 period. Column (5) also controls for the percent change in the age-adjusted rate of adults (18+) diagnosed with diabetes and lung cancer from 2005 to 2016 (these series were discontinued in 2016). Standard errors are clustered by state in parentheses. $^{+}p < .1$, $*p < .05$, $**p < .01$, $***p < .001$.

TABLE A5 Effect of ASC-CON repeal on hospital service reductions per 100,000 state population in rural areas.

	(1) Service Reductions	(2) Service Reductions	(3) Service Reductions	(4) Service Reductions	(5) Service Reductions
ASC-CON repeal	−0.097* (0.043)	−0.096* (0.044)	−0.098^{+} (0.052)	−0.083 (0.070)	−0.095 (0.073)
Rural population, baseline		✓	✓	✓	✓
Unemployment rate			✓	✓	✓
Rural population, % change				✓	✓
Elderly (65+), % change				✓	✓
Hispanic, % change				✓	✓
Black, % change				✓	✓
Adults diagnosed diabetes + lung cancer, % change					✓
R^2	.019	.037	.037	.165	.172
N	47	47	47	47	47

Note: The dependent variable is the number of rural hospital service reductions from 2005–2019 per 100,000 rural population. No rural counties exist in Delaware, New Jersey, Rhode Island, and the District of Columbia. Column (2) controls for the percentage of the rural state population in 2005 and the average unemployment rate in the state over the 2005–2019 period. Column (3) also controls for the percent change in the rural population between 2005 and 2019. Column (4) also controls for the percent changes in the Elderly (65+), Hispanic, and Black populations in the state over the 2005–2019 period. Column (5) also controls for the percent change in the age-adjusted rate of adults (18+) diagnosed with diabetes and lung cancer from 2005 to 2016 (these series were discontinued in 2016). Standard errors are clustered by state in parentheses. $+p < .1$, $*p < .05$, $**p < .01$, $***p < .001$.

TABLE A6 Effect of ASC-CON repeal on beds lost to service reductions per 100,000 state population in rural areas.

	(1) Closed Beds	(2) Closed Beds	(3) Closed Beds	(4) Closed Beds	(5) Closed Beds
ASC-CON repeal	−6.407* (2.530)	−6.318* (2.572)	−6.994* (3.388)	−8.479^{+} (4.849)	−9.281^{+} (4.830)
Rural population, baseline		✓	✓	✓	✓
Unemployment rate			✓	✓	✓
Rural population, % change				✓	✓
Elderly (65+), % change				✓	✓
Hispanic, % change				✓	✓
Black, % change				✓	✓
Adults diagnosed diabetes + lung cancer, % change					✓
R^2	.017	.065	.073	.133	.139
N	47	47	47	47	47

Note: The dependent variable is the number of beds in rural hospital service reductions from 2005–2019 per 100,000 rural population in the state. No rural counties exist in Delaware, New Jersey, Rhode Island, and the District of Columbia. Column (2) controls for the percentage of the state population that was rural in 2005 and the average unemployment rate in the state over the 2005–2019 period. Column (3) also controls for the percent change in the rural population between 2005 and 2019. Column (4) also controls for the percent changes in the Elderly (65+), Hispanic, and Black populations in the state over the 2005–2019 period. Column (5) also controls for the percent change in the age-adjusted rate of adults (18+) diagnosed with diabetes and lung cancer from 2005 to 2016 (these series were discontinued in 2016). Standard errors are clustered by state in parentheses. $+p < .1$, $*p < .05$, $**p < .01$, $***p < .001$.

TABLE A7 Ambulatory surgical centers at baseline in ASC-CON repeal states.

	(1) Mean	(2) SD
ASCs per 100 K state population	1.179	0.529
Rural ASCs per 100 K rural population	0.539	0.432
N (*N* rural)	6 (5)	

Note: There are fewer observations in rural areas because New Jersey does not have rural counties.

TESTIMONY OF THE MAINE MEDICAL ASSOCIATION AND THE MAINE OSTEOPATHIC ASSOCIATION

Room 202, Cross Building, Augusta, Maine
Wednesday, October 8, 2025

Good Afternoon, Senator Tipping, Representative Boyer, and Members of the Commission to Evaluate the Scope of Regulatory Review and Oversight over Health Care Transactions That Impact the Delivery of Health Care Services in the State. My name is Anne Sedlack, and I am the Director of Advocacy at the Maine Medical Association. I am submitting this testimony on behalf of the Maine Medical Association and the Maine Osteopathic Association.

