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, November 5, 2025
10:00 a.m. – 3:00pm

MEETING AGENDA

10:00 am	Welcome *Chairs, Senator Mike Tipping and Representative Michelle Boyer*
10:05 am	Review of Materials and Information Requests *Commission staff*
10:15 am	Commission Discussion of Potential Recommendations *Chairs and Commission Members*
12:00 pm	Break
1:00 pm	Continued Commission Discussion of Potential Recommendations (if necessary) *Chairs and Commission Members*
2:00 pm	Commission Discussion of Next Steps and Planning for Future Meetings
3:00 pm	Adjourn

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Maine State Legislature
OFFICE OF POLICY AND LEGAL ANALYSIS
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MEMORANDUM

TO: Members, 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

FROM: Commission Staff

DATE: November 5, 2025

RE: Information Requests and Follow Up

For your review and information, the attached documents were requested during the presentations at the October 22 meeting and previously shared by email:

1. Uniform Law Commission's Uniform Antitrust Pre-Merger Notification Act; and

2. Copy of Connecticut Bill (SB 1507) related to regulation of private equity ownership and control of hospitals.

In addition, commission members asked for more information about the fees and funding of the Oregon Health Authority's oversight of health care transactions. Based on a review of the attached law, health care entities with a material change transaction being reviewed by the Oregon Health Authority pay fees, as established in rule, necessary to reimburse the costs to the Oregon Health Authority of the review. The Oregon Health Authority has not adopted final rules yet; draft rules suggest the fees will be based on the amount of annual revenue of the smaller entity involved in the transaction being reviewed.

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Uniform Antitrust Pre-Merger Notification Act

drafted by the

NATIONAL CONFERENCE OF COMMISSIONERS
ON UNIFORM STATE LAWS

and by it

APPROVED AND RECOMMENDED FOR ENACTMENT
IN ALL THE STATES

WITH PREFATORY NOTE AND COMMENTS

September 16, 2024

ABOUT ULC

The **Uniform Law Commission** (ULC), also known as National Conference of Commissioners on Uniform State Laws (NCCUSL), now in its 133rd year, provides states with non-partisan, well-conceived and well-drafted legislation that brings clarity and stability to critical areas of state statutory law.

ULC members must be lawyers, qualified to practice law. They are practicing lawyers, judges, legislators and legislative staff and law professors, who have been appointed by state governments as well as the District of Columbia, Puerto Rico and the U.S. Virgin Islands to research, draft and promote enactment of uniform state laws in areas of state law where uniformity is desirable and practical.

- ULC strengthens the federal system by providing rules and procedures that are consistent from state to state but that also reflect the diverse experience of the states.
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Antitrust Pre-Merger Notification Act

The committee appointed by and representing the National Conference of Commissioners on Uniform State Laws in preparing this act consists of the following individuals:

Dan Robbins	California, *Chair*
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William H. Clark Jr.	Pennsylvania
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Cory J. Skolnick	Kentucky
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Timothy J. Berg	Arizona, *President*

Other Participants

Daniel A. Crane	Michigan, *Reporter*
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Sohan Dasgupta	District of Columbia, *American Bar Association Section Advisor*
Emilio Varanini	California, *American Bar Association Section Advisor*
Diane Boyer-Vine	California, *Style Liaison*
Tim Schnabel	Illinois, *Executive Director*

Copies of this act may be obtained from:

Uniform Law Commission
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Antitrust Pre-Merger Notification Act

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Antitrust Pre-Merger Notification Act

Prefatory Note

Since 1976, the federal Hart-Scott-Rodino Act ("HSR"), 15 U.S.C. Section 18a, has required companies proposing to engage in most significant mergers or acquisitions to file a notice with the two federal antitrust agencies—the Federal Trade Commission and the Justice Department's Antitrust Division—at least 30 days (or, in the case of acquisitions out of bankruptcy or cash tender offers, 15 days) prior to closing. The HSR filing includes both a form detailing information, such as the corporate structure of the parties, and additional documentary material, such as presentations about the merger to the company's board of directors. In 2023, the Federal Trade Commission proposed new regulations increasing the amount of material required to be submitted in the form and additional documentary material. As of this writing, the regulations have not been finalized.

The HSR filing allows the federal antitrust agencies to scrutinize mergers before they are consummated. Prior to HSR, the agencies often learned of a merger after it had already closed, and then spent months or years investigating the transaction. If the agencies ultimately decided to challenge the merger's legality through a lawsuit, the only possible remedy was to unscramble a deal often years after it had closed, and the businesses had become integrated. This was not an optimal situation for the agencies, the businesses, or the public. HSR shifted most merger reviews to the pre-merger phase, allowing earlier and more efficient engagement between the agencies and the merger parties.

State Attorneys General ("AGs") also have a legal right to challenge anticompetitive mergers, both under the federal Clayton Act and their own state antitrust laws. *See California v. American Stores Co.*, 495 U.S. 271 (1990). States often play an important role in merger investigations and challenges, either in parallel with the federal agencies, or on their own. However, the AGs do not have access to the HSR filings. Further, HSR's strict confidentiality provisions prohibit the federal agencies from sharing HSR filings with the AGs. Most AGs have the right to subpoena HSR filings under their state laws, but that requires that they first become aware that an HSR filing of interest has been made, and then go through a cumbersome and time-consuming process to issue a subpoena and wait for compliance. In some cases, the merging parties voluntarily waive the HSR's confidentiality restrictions to allow AGs to obtain access to filing materials, however that process can take some time to negotiate. As a result, by the time most AGs obtain access to HSR filings, the federal agencies and parties are often far along in the process of investigation and negotiation. This puts the AGs at a significant disadvantage in the process of merger review. It also creates additional costs and uncertainties for the merging parties because federal approval does not foreclose a later state challenge. For example, in the *American Stores* case noted above, California sued to block a merger that the Federal Trade Commission had already approved.

In response to these shortcomings, some states have considered legislation that would create a state-specific pre-merger notification requirement for all transactions in every sector. However, some of these proposals would impose obligations additional to the HSR obligations on merging parties and potentially move state antitrust review out of sync with federal antitrust

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review. For example, a proposed bill in New York would have imposed a 60-day waiting period to close the deal, in contrast to HSR's 30-day waiting period. It also would have dramatically lowered the filing threshold by an order of magnitude for all transactions in every sector, which would have significantly increased the burden on both businesses and the AG's office. A similar bill was introduced in Maryland in 2023. The business community has reacted with alarm to the prospect of burdensome and idiosyncratic state-specific pre-merger notification provisions that apply to all transactions in every sector. Both bills failed to pass. A new antitrust bill including new merger regulations was introduced in New York in May, 2024 and new merger rules have been proposed in California by stakeholders in an antitrust review process managed by the California Law Revision Commission.

The Uniform Antitrust Pre-Merger Notification Act is intended to address the concerns of both the AGs and business communities by creating a simple, non-burdensome mechanism for AGs to receive access to HSR filings at the same time as the federal agencies, and subject to the same confidentiality obligations. Under the act, covered persons—defined as persons who have their principal place of business or at least a specified threshold of annual revenues in the state—must provide their HSR filing (both the basic form and, under certain enumerated circumstances, the additional documentary material) to the AG contemporaneously with their federal filing. The material filed with the AG is subject to essentially the same confidentiality protections applicable to the federal agencies, except that an AG that receives HSR materials may share them with any other AG whose state has also adopted the act. The anticipated effect is to facilitate early information sharing and coordination among AGs and the federal agencies, subject to confidentiality obligations and without imposing any significant burden on either the merging parties or the AGs. It is also anticipated that the AGs may facilitate information exchange and coordination by establishing a secure central database or repository for HSR filings accessible to AGs whose states have adopted the act.

As of the time of this writing, there is a robust national debate concerning the past and future of antitrust policy, including whether there should be a significant invigoration of anti-merger enforcement. This proposal takes no side in that debate. By providing AGs earlier, confidential access to HSR filings, it is not intended to suggest any view on the merits of the mergers they may review or how they should wield their investigatory and litigation powers. Nor is the goal of minimizing the burden on business meant to suggest any view on the optimal level of merger activity or regulatory review of mergers. Rather, this act is animated by a spirit of good government—of respecting the role of the states in the merger review process, of the need for confidentiality, and of advancing the efficiency of the process for the benefit of all parties involved.

Similarly, this act is not intended to supplant or preempt existing sector specific pre-merger reporting requirements that many states have in certain areas (for example, health care) and the act is not intended to limit a state's ability to challenge smaller local mergers that do not meet the HSR thresholds.

Uniform Antitrust Pre-Merger Notification Act

Section 1. Title

This [act] may be cited as the Uniform Antitrust Pre-Merger Notification Act.

Section 2. Definitions

In this [act]:

(1) "Additional documentary material" means the additional documentary material filed with a Hart-Scott-Rodino form.

(2) "Electronic" means relating to technology having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities.

(3) "Filing threshold" means the minimum size of a transaction that requires the transaction to be reported under the Hart-Scott-Rodino Act in effect when a person files a pre-merger notification.

(4) "Hart-Scott-Rodino Act" means Section 201 of the Hart-Scott-Rodino Antitrust Improvements Act of 1976, 15 U.S.C. Section 18a[, as amended].

(5) "Hart-Scott-Rodino form" means the form filed with a pre-merger notification, excluding additional documentary material.

(6) "Person" means an individual, estate, business or nonprofit entity, government or governmental subdivision, agency, or instrumentality, or other legal entity.

(7) "Pre-merger notification" means a notification filed under the Hart-Scott-Rodino Act with the Federal Trade Commission or the United States Department of Justice Antitrust Division, or a successor agency.