The Maine Medical Association (MMA) is a professional organization representing more than 4,300 allopathic and osteopathic physicians, residents, and medical students in Maine. MMA's mission is to support Maine physicians, advance the quality of medicine in Maine, and promote the health of all Maine people. The Maine Osteopathic Association (MOA) is a professional organization representing more than 1,200 osteopathic physicians, residents, and medical students in Maine whose mission is to serve the Osteopathic profession of the State of Maine through a coordinated effort of professional education, advocacy, and member services in order to ensure the availability of quality osteopathic health care to the people of this State.

We appreciate this opportunity to share some initial thoughts as the Commission begins its work pursuant to Resolve 2025, Chapter 106. Our professional Associations have diverse memberships, and as such have diverse opinions about the issues before the Commission. Physicians have a great interest in and a strong personal stake in the results under this Resolve, so we will closely follow the Commission's deliberations and will provide input and feedback as appropriate.

At this initial meeting, we would like to share three core considerations that we hope the Commission will keep in mind as it deliberates on its recommendations.

First, we understand the reasons for why the Legislature directed this Commission to consider the role of the State in changes in our health care marketplace, including consolidation in large integrated health systems; entry into the Maine market of foreign corporate interests, the closure of health care entities or of service lines, and the role of private equity financing in recent transactions in Maine. These reasons, such as closures of the health system, affect the people of Maine every single day, and we do not take them lightly.

We know that factors such as financing of medical services, regulatory complexity and its attendant administrative burdens, and the need for capital for necessary investment in medical equipment and information technology influence the Maine market as they do the rest of the country.

As such, our first core consideration is that we hope this Commission recognizes that Maine healthcare organizations act rationally and in good faith in response to all these factors when making decisions.

Second, healthcare in our country is heavily influenced by the federal government's policy decisions, such as the roles of the Medicare and Medicaid programs, ERISA, and HIPAA, for example. In the absence of comprehensive reform at the federal level, we urge the Commission to carefully consider whether to increase the state's regulatory authority over healthcare transactions, including licensing authority, antitrust law enforcement, and the certificate-of-need process.

As such, our second core consideration is that we hope this Commission will begin its work by inventorying the regulatory tools already available, so we can avoid layering new regulation without purpose.

Third, our Associations represent physicians in all medical specialties in all types of practice settings (employed or independent, large or small, traditional private practice or "direct care") in all geographic regions of our state.. We believe it is a central part of our mission to advocate for as much physician autonomy and choice of practice modality as our current system permits.

As such, our third and final core consideration is that we hope this Commission understands that preserving physician autonomy and choice is in society's interest, too, because it is the critical basis for ensuring career satisfaction, avoiding burnout, and delivering high-quality care to patients.

Finally, we would like to share a note about one aspect of our membership – the independent, private practice setting.

A minority of physicians today, both in Maine and nationwide, opt for an independent, private practice model due to the market forces mentioned above. However, those who opt to remain in independent, private practice feel strongly about preserving an environment that allows such a model to thrive. Both Associations have long worked to support these members. For example, MMA members formed the MMA's Independent Practice Section (IPS) as a forum for advocacy on their behalf.

IPS members strongly oppose any additional state regulation of business transactions involving solely independent, private practices and any expansion of the scope of the certificate-of-need law. Rather, the IPS members ask that the Commission consider increasing the scope of CON review by increasing the thresholds for review for "capital expenditures" and "major medical equipment," and reconsidering the application of CON review to any "new health service." Moreover, IPS members contend that, because they are mostly small businesses built on the personal capital of individual physicians and are taxpaying businesses, the state government simply does not have the same regulatory interest in them as it does in non-profit, tax-exempt healthcare entities.

Thank you for considering our initial comments as you begin your work under this Resolve. And thank you for agreeing to serve on this Commission. We look forward to following your deliberations and providing any assistance you may need.

Thank you for considering the thoughts of Maine's physicians.