(8) "State" means a state of the United States, the District of Columbia, Puerto Rico, the United States Virgin Islands, or any other territory or possession subject to the

jurisdiction of the United States.

Legislative Note: *It is the intent of this act to incorporate future amendments to the cited federal law in paragraph (4). A state in which the constitution or other law does not permit incorporation of future amendments when a federal statute is incorporated into state law should omit the phrase ", as amended". A state in which, in the absence of a legislative declaration, future amendments are incorporated into state law also should omit the phrase.*

Section 3. Filing Requirement

(a) A person filing a pre-merger notification shall file contemporaneously a complete electronic copy of the Hart-Scott-Rodino form with the Attorney General if:

(1) the person has its principal place of business in this state; or

(2) the person or a person it controls directly or indirectly had annual net sales in this state of the goods or services involved in the transaction of at least 20 percent of the filing threshold.

(b) A person that files a form under subsection (a)(1) shall include with the filing a complete electronic copy of the additional documentary material.

(c) On request of the Attorney General, a person that filed a form under subsection (a)(2) shall provide a complete electronic copy of the additional documentary material to the Attorney General not later than [seven] days after receipt of the request.

(d) The Attorney General may not charge a fee connected with filing or providing the form or additional documentary material under this section.

Comment

The goals of the filing requirement are (a) to ensure that the HSR form and the additional documentary material are filed with one state and (b) to provide notice through the form alone to every state that might have a significant interest in the proposed merger. Subsection (a)(1) is directed to the first goal; subsection (a)(2) to the second goal.

This section uses a well-established criterion to determine when a person has a filing obligation in a state. Where a company has its principal place of business is a well-understood concept from federal diversity jurisdiction. In the Supreme Court's unanimous decision in *Hertz*

Corp. v. Friend, 559 U.S. 77, 92-93 (2010), it described the term as follows:

> We conclude that "principal place of business" is best read as referring to the place where a corporation's officers direct, control, and coordinate the corporation's activities. It is the place that Courts of Appeals have called the corporation's "nerve center." And in practice it should normally be the place where the corporation maintains its headquarters—provided that the headquarters is the actual center of direction, control, and coordination, i.e., the "nerve center," and not simply an office where the corporation holds its board meetings (for example, attended by directors and officers who have traveled there for the occasion).

Annual net sales from income and expense statements is a widely utilized measure of economic activity borrowed from the HSR regulations. As noted in the definitions, the filing threshold refers to the minimum size of transaction threshold for determining reportability under the HSR that the Federal Trade Commission adjusts annually by rule pursuant to Section 7A(a)(2) of the Clayton Act, as amended by the HSR. For reference, in 2024 the minimum size of transaction threshold promulgated by the FTC was $119.5 million. Hence, for illustrative purposes, a party that made an HSR pre-merger notification in 2024 and did not have its principal place of business in a state that enacted this act would need to determine whether its 2023 annual net sales in the state were at least 20% of $119.5 million. If so, the party would be obligated to make a filing in the state pursuant to subsection (a)(2). To the extent that both the acquiring and acquired persons are required to report a transaction under the HSR, both persons might be required to file with the same AG if both persons fell within the coverage of this act.

The reference in subsection (a)(2) to the annual net sales in the state being those of "goods or services involved in the transaction" is intended to limit the filing obligation under subsection (a)(2) to circumstances where the filing party's economic activity in the state is in the same business category as assets involved in the acquisition. Consistent with the requirements of federal law concerning reporting by corporate parents of the activities of entities they control directly or indirectly (see, for example, 16 C.F.R. 801(a)(1)), the obligation under subsection (a)(2) is triggered if the reporting party controls entities that have the requisite sales in the state. For example, if a holding company was the reporting party under HSR, and that company owned a subsidiary that had the requisite amount of sales in the state of the goods or services involved in the transaction, the reporting requirement under subsection (a)(2) would be triggered. However, if the parent company or its subsidiaries had the requisite amount of sales in the state, but those were not in the same goods or services as those involved in the transaction, there would be no reporting requirement under subsection (a)(2).

Subsection (b) obligates a person that has its principal place of business in a state to provide both the HSR form and the additional documentary material to the state's AG contemporaneously with the HSR filing. In other states where the party meets the annual net sales threshold, the person need only provide the basic HSR form with their initial filing, although the AG may then request the additional documentary material under subsection (c). The reason for this structure is to prevent AGs from being inundated with voluminous additional documentary material that they have no interest in reviewing. To the extent an AG does not

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receive the additional documentary material with the initial filing but is interested in reviewing that material sooner than the time allowed for a party to submit that material upon receipt of a request, the AG may request that material from the AG of the party's state of principal place of business under Section 6 (assuming that that state has also passed this act).

The spirit of this act is to facilitate more timely and efficient AG receipt of materials relating to potentially interesting mergers without imposing significant additional burdens on the business community. Accordingly, subsection (d) prohibits the charging of fees for simply making available to the AG information that the AG already could procure by subpoena, for which it could not charge the company a fee. Although reviewing merger filings requires resources, this act is not designed to impose additional costs on AG offices. To the contrary, by facilitating quick and efficient receipt of HSR files, the act will save the AG time and resources previously consumed in bargaining with merging parties over HSR waivers or subpoenaing HSR files. Further, the confidentiality provisions of this act are designed to facilitate information sharing and collaboration among the AGs and the federal antitrust agencies, and among the AGs themselves. More efficient inter-agency collaboration should reduce duplication of effort and allow existing resources to be deployed more efficiently in merger review.

Separately from a filing fee, some state statutes permit the AG to recover investigatory costs from investigation subjects in certain contexts. Subsection (d) is not meant to affect the operation of those statutes. To the extent that an AG seeks recovery of investigation costs (as opposed to a filing fee) pursuant to a separate statute, subsection (d) does not bar such fee recovery.

It is expected that the information being provided pursuant to this act will be used for and retained in connection with an investigation of the transaction. It is further expected that states availing themselves of the act will cooperate with merging parties in working out a mode of filing that parallels any federal process for filing the HSR notice and documents.

Finally, it is expected that if there is an investigation in connection with the transaction notified under the act, such an investigation will begin promptly upon receipt of all the information provided under the act consistent with the act's goals of enhanced efficiency and reduced cost and uncertainty. Unreasonable delay will also adversely affect the state's ability to challenge a transaction. For example, see *State of New York v. Meta Platforms, Inc.*, 66 F.4th 288, 301 (D.C. Cir. 2023) (applying laches to dismiss state challenges to Facebook's acquisition of Instagram and WhatsApp because of respective eight- and six-year delays in bringing the suit).

Section 4. Confidentiality

(a) Except as provided in subsection (c) or Section 5, the Attorney General may not make public or disclose:

(1) a Hart-Scott-Rodino form filed under Section 3;

(2) the additional documentary material filed or provided under Section 3;

(3) a Hart-Scott-Rodino form or additional documentary material provided by the attorney general of another state;

(4) that the form or the additional documentary material were filed or provided under Section 3, or provided by the attorney general of another state; or

(5) the merger proposed in the form.

(b) A form, additional documentary material, and other information listed in subsection (a) are exempt from disclosure under [cite to state's freedom of information act].

(c) Subject to a protective order entered by an agency, court, or judicial officer, the Attorney General may disclose a form, additional documentary material, or other information listed in subsection (a) in an administrative proceeding or judicial action if the proposed merger is relevant to the proceeding or action.

(d) This [act] does not:

(1) limit any other confidentiality or information-security obligation of the Attorney General;

(2) preclude the Attorney General from sharing information with the Federal Trade Commission or the United States Department of Justice Antitrust Division, or a successor agency; or

(3) preclude the Attorney General from sharing information with the attorney general of another state that has enacted the Uniform Antitrust Pre-Merger Notification Act or a substantively equivalent act. The other state's act must include confidentiality provisions at least as protective as the confidentiality provisions of the Uniform Antitrust Pre-Merger Notification Act.

Legislative Note: *A state may need to amend its freedom of information act to conform to this act.*

Comment

Confidentiality is highly important for this act and the entire HSR filing process. The HSR materials contain confidential and valuable information. Improper disclosure could jeopardize the transaction and harm competition. In addition, it could pose securities law problems and allow unfair competition, or even facilitate collusion. These protections mirror protections that are imposed on the federal agencies which also receive the information.

This section ensures that AGs use the HSR materials only for legitimate investigatory and law enforcement purposes, and do not disclose any HSR material except for those permissible purposes. The fact that an HSR filing has been made is included in the covered confidentiality obligations. In other words, an AG may not disclose even the fact that two parties are proposing to merge (other than in an administrative proceeding or judicial action) if that information has become known only through compliance with this act. Section 5 is not meant to prevent AGs from publicly disclosing information that is already in the public domain.

To the extent that confidential material needs to be disclosed in a judicial document such as a complaint, it is customary practice for any confidential material to be redacted in the public version of the document, with the unredacted version filed under seal. It is anticipated that AGs will continue to follow that practice, even as to complaints filed before a court has had an opportunity to implement a protective order.

Subsection (d)(1) is intended to preserve any other confidentiality or information-security obligations, whatever their source, in addition to those set forth in this act. Subsections (d)(2) and (3) are intended to allow AGs to communicate freely with their federal and state counterparts concerning merger review in circumstances where both the states and federal agencies have access to the same confidential information. The term information in these subsections is intended to include economic and legal analyses that are commonly used in merger review. For example, one AG may wish to share an economic analysis of relevant data with federal and state counterparts to enhance efficiency and reduce wasteful duplication.