Best,

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Richard A. Bennett
Senator, District 18

THE MAINE SENATE
132nd Legislature

3 State House Station
Augusta, Maine 04333

October 8, 2025

The Honorable Michael Tipping, Senate Chair
The Honorable Michelle Boyer, House Chair
Commission to Evaluate the Scope of Regulatory Review and Oversight over Health Care Transactions That Impact the Delivery of Health Care Services in the State
100 State House Station
Augusta, ME 04333

Dear Senator Tipping, Representative Boyer, and members of the Commission to Evaluate the Scope of Regulatory Review and Oversight over Health Care Transactions That Impact the Delivery of Health Care Services in the State:

Too many Mainers continue to face significant barriers to accessing health care and I fear these challenges may worsen without meaningful policy change. When reviewing your duties, I was encouraged to see that the Commission will be evaluating potential updates to certificate of need laws, reviewing oversight of major health care transactions and ownership shifts, examining the influence of private equity and real estate investment in hospitals, and identifying best practices from other states to inform legislative action. These are incredibly important matters and I want to thank you all for your willingness to take them up.

During your discussion of pending legislation, I urge you to consider my testimony in support of LD 985, *An Act to Impose a Moratorium on the Ownership or Operation of Hospitals in the State by Private Equity Companies or Real Estate Investment Trusts*, which is attached. I believe proactive steps are necessary to protect the long-term health and well-being of our communities.

Thank you for your attention to this matter.

Sincerely,

Richard Bennett
Senator

*State House (207) 287-1505 * Fax (207) 287-1527 * Toll Free 1-800-423-6900 * TTY 711*
*Richard.Bennett@legislature.maine.gov * legislature.maine.gov/senate*

Richard A. Bennett
Senator, District 18

THE MAINE SENATE
132nd Legislature

3 State House Station
Augusta, Maine 04333

Joint Standing Committee on Health Coverage, Insurance and Financial Services on LD 985, An Act to Impose a Moratorium on the Ownership or Operation of Hospitals in the State by Private Equity Companies or Real Estate Investment Trusts
May 6, 2025

Good morning, Senator Bailey, Representative Mathieson, and distinguished members of the Joint Standing Committee on Health Coverage, Insurance and Financial Services:

I am Senator Rick Bennett of Oxford, and I have the privilege of representing the people of 14 wonderful communities in Western Maine. I am pleased to cosponsor of LD 985, "An Act to Impose a Moratorium on the Ownership or Operation of Hospitals in the State by Private Equity Companies or Real Estate Investment Trusts."

Let me begin by saying that health care in Maine today is a far cry from what it was when I was growing up. Back then, medicine was local and personal. Many of us had family doctors we knew by name, who lived in our towns, whose kids went to school with ours. Today, most of those small, independent practices have been absorbed by large hospital systems. While these systems have often stepped in out of necessity, to prevent service disruptions, it is undeniable that we have lost something in the process — something deeply rooted in trust, accessibility, and community.

Now we face another threat — a newer, more insidious one. As hospitals across our state grapple with financial pressures, they may be tempted by outside buyers promising fast relief. But not all lifelines come without strings. Increasingly across the country, we see private equity firms and real estate investment trusts — entities with no medical expertise or community accountability — taking over struggling nonprofit hospitals. Their business model is not subtle: cut services, raise costs, and extract profit. When the returns aren't high enough, they close shop. And it's the people — our people — who are left behind.

We've already got challenges in rural health care. In parts of Maine, it's not unusual to drive 30, 45 minutes, or more just to see a doctor. If a hospital closes because it no longer serves a financial interest, that drive can become two hours. For an elderly patient, for someone without reliable transportation, or for someone in the middle of a medical emergency — that can be the difference between life and death.

We are at a crossroads. Do we continue to let out-of-state investors with no stake in our communities buy up the institutions that safeguard our health? Or do we pause — as LD 985 proposes — and give ourselves time to assess, to protect, and to preserve what matters most?

LD 985 establishes a five-year moratorium on private equity and REIT ownership of hospitals in Maine. This is not a ban. This is a timeout — a deliberate, responsible pause — to ensure that our

Legislature and regulatory agencies have the tools and insight necessary to prevent profiteering at the expense of public health.