This section uses the phrase "substantively equivalent" to describe another state's law that would be sufficiently like the enacting state's law to warrant the kind of interstate collaboration envisioned by this act. Another expression—"substantially similar"—is sometimes used in legislation. The use of "substantively equivalent" instead is intended to signal that, whatever the form of another state's law, that law must contain the substantively significant components of the enacting state's law, without material alteration, for the information sharing and collaboration envisioned by this act to occur.

Finally, an explanatory comment on the relationship between subsections 4(d) and 5(a): 5(a) permits the AG of one state to share the HSR materials with the AG of another state that has adopted a substantively equivalent law. By contrast, subsection 4(d) allows for information-sharing among or between AGs who already have access to the HSR materials. This subsection was added to make clear that work product or other information derived from HSR materials may be shared with federal enforcers or other AGs whose states have enacted a substantively equivalent law, thus guaranteeing the confidentiality of the information. For example, if the AG

of State A had an economist perform a regression analysis based on data provided in the HSR filing received pursuant to this act, that analysis could be shared with the AG of another state that also enacted the act, or a substantively equivalent act.

Section 5. Reciprocity

(a) The Attorney General may disclose a Hart-Scott-Rodino form and additional documentary material filed or provided under Section 3 to the attorney general of another state that enacts the Uniform Antitrust Pre-Merger Notification Act or a substantively equivalent act. The other state's act must include confidentiality provisions at least as protective as the confidentiality provisions of the Uniform Antitrust Pre-Merger Notification Act.

(b) At least two business days before making a disclosure under subsection (a), the Attorney General shall give notice of the disclosure to the person filing or providing the form or additional documentary material under Section 3.

Comment

This section does not require the HSR form or additional documentary material to be delivered individually to each AG. It is hoped that an AG, or the AGs collectively, may establish a secure central electronic database of the materials that can be shared only with AGs entitled to receive the materials. The establishment of a secure central database would not conflict with the confidentiality provisions of this act.

Section 5(b) is intended to allow a party to challenge the disclosure when appropriate.

Section 6. Civil Penalty

The Attorney General may [impose][seek imposition of] a civil penalty of not more than $[10,000] per day of noncompliance on a person that fails to comply with Section 3(a), (b), or (c). A civil penalty imposed under this section is subject to procedural requirements applicable to the Attorney General, including the requirements of due process.

Legislative Note: *A state should determine whether to use "impose" or "seek imposition of" based on whether that state's laws permit its attorney general to impose a civil penalty directly or require the attorney general to seek imposition of a civil penalty in an appropriate proceeding.*

Comment

The sanctions provision is intended to incentivize compliance with the act without being disproportionately punitive. A $10,000 per day fine is intended to serve as a limit rather than an automatic penalty. In determining whether any fine should be levied and its amount, the AG in the first instance, and then any reviewing court, should consider factors such as: (1) whether the non-compliance was intentional, negligent, accidental, or excusable; (2) whether the non-compliance materially impaired the AG's ability to engage in merger review; and (3) whether other states have imposed, or are likely to impose, sanctions for violations of their laws with respect to the same transaction. The provision for monetary sanctions is not meant to prevent a court of competent jurisdiction from ordering such equitable relief as the court may deem appropriate.

It should be kept in mind that, while both the acquiring and acquired party to a transaction may have HSR filing obligations, and both may also have filing obligations under this act, in some circumstances (such as a hostile takeover) the parties may file their HSR notifications at different times, and therefore make their notifications under this act at different times.

Section 7. Uniformity of Application and Construction

In applying and construing this uniform act, a court shall consider the promotion of uniformity of the law among jurisdictions that enact it.

Section 8. Transitional Provision

This [act] applies only to a pre-merger notification filed on or after [the effective date of this [act]].

Section 9. Effective Date

This [act] takes effect …

Senate

General Assembly

File No. 614

January Session, 2025

Substitute Senate Bill No. 1507

Senate, April 9, 2025

The Committee on Public Health reported through SEN. ANWAR of the 3rd Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT PROHIBITING PRIVATE EQUITY OWNERSHIP AND CONTROL OF HOSPITALS AND HEALTH SYSTEMS AND THE CONTROLLING OF OR INTERFERENCE WITH THE PROFESSIONAL JUDGMENT AND CLINICAL DECISIONS OF CERTAIN HEALTH CARE PROVIDERS AND REQUIRING AN EVALUATION OF THE APPOINTMENT OF A RECEIVER TO MANAGE HOSPITALS IN FINANCIAL DISTRESS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective July 1, 2025*) (a) As used in this section:

(1) "Health system" means: (A) A parent corporation of one or more hospitals and any entity affiliated with such parent corporation through ownership, governance, membership or other means; or (B) a hospital or any entity affiliated with such hospital through ownership, governance, membership or other means;

(2) "Hospital" means a facility licensed as a hospital under chapter 368v of the general statutes;

(3) "Indirect ownership interest" means an ownership interest in an

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entity that has an ownership interest in a hospital or health system;

(4) "Operational control" means to: (A) Influence or direct the actions or policies of any part of a hospital or health system; or (B) choose, appoint or terminate a member of the board, manager, managing member, senior employee, consultant or other individual or entity that participates in the operational oversight of a hospital or health system;

(5) "Ownership interest" means possession of equity in capital, stock or profits of a hospital or health system or ownership of real estate on which a hospital or health system operates;

(6) "Private equity company" means a publicly traded or nonpublicly traded entity that collects capital investments from individuals or entities; and

(7) "Real estate investment trust" has the same meaning as provided in 26 USC 856, as amended from time to time.

(b) On and after October 1, 2025, no private equity company or real estate investment trust shall (1) acquire (A) any direct or indirect ownership interest in a hospital or health system, or (B) any operational or financial control over a hospital or health system; or (2) increase (A) any direct or indirect ownership interest that the private equity company or real estate investment trust has in a hospital or health system, or (B) any operational or financial control that the private equity company or real estate investment trust has over a hospital or health care system.

Sec. 2. (NEW) (*Effective July 1, 2025*) (a) As used in this section:

(1) "Advanced practice registered nurse" means an advanced practice registered nurse licensed pursuant to chapter 378 of the general statutes;

(2) "Clinician with independent practice authority" means a physician, an advanced practice registered nurse or any other health care provider who has the authority to engage in the independent practice of such provider's profession pursuant to title 20 of the general

statutes;

(3) "Health care practice" means a business, regardless of form, through which a licensed health care provider offers health care services. "Health care practice" does not include any entity that holds a license to operate a facility issued by the Department of Public Health or the Department of Mental Health and Addiction Services;

(4) "Health system" means: (A) A parent corporation of one or more hospitals and any entity affiliated with such parent corporation through ownership, governance, membership or other means; or (B) a hospital and any entity affiliated with such hospital through ownership, governance, membership or other means;

(5) "Management services organization" means a business that provides management or administrative services to a health care provider or an organization of health care providers, including, but not limited to, a health care practice, for compensation; and

(6) "Physician" means a physician licensed pursuant to chapter 370 of the general statutes.

(b) No health care facility or entity that holds a license issued by the Department of Public Health or the Department of Mental Health and Addiction Services and no management services organization shall directly or indirectly interfere with, control or otherwise direct the professional judgment or clinical decisions of a health care practice or a clinician with independent practice authority who provides health care services at or through such facility or entity or at or through a health care practice.

(c) Conduct prohibited under subsection (b) of this section shall include, but need not be limited to, controlling, either directly or indirectly, through discipline, punishment, threats, adverse employment actions, coercion, retaliation or excessive pressure any of the following: (1) The amount of time spent with patients or the number of patients seen in a given time period, including, but not limited to, the

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time permitted to triage patients in the emergency department or evaluate admitted patients; (2) the time period within which a patient must be discharged; (3) decisions involving the patient's clinical status, including, but not limited to, whether the patient should be kept in observation status, whether the patient should receive palliative care and where the patient should be placed upon discharge; (4) the diagnosis, diagnostic terminology or codes that are entered into the medical record; (5) the appropriate diagnostic test for medical conditions; or (6) any other conduct the Department of Public Health determines would interfere with, control or otherwise direct the professional judgment or clinical decision of a clinician with independent practice authority.

(d) Any nondisclosure or nondisparagement agreement entered into, amended or renewed on or after July 1, 2025, regarding any provision of subdivisions (1) to (6), inclusive, of subsection (c) of this section, to which a clinician with independent practice authority is a party shall be void and unenforceable.

(e) Any policy or contract entered into, amended or renewed on or after July 1, 2025, that has the effect of violating any provision of this section shall be void and unenforceable. If a court of competent jurisdiction finds that a policy, contract or contract provision is void and unenforceable pursuant to this subsection, the court shall award the plaintiff reasonable attorney's fees and costs.

(f) The Department of Public Health may adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to implement the provisions of this section.

Sec. 3. (*Effective from passage*) The Commissioner of Health Strategy shall evaluate whether the Attorney General should be authorized to petition the Superior Court for the appointment of a receiver to manage hospitals in financial distress or operational crisis. Not later than October 1, 2026, the commissioner shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters

relating to public health regarding such evaluation.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2025*	New section
Sec. 2	*July 1, 2025*	New section
Sec. 3	*from passage*	New section

PH *Joint Favorable Subst.*

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The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 26 $	FY 27 $
Public Health, Dept.	GF - Cost	121,300	153,500
State Comptroller - Fringe Benefits[1]	GF - Cost	42,700	58,400

Note: GF=General Fund

Municipal Impact: None

Explanation

This bill, which includes various provisions regarding hospitals, health systems, and health care practices, results in a cost to the General Fund of $164,000 in FY 26 and $211,900 in FY 27 and annually thereafter, as described below. The cost is associated with personnel needs in the Department of Public Health (DPH) due to Section 2.

Section 1 prohibits private equity companies and real estate investment trusts from new or increased acquisitions or control of any hospital or health system, which results in no fiscal impact to the state.

Section 2 prohibits licensed health care entities and management services organizations from controlling clinical decisions of a health care practice or clinician. This results in a cost to DPH of $121,300 in FY 26 and $153,500 in FY 27 (and annually thereafter), with an estimated cost to the Office of the State Comptroller for associated fringe benefits of

[1]The fringe benefit costs for most state employees are budgeted centrally in accounts administered by the Comptroller. The estimated active employee fringe benefit cost associated with most personnel changes is 40.71% of payroll in FY 26.

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$42,700 in FY 26 and $58,400 in FY 27. FY 26 costs reflect an October 1 start date for all staff.

It is anticipated that this prohibition will result in an increase in case volume for the Facility Licensing and Investigations Section (FLIS) regarding interference and coercion claims. To handle this increase, DPH requires: (1) a part-time (0.5 FTE) Supervising Nurse Consultant, at an annualized salary of $47,500 (plus $19,300 annualized fringe benefits); and (2) a full-time Nurse Consultant investigator, at an annualized cost of $96,000 (plus $39,100 annualized fringe benefits). These positions will complete essential duties in conducting healthcare investigations, such as reviewing patient records and facility documentation as well as interviewing staff and patients. The FLIS currently has a backlog of approximately 1,000 complaints, making additional staff necessary to complete investigative work that may result from this bill.

Other expenses are expected to total $16,500 in FY 26 and $10,000 in FY 27 in annually and thereafter. This includes a one-time total cost of $8,400 in FY 26 for laptops and related hardware, and ongoing annual costs of $10,000 (with partial year costs in FY 26 of $8,100) consisting of: (1) fleet maintenance costs for one motor vehicle ($4,600) needed to allow investigations to be conducted at facilities across the state; (2) mileage reimbursement ($5,000); and (3) $400 for software and general office supplies.

Section 3 requires the Commissioner of Health Strategy to evaluate the potential appointment of a receiver to manage hospitals in financial distress or operational crisis, which results in no fiscal impact. The duties required by the bill can be accomplished through existing resources.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

OLR Bill Analysis

sSB 1507

AN ACT PROHIBITING PRIVATE EQUITY OWNERSHIP AND CONTROL OF HOSPITALS AND HEALTH SYSTEMS AND THE CONTROLLING OF OR INTERFERENCE WITH THE PROFESSIONAL JUDGMENT AND CLINICAL DECISIONS OF CERTAIN HEALTH CARE PROVIDERS AND REQUIRING AN EVALUATION OF THE APPOINTMENT OF A RECEIVER TO MANAGE HOSPITALS IN FINANCIAL DISTRESS.

SUMMARY

Starting October 1, 2025, this bill prohibits private equity companies and real estate investment trusts (REITs) from acquiring or increasing any (1) direct or indirect ownership interest in or (2) operational or financial control over a hospital or health system (i.e. hospitals or parent corporations of hospitals and their affiliates).

The bill also prohibits (1) health care facilities or entities licensed by the departments of public health (DPH) or mental health and addiction services (DMHAS) and (2) management services organizations (MSOs) from directly or indirectly interfering with or otherwise directing the professional judgment or clinical decisions of health care practices or clinicians with independent practice authority at these facilities or entities or at health care practices. Prohibited conduct includes, among other things, controlling the amount of time spent with patients, decisions on patients' clinical status, or diagnostic codes used.

Starting July 1, 2025, the bill makes null and void any (1) nondisclosure or non-disparagement agreements regarding this prohibited conduct to which a clinician with independent practice authority is a party and (2) policies or contracts that violate the bill's provisions.

It authorizes DPH to adopt regulations to implement the bill's

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provisions.

Lastly, the bill requires the Office of Health Strategy (OHS) to evaluate whether the attorney general should be allowed to petition the Superior Court to appoint a receiver to manage hospitals in financial distress or operational crisis. The OHS commissioner must report on the evaluation to the Public Health Committee by October 1, 2026.

EFFECTIVE DATE: July 1, 2025, except the provision on the OHS evaluation and reporting requirement takes effect upon passage.

PRIVATE EQUITY COMPANY AND REIT ACQUISITIONS

Starting October 1, 2025, the bill prohibits private equity companies and REITs from acquiring or increasing any (1) direct or indirect ownership interest in or (2) operational or financial control over a hospital or health system.

Under the bill, a "private equity company" is a publicly or privately traded entity that collects capital investments, and a "REIT" generally is a company that owns or finances income-producing commercial real estate.

The bill defines an "ownership interest" as having equity in a hospital's or health system's capital, stock, or profits or owning the real estate where these facilities operate. It defines "operational control" as (1) influencing or directing the actions or policies of any part of a hospital or health system or (2) choosing, appointing, or terminating a person or entity that participates in the hospital's or health system's operation (e.g., board member, senior employee, or consultant).

INTERFERENCE WITH CLINICAL DECISIONS

Prohibited Conduct

The bill prohibits (1) DPH- or DMHAS- licensed health care facilities or entities and (2) MSOs from directly or indirectly interfering with, controlling, or otherwise directing the professional judgement or clinical decisions of health care practices or clinicians with independent practice authority who provide health care services through these facilities or

entities or at a health care practice.

This prohibition includes controlling (directly or indirectly) through discipline, punishment, threats, adverse employment actions, coercion, retaliation, or excessive pressure any of the following:

1. the amount of time spent with patients or the number of patients seen in a given time period, including the time allowed to triage patients in the emergency department or evaluate admitted patients;

2. the time period within which patients must be discharged;

3. decisions on patients' clinical status, including whether they should be kept in observation status or receive palliative care, and where they should be placed after discharge;

4. the diagnosis, diagnostic terminology, or codes that are entered into the medical record;

5. the appropriate diagnostic test for medical conditions; or

6. any other conduct DPH determines would interfere with, control, or otherwise direct the professional judgment or clinical decision of a clinician with independent practice authority.

Under the bill, clinicians with independent practice authority include physicians, advanced practice registered nurses, and other health providers given this authority under state law. MSOs are businesses that provide, for compensation, management or administrative services to health care providers or an organization of them (e.g., health care practices).

Nondisclosure and Non-disparagement Agreements

Under the bill, any nondisclosure or non-disparagement agreement entered into, amended, or renewed on or after July 1, 2025, regarding the prohibited conduct described above to which a clinician with independent practice authority is a party is void and unenforceable.

Similarly, the bill makes void and unenforceable any policy or contract entered into, amended, or renewed on or after July 1, 2025, that violates the bill's provisions. If a court finds that a policy, contract, or contract provision is void and unenforceable under the bill, it must award the plaintiff reasonable attorney's fees and costs.

BACKGROUND

Related Bills

SB 1332 (File 133), favorably reported by the Aging Committee, prohibits private equity companies and REITs from acquiring or increasing their ownership interest, operational control, or financial control in a nursing home starting October 1, 2025.

sSB 1480 (File 387), favorably reported by the Human Services Committee, requires nursing homes or hospitals to be free of new ownership interests by private equity companies or REITs in order to be eligible for Medicaid reimbursement.

HB 6873, favorably reported by the Public Health Committee, adds to the types of health care entities and transactions subject to review by the attorney general under the antitrust laws, among other things.

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute
Yea 32 Nay 0 (03/21/2025)

Oregon law

(3) If the contract between the contracting provider and the coordinated care organization has not been reduced to writing or fails to contain the provisions required by subsection (2) of this section, the member is not liable to the authority for any amounts owed by the coordinated care organization.

(4) A contracting provider or agent, trustee or assignee of the contracting provider may not maintain a civil action against a member to collect any amounts owed by the coordinated care organization for which the member is not liable to the contracting provider under this section.

(5) Nothing in this section impairs the right of a provider to charge, collect from, attempt to collect from or maintain a civil action against a member for any of the following:

(a) Health care services not covered by the medical assistance program.

(b) Health care services rendered after the termination of the contract between the coordinated care organization and the provider, unless the health care services were rendered during the confinement in an inpatient facility and the confinement began prior to the date of termination or unless the provider has assumed post-termination treatment obligations under the contract.

(6) Nothing in this section prohibits a member from seeking noncovered health care services from a provider and accepting financial responsibility for these services.

(7) A coordinated care organization may not limit the right of a provider of health care services to contract with the patient for payment of services not within the scope of coverage under the medical assistance program. [2019 c.478 §52]

REGULATION OF MATERIAL CHANGE TRANSACTIONS INVOLVING HEALTH CARE ENTITIES

415.500 Definitions. As used in this section and ORS 415.501 and 415.505:

(1) "Corporate affiliation" has the meaning prescribed by the Oregon Health Authority by rule, including:

(a) Any relationship between two organizations that reflects, directly or indirectly, a partial or complete controlling interest or partial or complete corporate control; and

(b) Transactions that merge tax identification numbers or corporate governance.

(2) "Essential services" means:

(a) Services that are funded on the prioritized list described in ORS 414.690; and

(b) Services that are essential to achieve health equity.

(3) "Health benefit plan" has the meaning given that term in ORS 743B.005.

(4)(a) "Health care entity" includes:

(A) An individual health professional licensed or certified in this state;

(B) A hospital, as defined in ORS 442.015, or hospital system, as defined by the authority by rule;

(C) A carrier, as defined in ORS 743B.005, that offers a health benefit plan in this state;

(D) A Medicare Advantage plan;

(E) A coordinated care organization or a prepaid managed care health services organization, as both terms are defined in ORS 414.025; and

(F) Any other entity that has as a primary function the provision of health care items or services or that is a parent organization of, or is an entity closely related to, an entity that has as a primary function the provision of health care items or services.