We cannot afford to be reactive when it comes to health care. We must be proactive, especially when the well-being of our citizens is on the line. I urge you to support this thoughtful and necessary legislation.

Thank you for your time and your consideration.

*Housing and Economic Development Committee * Government Oversight Committee*
*State House (207) 287-1505 * Fax (207) 287-1527 * Toll Free 1-800-423-6900 * TTY 711*
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Senator Tipping, Representative Boyer, and distinguished members of the Commission:

My name is David Jolly, I live in Penobscot, and I am Vice Chair of Maine AllCare, a state-wide organization advocating universal health care for Maine. Maine AllCare worked with Senator Tipping and others on the development of LD 985, which places a one-year moratorium on private equity (PE) acquisition of Maine hospitals.

Many of our hospitals, especially those in rural areas, are in dire financial straits. According to the Center for Healthcare Quality and Payment Reform, nearly half of our 24 rural hospitals are at risk of closing.[1] But private equity firms are not the answer. Their takeover of Maine hospitals would only make a bad situation worse.

I say that for several reasons. First and foremost, the goals of private equity are incompatible with those of health care. PE firms seek a return on investment as high and as fast as possible; they then sell the investment quickly and move on to their next conquest. In health care patient well-being, not profit, should be the primary concern.

Second, private equity firms do not save hospitals. In 2024, according to the Private Equity Stakeholder Project, private equity companies accounted for 21 per cent of all health care bankruptcies and for seven of the eight largest.[2] PE bankruptcies have led to the permanent closing of community hospitals in Massachusetts and Pennsylvania.

Third, private equity firms compromise care. A 2023 study published in the *Journal of the American Medical Association* found that Medicare patients at hospitals owned by PE firms experienced a 25% increase in hospital-acquired complications, mainly falls and blood-stream infections, compared to Medicare patients at other hospitals.[3] The senior author of that study believes that those findings can be explained largely by the staffing cuts PE firms often impose on hospitals to maximize short-term profits.[4] Another study published in JAMA in 2025 found that patients at private equity-acquired hospitals rated their hospital experiences lower than patients at other hospitals did.[5]

LD 985 gives you a brief period to develop rules to regulate the purchase of healthcare facilities by private equity firms. Fortunately, legislation in other states can provide models for you to consider. Twelve states are now considering legislation to regulate healthcare markets. This legislation generally takes one of two forms:

- Requirements to provide notice and related disclosures to state regulators for certain healthcare transactions.
- Corporate practice of medicine (CPOM) restrictions that reserve certain activities for licensed healthcare professionals. Private equity firms have sometimes used

management service organizations (MSOs) as a work-around to CPOM restrictions, so some recent legislation would also place restrictions on MSOs.

The legislative proposals in these 12 states are summarized in an alert from the Goodwin law firm that I've attached to my testimony.[6] I also encourage you to consider New Mexico's recently passed HB586,[7] which is not listed in the Goodwin alert. This set of health care transaction regulations is one of the strongest in the country. As summarized in a Millbank Memorial Fund issue brief,

> HB 586 requires prior approval from the state for hospital mergers, changes in hospital control, and acquisitions of health care practices by provider organizations affiliated with a health insurer. The law outlines several key considerations that the state's health care authority must weigh when evaluating a proposed transaction, including the likely impact of the transaction on essential services, patient costs, the health care 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.[8]

Let me conclude by stating the obvious. While private equity acquisition of Maine hospitals will only make a bad situation worse, regulating these transactions will not solve the financial issues confronting Maine hospitals. Maine AllCare believes the best strategy for doing that would be global budgeting, which we propose in the All Maine Health Program,[9] our plan for universal health care in Maine. Under global budgeting each hospital would negotiate an annual budget with the appropriate state agency. The budget could be based on a combination of factors: revenues or costs from the prior year, service mix, population served, and cost of uncompensated care. This is no pipedream. Maryland adopted global budgeting for its hospitals in 2014. Since then, no hospitals in Maryland have closed, and hospital spending growth has held steady for nearly a decade.[10] Vermont and Pennsylvania are now moving towards global budgeting for their hospitals through pilot programs with the Center for Medicare and Medicaid Services.

I wish the Commission well in your deliberations. Please know Maine AllCare stands ready to assist you in that work in any way we can. Thank you for your time.