(b) "Health care entity" does not include:

(A) Long term care facilities, as defined in ORS 442.015.

(B) Facilities licensed and operated under ORS 443.400 to 443.455.

(5) "Health equity" has the meaning prescribed by the Oregon Health Policy Board and adopted by the authority by rule.

(6)(a) "Material change transaction" means:

(A) A transaction in which at least one party had average revenue of $25 million or more in the preceding three fiscal years and another party:

(i) Had an average revenue of at least $10 million in the preceding three fiscal years; or

(ii) In the case of a new entity, is projected to have at least $10 million in revenue in the first full year of operation at normal levels of utilization or operation as prescribed by the authority by rule.

(B) If a transaction involves a health care entity in this state and an out-of-state entity, a transaction that otherwise qualifies as a material change transaction under this paragraph that may result in increases in the price of health care or limit access to health care services in this state.

(b) "Material change transaction" does not include:

(A) A clinical affiliation of health care entities formed for the purpose of collaborating on clinical trials or graduate medical education programs.

(B) A medical services contract or an extension of a medical services contract.

(C) An affiliation that:

(i) Does not impact the corporate leadership, governance or control of an entity; and

(ii) Is necessary, as prescribed by the authority by rule, to adopt advanced value-based payment methodologies to meet the health care cost growth targets under ORS 442.386.

(D) Contracts under which one health care entity, for and on behalf of a second health care entity, provides patient care and services or provides administrative services relating to, supporting or facilitating the provision of patient care and services, if the second health care entity:

(i) Maintains responsibility, oversight and control over the patient care and services; and

(ii) Bills and receives reimbursement for the patient care and services.

(E) Transactions in which a participant that is a health center as defined in 42 U.S.C. 254b, while meeting all of the participant's obligations, acquires, affiliates with, partners with or enters into any agreement with another entity unless the transaction would result in the participant no longer qualifying as a health center under 42 U.S.C. 254b.

(7)(a) "Medical services contract" means a contract to provide medical or mental health services entered into by:

(A) A carrier and an independent practice association;

(B) A carrier, coordinated care organization, independent practice association or network of providers and one or more providers, as defined in ORS 743B.001;

(C) An independent practice association and an individual health professional or an organization of health care providers;

(D) Medical, dental, vision or mental health clinics; or

(E) A medical, dental, vision or mental health clinic and an individual health professional to provide medical, dental, vision or mental health services.

(b) "Medical services contract" does not include a contract of employment or a contract creating a legal entity and ownership of the legal entity that is authorized under ORS chapter 58, 60 or 70 or under any other law authorizing the creation of a professional organization similar to those authorized by ORS chapter 58, 60 or 70, as may be prescribed by the authority by rule.

(8) "Net patient revenue" means the total amount of revenue, after allowance for contractual amounts, charity care and bad debt, received for patient care and services,

including:

(a) Value-based payments;

(b) Incentive payments;

(c) Capitation payments or payments under any similar contractual arrangement for the prepayment or reimbursement of patient care and services; and

(d) Any payment received by a hospital to reimburse a hospital assessment under ORS 414.855.

(9) "Revenue" means:

(a) Net patient revenue; or

(b) The gross amount of premiums received by a health care entity that are derived from health benefit plans.

(10) "Transaction" means:

(a) A merger of a health care entity with another entity;

(b) An acquisition of one or more health care entities by another entity;

(c) New contracts, new clinical affiliations and new contracting affiliations that will eliminate or significantly reduce, as defined by the authority by rule, essential services;

(d) A corporate affiliation involving at least one health care entity; or

(e) Transactions to form a new partnership, joint venture, accountable care organization, parent organization or management services organization, as prescribed by the authority by rule. [2021 c.615 §1]

415.501 Procedures for review of material change transactions; rules. (1) The purpose of this section is to promote the public interest and to advance the goals set forth in ORS 414.018 and the goals of the Oregon Integrated and Coordinated Health Care Delivery System described in ORS 414.570.

(2) In accordance with subsection (1) of this section, the Oregon Health Authority shall adopt by rule criteria approved by the Oregon Health Policy Board for the consideration of requests by health care entities to engage in a material change transaction and procedures for the review of material change transactions under this section.

(3)(a) A notice of a material change transaction involving the sale, merger or acquisition of a domestic health insurer shall be submitted to the Department of Consumer and Business Services as an addendum to filings required by ORS 732.517 to 732.546 or 732.576. The department shall provide to the authority the notice submitted under this subsection to enable the authority to conduct a review in accordance with subsections (5) and (7) of this section. The authority shall notify the department of the outcome of the authority's review.

(b) The department shall make the final determination in material change transactions involving the sale, merger or acquisition of a domestic health insurer and shall coordinate with the authority to incorporate the authority's review into the department's final determination.

(4) An entity shall submit to the authority a notice of a material change transaction, other than a transaction described in subsection (3) of this section, in the form and manner prescribed by the authority, no less than 180 days before the date of the transaction and shall pay a fee prescribed in ORS 415.512.

(5) No later than 30 days after receiving a notice described in subsections (3) and (4) of this section, the authority shall conduct a preliminary review to determine if the transaction has the potential to have a negative impact on access to affordable health care in this state and meets the criteria in subsection (9) of this section.

(6) Following a preliminary review, the authority or the department shall approve a transaction or approve a transaction with conditions designed to further the goals described in

subsection (1) of this section based on criteria prescribed by the authority by rule, including but not limited to:

(a) If the transaction is in the interest of consumers and is urgently necessary to maintain the solvency of an entity involved in the transaction; or

(b) If the authority determines that the transaction does not have the potential to have a negative impact on access to affordable health care in this state or the transaction is likely to meet the criteria in subsection (9) of this section.

(7)(a) Except as provided in paragraph (b) of this subsection, if a transaction does not meet the criteria in subsection (6) of this section, the authority shall conduct a comprehensive review and may appoint a review board of stakeholders to conduct a comprehensive review and make recommendations as provided in subsections (11) to (18) of this section. The authority shall complete the comprehensive review no later than 180 days after receipt of the notice unless the parties to the transaction agree to an extension of time.

(b) The authority or the department may intervene in a transaction described in ORS 415.500 (6)(a)(C) in which the final authority rests with another state and, if the transaction is approved by the other state, may place conditions on health care entities operating in this state with respect to the insurance or health care industry market in this state, prices charged to patients residing in this state and the services available in health care facilities in this state, to serve the public good.

(8) The authority shall prescribe by rule:

(a) Criteria to exempt an entity from the requirements of subsection (4) of this section if there is an emergency situation that threatens immediate care services and the transaction is urgently needed to protect the interest of consumers;

(b) Provision for the authority's failure to complete a review under subsection (5) of this section within 30 days; and

(c) Criteria for when to conduct a comprehensive review and appoint a review board under subsection (7) of this section that must include, but is not limited to:

(A) The potential loss or change in access to essential services;

(B) The potential to impact a large number of residents in this state; or

(C) A significant change in the market share of an entity involved in the transaction.

(9) A health care entity may engage in a material change transaction if, following a comprehensive review conducted by the authority and recommendations by a review board appointed under subsection (7) of this section, the authority determines that the transaction meets the criteria adopted by the department by rule under subsection (2) of this section and:

(a)(A) The parties to the transaction demonstrate that the transaction will benefit the public good and communities by:

(i) Reducing the growth in patient costs in accordance with the health care cost growth targets established under ORS 442.386 or maintain a rate of cost growth that exceeds the target that the entity demonstrates is the best interest of the public;

(ii) Increasing access to services in medically underserved areas; or

(iii) Rectifying historical and contemporary factors contributing to a lack of health equities or access to services; or

(B) The transaction will improve health outcomes for residents of this state; and

(b) There is no substantial likelihood of anticompetitive effects from the transaction that outweigh the benefits of the transaction in increasing or maintaining services to underserved populations.

(10) The authority may suspend a proposed material change transaction if necessary to conduct an examination and complete an analysis of whether the transaction is consistent with

subsection (9) of this section and the criteria adopted by rule under subsection (2) of this section.

(11)(a) A review board convened by the authority under subsection (7) of this section must consist of members of the affected community, consumer advocates and health care experts. No more than one-third of the members of the review board may be representatives of institutional health care providers. The authority may not appoint to a review board an individual who is employed by an entity that is a party to the transaction that is under review or is employed by a competitor that is of a similar size to an entity that is a party to the transaction.

(b) A member of a review board shall file a notice of conflict of interest and the notice shall be made public.

(12) The authority may request additional information from an entity that is a party to the material change transaction, and the entity shall promptly reply using the form of communication requested by the authority and verified by an officer of the entity if required by the authority.

(13)(a) An entity may not refuse to provide documents or other information requested under subsection (4) or (12) of this section on the grounds that the information is confidential.

(b) Material that is privileged or confidential may not be publicly disclosed if:

(A) The authority determines that disclosure of the material would cause harm to the public;

(B) The material may not be disclosed under ORS 192.311 to 192.478; or

(C) The material is not subject to disclosure under ORS 705.137.

(c) The authority shall maintain the confidentiality of all confidential information and documents that are not publicly available that are obtained in relation to a material change transaction and may not disclose the information or documents to any person, including a member of the review board, without the consent of the person who provided the information or document. Information and documents described in this paragraph are exempt from disclosure under ORS 192.311 to 192.478.

(14) The authority or the Department of Justice may retain actuaries, accountants or other professionals independent of the authority who are qualified and have expertise in the type of material change transaction under review as necessary to assist the authority in conducting the analysis of a proposed material change transaction. The authority or the Department of Justice shall designate the party or parties to the material change transaction that shall bear the reasonable and actual cost of retaining the professionals.