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GOODWIN

ALERT · MARCH 20, 2025

States Continue to Pursue and Expand Healthcare Market Oversight at an Unprecedented Pace, With Significant Implications for Private Equity

BY John Goheen Joseph Harrington Andrew Jensen

Introduction

In recent years, states have shown an increased interest in regulating healthcare markets. The trend has accelerated further since the start of 2025, with a flurry of proposals in at least 12 states. Some of these proposed laws specifically aim to regulate private equity investment in healthcare, and all of these draft laws would profoundly affect the way private equity currently does business if passed in their current form. For regulated parties, this increase in state-level efforts contrasts with expected changes in federal priorities under new leadership at both the Federal Trade Commission ("FTC") and Department of Justice Antitrust Division. While healthcare will likely remain a focus, the new administration's appointments, particularly the exit and replacement of former FTC chair Lina Khan, a vocal critic of private equity, may signal reduced federal scrutiny for private equity investors.[1] Perhaps as a reaction to an anticipated federal recalibration, several states appear poised to pick up the torch from the Khan-led FTC and ramp up monitoring and enforcement around private equity's role in healthcare. In the first section of this alert, we provide an overview of the two predominant types of laws state lawmakers and regulators are pursuing, explain how they affect private equity, and describe trends for each type:

1. **Mini-HSR Laws**, which require parties to certain healthcare transactions to provide notice and related disclosures to state regulators
2. **Corporate Practice Restrictions**, which reserve certain activities for licensed healthcare professionals and are commonly referred to as corporate practice of medicine ("CPOM") or dentistry ("CPOD") restrictions

In the second section, we catalog the proposed laws in each state, categorizing each proposal and elucidating concrete impacts on private equity investors.

Mini-HSR Laws

What are Mini-HSR Laws?

The first category of measures comprises what we refer to as "Mini-HSR Laws," which largely parallel the reporting requirements under the federal Hart-Scott-Rodino Act. Mini-HSR Laws require parties to give advance notice of some subset of

healthcare-related transactions (frequently referred to as "Material Change Transactions") to state attorneys general or other state regulatory authorities.[2] These laws vary widely across jurisdictions, with the length of the notice period, breadth of the Material Change Transaction definition, and comprehensiveness of the regulatory filing itself all informing the intensity of the obligation under a given state's Mini-HSR Law. Without understating the impact of closing delays and ownership disclosures on private equity investors, the most consequential variable for Mini-HSR Laws is whether (and under what circumstances) state authorities can delay, place conditions on, or even block Material Change Transactions to preserve market competition, advance patient access to healthcare services, or promote similar interests. In the simplest possible terms, the states with the most restrictive Mini-HSR Laws require private equity investors to submit more frequent and comprehensive notice filings, wait longer, and obtain affirmative approval before parties can close a transaction.

How do Mini-HSR Laws affect private equity?

To comply with Mini-HSR Laws, private equity firms entering Material Change Transactions have to submit regulatory filings that can (1) be due earlier than other common regulatory filings (such as change of ownership filings for permits and Medicaid enrollments), (2) include more extensive disclosures about such firms and fund investors, and (3) involve demonstrating that the Material Change Transaction will not have certain effects, such as increased healthcare costs or reduced access. Making timely, comprehensive, effective filings requires earlier and more involved coordination between private equity firms and healthcare and antitrust counsel, as well as careful planning to protect sensitive information about limited partners and co-investors.

What are the trends in current Mini-HSR proposals?

Currently, at least 15 states have Mini-HSR Laws, as tracked on Goodwin's State Healthcare Transaction Notification Laws resource. Prior to 2020, Mini-HSR Laws were limited in number and scope, frequently focusing only on hospital mergers and acquisitions, likely reflecting states' desire to prevent hospital closures or bankruptcies. A second wave of these Mini-HSR Laws has taken effect since 2020, especially in the past two years, as many states have created new reporting regimes. The second-wave Mini-HSR Laws have generally been broader in scope, reflecting a shift in focus toward traditional antitrust concerns such as market consolidation and increasing healthcare costs. These more recent laws have, in some cases, targeted private equity firms specifically. Most recently, Massachusetts Governor Maura Healey signed a proposal into law in January (as detailed here) that grants state regulators greater authority to review Material Change Transactions, especially those involving private equity investment. The new law will become effective in April.

In contrast to the activity that characterized much of 2023 and 2024, nearly all current Mini-HSR proposals would strengthen existing Mini-HSR Laws, rather than create reporting regimes in new states. Since December 2024, officials in at least nine states (California, Connecticut, Illinois, Indiana, Massachusetts, New Mexico, New York, Vermont, and Washington) have introduced proposals to strengthen transaction review regimes by requiring regulatory filings in connection with new types of transactions or additional types of healthcare entities (with a particular focus on private equity) or by increasing state regulators' authority to impose conditions on Material Change Transactions or block them entirely. Measures in six of those nine states would establish or enhance the state's authority to block proposed transactions. Proposals in five states would impose additional or heightened requirements for private equity investors or private equity-backed providers. Only in Texas have lawmakers proposed creating a new Mini-HSR Law in a state currently lacking any such law. While it is unclear at this stage which of these proposals will take effect, Goodwin will continue to provide updates and track these various measures through the relevant legislative and regulatory processes.

Corporate Practice Restrictions: Background and Activity Summary

What are Corporate Practice Restrictions?

"Corporate Practice Restrictions" constitute the second category of legal requirements affecting private equity investors in healthcare. Corporate Practice Restrictions originate from the principle that unlicensed individuals and the corporations they own and control should not have influence over the clinical judgment of licensed healthcare professionals. Fundamental examples of Corporate Practice Restrictions are limitations on corporations' (other than those owned by licensed professionals) ownership of medical, dental, or other healthcare practices ("Clinical Entities") or employment of licensed healthcare

practitioners ("Licensed Clinicians"). [3] The scope and source of Corporate Practice Restrictions varies significantly from state to state — and even between licensed professions within a state. While some jurisdictions have codified their restrictions in statutes or regulations, others have common law restrictions established and refined across various judicial opinions or standards articulated in guidance by state attorneys general or licensing authorities.

Beyond the fundamental limitations on formal lay ownership of Clinical Entities and employment of Licensed Clinicians, Corporate Practice Restrictions have evolved to address modern healthcare businesses. In states with Corporate Practice Restrictions, private equity and other investors may comply with applicable laws by forming management services organizations ("MSOs"), which contract with Clinical Entities to manage the finances, operations, and other non-clinical elements of such businesses. States have sought to ensure that MSOs are not vehicles for lay investors to achieve *de facto* ownership of Clinical Entities or employment of Licensed Clinicians while formally complying with Corporate Practice Restrictions. Lawmakers, regulators, and courts have introduced new prohibitions and expanded and interpreted existing ones to preserve Licensed Clinicians' professional judgment. Examples include explicit restrictions on MSO involvement in establishing reimbursement rates for professional services or personnel decisions involving Licensed Clinicians and prohibitions on MSO management fees based on a percentage of Clinical Entity revenue or profits. Generally, the stronger a state's Corporate Practice Restrictions, the less involvement private equity-backed MSOs can have in managing Clinical Entities.

How do Corporate Practice Restrictions affect private equity?

In contrast to Mini-HSR Laws, which focus on a pre-closing process, Corporate Practice Restrictions require careful structuring of transactions and post-closing operations. Private equity investors pursuing platform and add-on deals with Clinical Entities must balance, on the one hand, the need for alignment between MSOs and Licensed Clinician-owners and, on the other, compliance with Corporate Practice Restrictions. Private equity firms must coordinate with corporate and healthcare counsel to ensure that the documents defining the MSO-Clinical Entity relationship, including management services agreements and other ancillary contracts, such as equity transfer restriction agreements ("ETRAs"), do not put MSOs in control of clinical decision making. In the most restrictive states, ETRAs may be limited or prohibited, meaning private equity investors must find alternative mechanisms to achieve alignment.

What are the trends in current Corporate Practice Restriction proposals?