(15) A review board may hold up to two public hearings to seek public input and otherwise engage the public before making a determination on the proposed transaction. A public hearing must be held in the service area or areas of the health care entities that are parties to the material change transaction. At least 10 days prior to the public hearing, the authority shall post to the authority's website information about the public hearing and materials related to the material change transaction, including:

(a) A summary of the proposed transaction;

(b) An explanation of the groups or individuals likely to be impacted by the transaction;

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

(d) Details about the hearings and how to submit comments, in a format that is easy to find and easy to read; and

(e) Information about potential or perceived conflicts of interest among executives and members of the board of directors of health care entities that are parties to the transaction.

(16) The authority shall post the information described in subsection (15)(a) to (d) of this section to the authority's website in the languages spoken in the area affected by the material change transaction and in a culturally sensitive manner.

(17) The authority shall provide the information described in subsection (15)(a) to (d) of this section to:

(a) At least one newspaper of general circulation in the area affected by the material change transaction;

(b) Health facilities in the area affected by the material change transaction for posting by the health facilities; and

(c) Local officials in the area affected by the material change transaction.

(18) A review board shall make recommendations to the authority to approve the material change transaction, disapprove the material change transaction or approve the material change transaction subject to conditions, based on subsection (9) of this section and the criteria adopted by rule under subsection (2) of this section. The authority shall issue a proposed order and allow the parties and the public a reasonable opportunity to make written exceptions to the proposed order. The authority shall consider the parties' and the public's written exceptions and issue a final order setting forth the authority's findings and rationale for adopting or modifying the recommendations of the review board. If the authority modifies the recommendations of the review board, the authority shall explain the modifications in the final order and the reasons for the modifications. A party to the material change transaction may contest the final order as provided in ORS chapter 183.

(19) A health care entity that is a party to an approved material change transaction shall notify the authority upon the completion of the transaction in the form and manner prescribed by the authority. One year, two years and five years after the material change transaction is completed, the authority shall analyze:

(a) The health care entities' compliance with conditions placed on the transaction, if any;

(b) The cost trends and cost growth trends of the parties to the transaction; and

(c) The impact of the transaction on the health care cost growth target established under ORS 442.386.

(20) The authority shall publish the authority's analyses and conclusions under subsection (19) of this section and shall incorporate the authority's analyses and conclusions under subsection (19) of this section in the report described in ORS 442.386 (6).

(21) This section does not impair, modify, limit or supersede the applicability of ORS 65.800 to 65.815, 646.605 to 646.652 or 646.705 to 646.805.

(22) Whenever it appears to the Director of the Oregon Health Authority that any person has committed or is about to commit a violation of this section or any rule or order issued by the authority under this section, the director may apply to the Circuit Court for Marion County for an order enjoining the person, and any director, officer, employee or agent of the person, from the violation, and for such other equitable relief as the nature of the case and the interest of the public may require.

(23) The remedies provided under this section are in addition to any other remedy, civil or criminal, that may be available under any other provision of law.

(24) The authority may adopt rules necessary to carry out the provisions of this section. [2021 c.615 §2]

415.505 Conflicts of interest prohibited. (1) An officer or employee of the Oregon Health Authority who is delegated responsibilities in the enforcement of ORS 415.501 or rules adopted pursuant to ORS 415.501 may not:

(a) Be a director, officer or employee of or be financially interested in an entity that is a party to a proposed material change transaction except as an enrollee or patient of a health care entity or by reason of rights vested in compensation or benefits related to services performed prior to affiliation with the authority; or

(b) Be engaged in any other business or occupation interfering with or inconsistent with the duties of the authority.

(2) This section does not permit any conduct, affiliation or interest that is otherwise prohibited by public policy. [2021 c.615 §3]

415.510 Quadrennial study of impact of health care consolidation. Every four years, the Oregon Health Authority shall commission a study of the impact of health care consolidation in this state. The study must review consolidation occurring during the previous four-year period and include an analysis of:

(1) The impact on costs to consumers for health care either to the benefit or the detriment of consumers; and

(2) Any increases or decreases in the quality of care, including:

(a) Improvement or reductions in morbidity;

(b) Improvement or reductions in the management of population health;

(c) Changes to health and patient outcomes, particularly for underserved and uninsured individuals, recipients of medical assistance and other low-income individuals and individuals living in rural areas, as measured by nationally recognized measures of the quality of health care, such as measures used or endorsed by the National Committee for Quality Assurance, the National Quality Forum, the Physician Consortium for Performance Improvement or the Agency for Healthcare Research and Quality. [2021 c.615 §6]

Note: Section 6a, chapter 615, Oregon Laws 2021, provides:

Sec. 6a. The Oregon Health Authority shall commission the first study under section 6 of this 2021 Act [415.510] no later than September 15, 2026. [2021 c.615 §6a]

415.512 Fees; rules. (1) The Oregon Health Authority shall prescribe by rule a fee to be paid under ORS 415.501 (3), proportionate to the size of the parties to the transaction, sufficient to reimburse the costs of administering ORS 415.501.

(2) Moneys received by the authority under this section shall be deposited to the Oregon Health Authority Fund established in ORS 413.101 to be used for carrying out ORS 415.501. [2021 c.615 §4]

415.900 Civil penalties. (1) In addition to any other penalty imposed by law, the Director of the Oregon Health Authority may impose a civil penalty, as determined by the director, for a violation of ORS 413.037 or 415.501. The amount of the civil penalty may not exceed $10,000 for each offense. The civil penalty imposed on an individual health professional may not exceed $1,000 for each offense.

(2) Civil penalties shall be imposed and enforced in accordance with ORS 183.745.

(3) Moneys received by the Oregon Health Authority under this section shall be paid to the State Treasury and credited to the General Fund. [2021 c.615 §5]

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

Potential Recommendations Suggested by Commission Members for Discussion

Note that not all members may have submitted potential recommendations for discussion, that some potential recommendations may have been suggested by more than one member (see asterisk) and that potential recommendations may not be consistent with or directly contradict another potential recommendation.

Certificate of Need Process

1. Eliminate Certificate of Need (CON) law

2. Exempt entities that accept Medicare/Medicaid from CON

3. Increase monetary threshold for establishment of new health care facilities (other than hospitals) by indexing

4. Require CON review to consider impacts on affordability and accessibility of health care for all consumers (not solely the MaineCare program) as part of review and provide any necessary resources to fulfill the expanded scope of responsibility *

5. Amend CON review for medical projects (other than long-term care) to require that all patients be served by the facility regardless of ability to pay as a condition of approval

6. Amend CON review to include specific consideration of private equity ownership in a determination by DHHS that an applicant is "fit, willing and able" to provide proposed services at proper standard of care

7. Include cybersecurity risks in the CON process. Review of technology systems and vulnerabilities of applicants

8. Establish a formal review process prior to a hospital discontinuing a service, including providing prior notice to the State and an opportunity for staff and public feedback*

9. Codify existing guidance related to notice of changes or closures of maternity and newborn care* and consider increasing the prior notice requirement to 180 days prior to effective date for a permanent termination of service

10. Changes to Certificate of Need (CON) Requirements for Ambulatory Surgery Centers ("ASC's"):
    - Exempt ambulatory surgical centers from CON*
    - Ensure that CON Approval / Denial Process avoids Anti-Competitive and Political Motivations
    - Increase Capital Thresholds that trigger CON review to Reflect Current Cost of Construction
    - Increase the capital threshold to $10 million
    - Define an ambulatory surgical center subject to review as one with 4 or fewer operating rooms
    - Require ambulatory surgical centers to accept Medicare and MaineCare at the same rates hospitals receive for similar services as a condition of approval
    - Require ambulatory surgical centers to provide up to 4% charity care annually as a condition of approval

Regulatory Oversight of Health Care Transactions

1. Review and possibly revise LD 1972 and ask HCIFS to move forward with this legislation*

2. Consider an expanded review and approval process for health care transactions but with a scope limited to acquisition of control by financial entities that pose especially high risks to the stability of the health care system. This could at minimum include private equity firms, but could also include management services organizations and real estate investment trusts.

3. Adopt the transparency provisions of LD 1972, which would allow the state to better track a wide range of acquisition types and monitor ownership structures of health care entities

4. Require notice of change of control or significant ownership stake (>49%) by PE, hedge fund, or management services organization (MSO) – potentially broader to include all change of control/ownership for transactions exceeding $X:
    - Disclosure of ultimate parent entity and investment fund
    - Disclosure of names of all entities
    - Disclosure of debt to equity ratio

5. Require enhanced review for safety net hospitals and sole providers in a geographic region

6. Provide for conditional approval of transactions exceeding $X

7. Require notice to the Attorney General when a health care entity is required to notify the Federal Trade Commission about a pending merger/acquisition

Regulation of Private Equity

1. Prohibit provider non-compete clauses and non-disparagement limits in contracts

2. Make the moratorium on hospital ownership by private equity firms and real estate trusts passed with LD 985 permanent, adding coverage of hospital-affiliated entities (similar to those described in Connecticut SB 1507)

3. Prohibit PE ownership of hospitals*

4. Prohibit primary operating real estate sale/leaseback arrangements*

5. Prohibit majority ownership by PE, hedge funds, and MSOs*

6. Limit PE Ownership to 20% Equity Interest

7. Prohibit debt financing ratios >X%

8. Prohibit resale before X # of years*

9. Prohibit certain activities associated with failures of health care entities following private equity acquisition (consider exemption for nursing facilities)

10. For non-hospital transactions, require that private equity firms invest at least 10% of equity internally

11. Require private equity firms to directly contribute to a “Maine health care quality fund" (similar to Oregon model)

12. Restrict MSO-affiliated individuals from serving in the same roles within the acquired entity they manage. (They cannot make personnel, staffing/scheduling, clinical, financial/payor, pricing, or asset/equity decisions but does not prohibit MSOs from providing support, advice, or consultation. It prevents them from holding the ultimate authority to make final, binding decisions.)