As noted above, Corporate Practice Restrictions have evolved over time, moving from general principles about who can own Clinical Entities and employ Licensed Clinicians to limitations on specific business practices common to MSOs. Corporate Practice Restrictions proposed since December 2024 continue to sharpen the focus on the reality of professional practice management and place even clearer and more restrictive limits on MSOs. At least six states (California, Connecticut, Oregon, South Carolina, Vermont, and Washington) have seen proposals for new Corporate Practice Restrictions since December of 2024. At least three of the proposals (in Oregon, Vermont, and Washington) would limit ownership of or employment by MSOs for Licensed Clinician-owners and implicate the use of ETRAs. As with Mini-HSR proposals, Goodwin will continue to monitor and provide updates on these developments.

Summary of Proposed Mini-HSR Laws and Corporate Practice Restrictions

- **California:**
  - Mini-HSR Law: S.B. 25 would require *any* person making a transaction notification filing pursuant to the Hart-Scott-Rodino Act (including healthcare and private equity firms) to also file a copy of the form with the Attorney General. The additional filing would only be required if the filing person has (1) its principal place of business in California or (2) annual net sales in California for the goods or services involved in the transaction of at least 20 percent of the minimum HSR filing threshold (which is currently $126.4 million).
  - Mini-HSR Law: A.B. 1415 would expand the notice regime administered by the state's Office of Health Care Affordability ("OHCA") to require filings for transactions involving MSOs. The proposal would also extend the transaction reporting obligation, which currently applies to healthcare entities, to private equity firms and hedge funds.
  - Corporate Practice Restriction: S.B. 351 would prohibit private equity firms and hedge funds from interfering with the

professional judgment of physicians or dentists in California and from exercising any control over certain functions, such as hiring and firing Licensed Clinicians, determining the contents of medical records, or making billing and coding decisions. The prohibition would apply explicitly to MSOs owned directly or indirectly by private equity firms and hedge funds.

- **Connecticut:**
  - Mini-HSR Law: S.B. 261 would impose restrictions on private equity firms buying, operating, or holding a controlling interest in hospitals, including by limiting the ability of such firms to lease property back to the hospital for a fee after purchasing the land rights.
  - Mini-HSR Law: S.B. 567 would expand the authority of the Attorney General and Commissioner of Health Strategy to regulate private equity ownership of hospitals, radiology groups, and drug rehabilitation facilities. Further, the law would restrict "self-dealing property transactions."
  - Mini-HSR Law and Corporate Practice Restriction: S.B. 469 would restrict private equity firms from acquiring hospitals, prohibit hospitals from entering real estate investment trust ("REIT") transactions, and establish physician-led ownership requirements for certain medical groups and centers.
  - Mini-HSR Law: S.B. 837 would require group practices to submit information about intended acquisitions or mergers to the Commissioner of Health Strategy, repeal the presumption in favor of approving certificate-of-need applications for large group practice ownership transfers, and mandate the Health Care Cabinet to develop legislative recommendations to increase oversight of group practice mergers and acquisitions.
  - Mini-HSR Law: H.B. 6570 would prohibit private equity firms from acquiring ownership or control of healthcare provider practices or facilities and would require healthcare administrators to disclose ownership structures and significant changes in such structures to the Health Systems Planning Unit. The Attorney General would be authorized to enforce these provisions.
  - Mini-HSR Law and Corporate Practice Restriction: S.B. 1507 would prohibit any transaction effecting new or increased private equity or REIT ownership of hospitals, health systems, or group practices. It would also prohibit healthcare facilities and MSOs from engaging in certain activities that interfere with or control the professional judgment or clinical decisions of Licensed Clinicians.
- **Illinois:** Mini-HSR Law: S.B. 1998 would update the state's current Mini-HSR Law to require private equity firms and hedge funds to obtain consent from the Attorney General if they provide financing for certain covered healthcare transactions.
- **Indiana:** Mini-HSR Law: H.B. 1666 would require private equity firms acquiring a healthcare facility, regardless of the total assets at issue, to submit a 90-day pre-closing notice. Under a new consent requirement, the Attorney General would have 45 days to approve or deny the transaction. Further, healthcare entities, including hospitals, insurers, and pharmacy benefits managers, would be required to file annual ownership structure reports.
- **Massachusetts:** Mini-HSR Law: S.D. 1910 would prohibit private equity firms from engaging in transactions that are likely to cause financial distress to a healthcare provider due to debt placement. In addition, the legislation would create requirements for how private equity firms direct healthcare providers to pay fees and issue dividends, while also requiring private equity firms to deposit a bond with the Department of Health.
- **New Mexico:** Mini-HSR Law: S.B. 14 would require private equity transactions involving certain healthcare entities to provide a pre-closing notice to the Office of Superintendent of Insurance ("OSI") no later than 60 days prior to the proposed date. The OSI would be authorized to require a cost and market impact review, in which case parties would need to obtain OSI approval with or without conditions.
- **New York:** Mini-HSR Law: H.M.H. Article VII Legislation, Part S would expand the notice requirement under the state's current Mini-HSR Law from 30 days to 60 days and require parties to disclose any sale-leaseback agreements, the impact of the transaction on competition, and whether a party to the transaction owns another healthcare entity that closed or reduced services. If the Department of Health determined a cost and market impact review was necessary, it would have 180 days from the notice date to issue a final report. For a five-year period following closing, the Department would continue to monitor

covered transactions.[4]

- **Oregon:** Corporate Practice Restriction: S.B. 951 would limit certain overlapping ownership and control relationships between MSOs and contracted Clinical Entities. It would also prohibit MSOs from influencing certain Clinical Entity activities and limit certain restrictions common to ETRAs.
- **South Carolina:** Corporate Practice Restriction: S.B. 46 would codify restrictions on corporate interference with physicians' professional judgment and prohibit certain restrictive covenants in physician contracts.
- **Texas:** Mini-HSR Law: H.B. 985 would require a hospital that acquires an outpatient healthcare facility to provide written notice to the Attorney General and to the Health and Human Services Commission.
- **Vermont:** Mini-HSR Law and Corporate Practice Restriction: H.B. 71 would require healthcare entities to notify the Green Mountain Care Board at least 180 days prior to entering into Material Change Transactions. The Board, in consultation with the Attorney General, would have 30 days to review the transaction and approve, approve with conditions, or disapprove. A comprehensive review could also be initiated, which would extend the review process by 90 days. The proposal would also prohibit shareholders, directors, and officers of medical practices from owning or holding certain positions in contracted MSOs and prohibit Licensed Clinician owners from transferring control over a Clinical Entity's equity or assets, a common feature of ETRAs.
- **Washington:**
  - Mini-HSR Law: S.B. 5561 would require healthcare entities to annually disclose information on entities with a controlling interest or ownership stake in healthcare providers, including financial and organizational information. The information would form a public interactive tool displaying changes in ownership or control, organization structures, and trends in consolidation.
  - Mini-HSR Law: H.B. 1072 would require healthcare entities that provide protected healthcare services, such as reproductive services, death with dignity services, and gender-affirming care, to notify the Department of Health at least 60 days prior to entering into a transaction. The Department would have 60 days to review and issue a final determination; otherwise, the transaction would be considered approved.
  - Corporate Practice Restriction: S.B. 5387 would prohibit shareholders, directors, and officers of healthcare practices from owning or holding certain positions in MSOs with which such practices are contracted. The proposal would also prohibit such individuals from relinquishing certain control over the sale of a healthcare practice's shares or assets, a common feature of ETRAs.

The Goodwin team will continue to monitor these developments. Please contact the authors if you have any questions.

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[1] Notably, the FTC's first deal challenge in the new administration was brought against a private equity-backed transaction but asserted only traditional consolidation of competition theories of harm, rather than novel private equity-specific theories such as roll-ups.

[2] This alert categorizes certain proposals, namely outright prohibitions on private equity ownership of certain healthcare entities and laws requiring disclosure of healthcare entity ownership outside of the transaction context, as Mini-HSR Laws. Although such proposals do not specifically require pre-transaction regulatory filings, they impose requirements and restrictions on private equity investors that are comparable to those imposed by Mini-HSR Laws.

[3] Some states prohibit anyone other than a Licensed Clinician from owning any percentage of Clinical Entity, while others require that Licensed Clinicians own a majority of such entities.

[4] New York has also recently introduced the "21st Century Antitrust Act." While not healthcare-specific, the basic principle is that if you "conduct business" in New York and are making a federal HSR filing, then you must also submit the HSR to the New York Attorney General. *See NY State Assembly Bill 2025-A2015.*

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