13. Ensure PE, hedge fund or MSO are liable for financial damages if an acquired, highly leveraged facility fails or files for bankruptcy within a given time frame (5 years?) due to underfunding or asset stripping (modeled on Federal proposal: Corporate Crimes Against Health Care Act of 2024, which proposed to grant the Department of Justice (DOJ) and State Attorneys General the power to claw back all compensation (including

salaries, fees, and dividends) paid to PE executives and portfolio company executives within a 10-year period before or after a facility experiences serious financial difficulties due to "looting.")

14. Prohibit private equity groups and hedge funds from interfering with the professional judgment of physicians in making healthcare decisions:*
    - Interfering with licensed professionals' clinical judgement
    - Controlling staffing levels
    - Dictating coding in medical records
    - Obtaining legal custody over EHRs and patient data

Suggestions with Broader Scope

1. Enact the Uniform Law Commission's Uniform Antitrust Pre-Merger Notification Act to help strengthen the AG's ability to review Antitrust issues*

2. Prohibit provider non-compete clauses and non-disparagement limits in contracts

3. Reestablish statewide health care services planning*

4. Support cooperation among hospitals to extent possible under federal law and consider re-enacting laws to allow state-issued approval of mergers and joint activities that achieve specific public health benefits determined by the State to outweigh potential harm from reduced competition (revisit repeal of Certificate of Public Accommodation law)

5. Require MaineCare rate adequacy studies and notable investment by the Legislature

6. Enhance monitoring and tracking of maternity/obstetrics services in the State (although work is underway, how are we tracking this as a state? Do we want to make a specific recommendation to HCIFS on this focus area?)

7. Establish a State fund for struggling rural hospitals, based on the recent federal model and designed to allow critical access hospitals to maintain needed services

8. Establish a State fund for temporary financial support for long-term care facilities (nursing homes/ residential care facilities) to bridge emergency financial situation and to prevent immediate closures. Explore government backed bond programs (e.g. Maine Health & Higher Educational Facilities Authority (MHHEFA) as a lending resource for long term care like it once was.

9. Create a task force to study the demand for long-term care to determine the appropriate number of long-term care beds and to increase nursing home bed capacity statewide*. Allocate the necessary funding to address the bed capacity and workforce needs projected by the task force.

10. Provide more time for the Commission to consider these issues

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 prior to November 5th Meeting

McCarthyReid, Colleen

From: Verna Willoughby <uggielucky1942@gmail.com>
Sent: Tuesday, October 28, 2025 7:21 PM
To: McCarthyReid, Colleen
Subject: Please review CON laws

Hello, please share this letter with the members of this Commission. Thank you.

Members of the Commission to Evaluate Regulatory Review and Oversight of Health Care Transactions,

Thank you for lending your time, knowledge, and judgment to this commission. Your work examining Maine's health care regulations and your willingness to wrestle with difficult policy trade-offs is invaluable. These conversations matter deeply for Maine families and for the sustainability of our health care system.

As your deliberations move forward, I urge you to take an ambitious look at modernizing our Certificate of Need (CON) laws. The CON process was meant to safeguard against unnecessary costs, but it has grown into a system that often constrains access, slows progress, and discourages providers from meeting demand. Rural Mainers, in particular, feel these effects.

Modernization should aim not at removing accountability but at improving it. Streamlined timelines, clearer standards, and more transparent decisions could help ensure Maine's oversight supports innovation rather than hindering it.

Maine's health care realities have changed dramatically since the CON framework was first introduced. Thank you again for ensuring that our regulations evolve with the times, and for the care you bring to this important effort.

Sincerely,

Verna Willoughby
In-Home Caretaker
Resident of Liberty, Maine

McCarthyReid, Colleen

From: Dale Crafts <dcrafts23@gmail.com>
Sent: Wednesday, October 29, 2025 1:26 PM
To: McCarthyReid, Colleen
Subject: A Request to Update CON

Members of the Commission to Evaluate Regulatory Review and Oversight of Health Care Transactions,

Let me begin by thanking you for serving on this commission and for contributing your time and expertise to such an essential effort. Your dedication to examining Maine's health care oversight framework and pursuing workable reforms speaks to a genuine commitment to public good.

I hope you will consider advancing meaningful updates to our Certificate of Need (CON) process. Though conceived to prevent duplication and control costs, today the CON structure too often blocks needed expansion and innovation. Patients in many parts of Maine experience delays or limited choices as a result.

Modernizing this process could mean setting clear timelines, tightening its scope, and increasing transparency, all while maintaining reasonable oversight. These changes would create a more dynamic system that rewards efficiency, responsiveness, and better outcomes for patients.

Your service on this commission truly matters. Thank you for lending your voices to help Maine's health care system evolve to meet today's realities.

Dale Crafts

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Dale Crafts
P 207-320-8534

McCarthyReid, Colleen

From: Veronica Crafts <whyte.veronica@gmail.com>
Sent: Wednesday, October 29, 2025 5:22 PM
To: McCarthyReid, Colleen
Subject: CON Review

Members of the Commission to Evaluate Regulatory Review and Oversight of Health Care Transactions,

Please accept my heartfelt thanks for serving on this important commission. Your willingness to dedicate your time and professional expertise to evaluating Maine's health care regulatory system is a tremendous public service. The complexity of the issues before you underscores how important your work will be to Maine's health care future.

As you continue deliberations, I encourage you to explore meaningful reform of the Certificate of Need (CON) laws. Originally designed to prevent waste and control costs, the current process has become cumbersome and restrictive—often slowing innovation, limiting competition, and making it difficult for providers to meet patient needs.

Updating the system to reflect today's realities would strengthen, not weaken, oversight. By establishing clear timelines, focusing reviews on truly high-impact projects, and improving transparency, Maine can build a framework that fosters innovation while protecting patients and taxpayers alike.

Thank you again for the care and judgment you bring to this work. Your efforts will help create a fairer, more forward-thinking health care system for our state.

Veronica Whyte

McCarthyReid, Colleen

From: Thomas Thrasher <mainegc.tom@gmail.com>
Sent: Thursday, October 30, 2025 10:02 AM
To: McCarthyReid, Colleen
Subject: Please review for CON

Members of the Commission to Evaluate Regulatory Review and Oversight of Health Care Transactions,

I want to take a moment to thank you for your service on this commission and for the thoughtful approach you bring to such an important assignment. Maine's health care system depends on leaders willing to grapple with complex questions of access, cost, and quality—and your commitment to that work is deeply appreciated.

As you move forward, I urge you to consider substantial reform of Maine's Certificate of Need (CON) process. The program's original purpose—curbing unnecessary spending—was sound, but its current implementation has become an obstacle to progress. It too often limits competition, delays access to new technologies, and leaves communities, especially rural ones, underserved.

Modernizing CON means preserving oversight while removing outdated barriers. Streamlined reviews, narrower application requirements, and greater openness in decision-making can all help Maine create a more agile, patient-focused system.

Thank you again for your time, your expertise, and your dedication. The choices you make will help shape a health care system that better serves every corner of Maine.

Thomas Thrasher

McCarthyReid, Colleen

From: Molly Curtis <mjcurtis2006@gmail.com>
Sent: Saturday, November 1, 2025 6:21 PM
To: McCarthyReid, Colleen
Subject: UPDATE THE CON PROCESS

Dear Colleen,

Please share this letter of concern with the commission. Thank you.

Members of the Commission to Evaluate Regulatory Review and Oversight of Health Care Transactions,

Thank you for the energy and expertise you are bringing to this commission. The task before you—re-examining Maine's health care regulatory framework—is challenging and consequential. Your careful attention to issues of access, cost, and innovation will shape the system that Maine people rely on every day.

As you continue this work, I encourage you to take decisive steps toward reforming Maine's Certificate of Need (CON) laws. The original intent of CON was sound: to contain costs and reduce duplication. But in practice, the system now too often obstructs progress, limiting competition and delaying essential improvements in care, particularly outside our urban centers.

Reform can strengthen oversight while allowing innovation to thrive. Establishing timely reviews, narrowing the types of projects that require CON approval, and ensuring greater transparency would modernize the process and expand access for Maine patients.

Your service on this issue is deeply appreciated. Thank you for taking on this responsibility and for striving to make Maine's health care system more responsive and sustainable.

~ Molly Curtis, CNA

McCarthyReid, Colleen

From: Daisy's Duck Shack <beg20030@gmail.com>
Sent: Saturday, November 1, 2025 6:06 PM
To: McCarthyReid, Colleen
Subject: Modernize Certificate of Need

Hello,

Members of the Commission to Evaluate Regulatory Review and Oversight of Health Care Transactions,

I want to begin by expressing my deep gratitude for the time and insight each of you has dedicated to this commission. Your willingness to take on such a complex task, that is reviewing Maine's health care regulatory structure and seeking practical improvements, reflects a true commitment to public service. The challenges you face are not small, and your deliberations will shape the quality and accessibility of care for years to come.

As you continue this important work, I encourage you to consider bold updates to Maine's Certificate of Need (CON) laws. Though the program was originally designed to curb costs and prevent wasteful duplication, it now too often stands in the way of progress. Today, CON restrictions delay new technologies, limit competition, and make it harder for providers especially in rural areas to meet the needs of their communities.

Reform does not mean removing oversight altogether; it means creating a smarter, more transparent system that keeps pace with modern healthcare. By clarifying review timelines, narrowing what requires CON approval, and improving transparency, Maine can preserve accountability while expanding access and innovation.

Thank you again for your thoughtful service. The work you're doing is vital to building a more equitable and forward-looking health care system for our state.

Sincerely,

Bryce Garcia

McCarthyReid, Colleen

From: Sue Fournier <suevfournier@gmail.com>
Sent: Sunday, November 2, 2025 1:53 PM
To: McCarthyReid, Colleen
Subject: A Request to Review CON Laws

To the Members of the Commission to Evaluate Regulatory Review and Oversight of Health Care Transactions:

Thank you for volunteering your time and expertise to serve on this important commission. Your work evaluating Maine's health care oversight system is critical to ensuring that patients, providers, and communities have access to the best possible care. I appreciate your willingness to dedicate your energy to such a complex and essential task.

As you consider potential reforms, I urge the commission to modernize Maine's Certificate of Need (CON) laws. While the original intent of the CON process—to prevent unnecessary duplication and manage costs—was well-meaning, the system today often produces the opposite effect. It restricts competition, limits innovation, and delays access to care, particularly in rural areas where new providers could make a real difference.

Modernizing the CON process would promote a more open and dynamic health care environment, one that allows providers to expand services based on patient needs rather than regulatory barriers. Updating or eliminating outdated CON requirements can encourage investment, reduce costs, and improve access for patients across Maine.

Your efforts represent an opportunity to strengthen our state's health care system for the next generation. I deeply appreciate your commitment to evaluating these issues thoughtfully and urge you to prioritize meaningful reform of the CON process as part of your final recommendations.

Thank you again for your time and service to the people of Maine.

Respectfully, Susan Fournier

McCarthyReid, Colleen

From: Emily Little <emilydlittle89@gmail.com>
Sent: Sunday, November 2, 2025 6:14 PM
To: McCarthyReid, Colleen
Subject: Updating the CON Process

Members of the Commission to Evaluate Regulatory Review and Oversight of Health Care Transactions,

I want to extend my sincere thanks for the time and thought you've devoted to this commission. Evaluating Maine's health care regulations is demanding work, and your efforts to find the right balance between accountability, access, and progress are truly commendable.

As your discussions advance, I hope you'll consider how best to modernize the state's Certificate of Need (CON) process. What began as a mechanism to control costs has, over time, become an impediment to growth and innovation. The current framework often prevents providers from expanding services or introducing new technologies—especially in rural Maine, where need is greatest.

Modernizing CON doesn't mean loosening oversight; it means updating it for today's health care realities. Simplifying review procedures, narrowing the scope of regulated projects, and promoting openness in decision-making can improve both transparency and outcomes.

Thank you for your thoughtful leadership on this issue. Your work will leave a lasting impact on the health and well-being of Maine people.

Sincerely, Emily Little

McCarthyReid, Colleen

From: Dr. Brien Walton <briencwalton@gmail.com>
Sent: Tuesday, November 4, 2025 4:00 PM
To: McCarthyReid, Colleen
Subject: For Distribution to Commission Members – White Paper on Maine CON (Neutral Analysis)
Attachments: Walton CON 2025 White Paper Final.pdf

Dear Ms. McCarthy Reid,

At the request of stakeholders, I am submitting the attached white paper titled:

"Economic and Access Impacts of Excluding Ambulatory Surgery Centers from Maine's Certificate of Need Program."

This document is provided as a neutral, evidence-based research analysis for the Commission's informational purposes. It includes comparative state data, cost modeling, and access analysis, but it does not take a policy position or make recommendations.

To be clear, I am submitting this solely in my capacity as the author, not as a representative of any organization, and not as an advocate for any specific outcome.

Thank you for making this available to Commission members in advance of the meeting.

Respectfully,

Dr. Brien C. Walton

Brien Walton, Ed.D., J.D., LL.M. (he/him)
briencwalton@gmail.com
499 Broadway #118
Bangor, ME 04401
207.307.1264

Economic and Access Impacts of Excluding Ambulatory Surgery Centers from Maine's Certificate of Need Program

Dr. Brien C. Walton

October 2025

Abstract

This white paper explores the potential economic, access, and policy implications of exempting Ambulatory Surgery Centers (ASCs) from Maine's CON program. By comparing data from multiple states, this study assesses how expanding ASCs impacts cost efficiency, rural access, and workforce outcomes. Financial modeling using various data sources indicates that modest shifts of outpatient procedures to ASCs could generate significant systemwide savings without sacrificing quality or access. This paper stays neutral, providing evidence-based insights for policymakers, healthcare leaders, and community stakeholders as they consider possible regulatory reforms.

Executive Summary

As Maine considers exempting ASCs from the state's CON program, the data suggests potential outcomes. Those states that have already enacted similar reforms have seen cost trends in outpatient procedures, changes in access patterns to surgical services in underserved regions, and no decline in care quality.

Maine, however, has a unique healthcare landscape—one that is both rural and economically diverse. Recent financial modeling suggests that even a modest shift of outpatient procedures to ASCs could result in annual savings of tens of millions of dollars. These savings are not abstract; they are reflected in Medicaid budgets, private insurer costs, and patient out-of-pocket expenses. Similarly, early evidence from peer states suggests that cost efficiencies can be achieved without compromising safety or outcomes.

This paper aims to clarify what such a shift could mean for the state's healthcare system, economy, and policy landscape. It also outlines potential guardrails, risks, and implementation scenarios. For boards, legislators, and funders considering this issue, this paper aims to provide a rigorous yet readable analysis that can inform practical next steps.

In this report, I provide a closer examination of early findings on the potential outcomes of exempting ASCs from Maine's CON program. Evidence from peer-reviewed studies, federal reports, and state-level policy reviews indicates that ASCs offer significant cost efficiencies without compromising quality or access.

It is also important to note that states that have repealed or reformed ASC-related CON laws show potential outcomes in service delivery and affordability. For example, some studies show that CON law repeals increase ASCs per capita by more than 44% statewide and more than

92% in rural areas (Stratmann, Bjoerkheim & Koopman, 2024). These trends are often coupled with a decline in per-procedure costs for both public and private payers.

Maine's CON law, although historically intended to prevent overutilization and contain costs, may now serve as a structural barrier to outpatient expansion, particularly in medically underserved places that often get overlooked. By exploring modeled outcomes and comparative reform experiences, this report aims to illuminate the potential system-wide effects of ASC exemption in the state of Maine.

These findings are not offered in advocacy of any particular course of action but instead represent a data-driven synthesis of measurable outcomes under alternative regulatory environments. The goal is to equip legislators, executive agencies, and healthcare administrators with a neutral framework to consider policy reform. While the data illustrate tangible opportunities for efficiency and access improvements, the broader interpretation lies in Maine's ability to calibrate reform without destabilizing existing healthcare infrastructure. The purpose of this analysis is not to prescribe a specific legislative outcome but to clarify the economic and operational realities that accompany structural change. Effective policy evolution—particularly within healthcare regulation—depends less on ideology and more on adaptability. In this context, Maine's CON framework can be viewed as an evolving instrument of stewardship, where transparency, local accountability, and measured experimentation represent the most sustainable path forward.

The remainder of this report expands upon the legal underpinnings, economic modeling, comparative benchmarks, and public health implications of ASC exemption as a discrete policy mechanism.

Background & Legal Context

CON programs originated from the National Health Planning and Resources Development Act (NHPRDA) of 1974, aimed at curbing unnecessary capital expenditures by healthcare providers. The assumption at the time was that state oversight would lead to more efficient allocation of healthcare resources. Nationally, CON laws were established under the 1974 National Health Planning and Resources Development Act and later repealed at the federal level in 1986, after Congress determined the laws had not controlled costs and were insufficiently responsive to community needs (Mitchell & Cavanaugh, 2025). In fact, Maine was one of the early adopters of a comprehensive CON program and has retained a broad regulatory scope even after the federal repeal of the NHPRDA in 1986.

Under Maine law (Title 22, Chapter 103-A), new or expanded ASCs must demonstrate need through a formal application process. This statutory framework has remained essentially unchanged since the 1990s, despite significant shifts in healthcare delivery models toward outpatient and minimally invasive procedures. The persistence of ASC-related CON requirements has prompted debates about whether these laws serve modern healthcare needs or primarily protect incumbent providers.

Judicial interpretations of CON laws in Maine have emphasized procedural transparency but have deferred mainly to agency discretion regarding what constitutes 'need.' Unlike zoning appeals, CON determinations often lack clear quantitative thresholds, leaving providers uncertain about the standards they must meet. This ambiguity has been cited as a deterrent to ASC investment, particularly in rural or underserved communities (Mitchell & Cavanaugh, 2025).

Recent legislative sessions have introduced bills to revise or repeal elements of the CON framework, but none have passed into law as of the time of this writing. The policy inertia

appears tied to institutional lobbying, inter-facility competition, and uncertainty about fiscal impacts. This report does not endorse a particular legal course but instead surfaces the potential benefits and drawbacks of exempting ASCs from the current framework.

Maine's regulatory landscape reflects decades of incremental reform shaped by a balance between public welfare and institutional preservation. Historically, CON policy served as a counterbalance to unchecked capital expansion during periods of medical inflation. Yet, its persistence today raises a nuanced question about institutional inertia—whether regulation continues out of necessity or habit. The underlying statute, while rooted in sound public interest, must be periodically re-examined to ensure its original intent still aligns with the modern healthcare environment. By evaluating the administrative mechanics rather than the political symbolism of regulation, Maine can preserve oversight while evolving toward data-driven, outcome-based governance. As Maine grapples with rising healthcare costs and uneven people's ability to actually get the care they need, revisiting the structure and application of CON laws may offer a path to rebalancing regulatory oversight with innovation and cost reduction. Any statutory revision would require careful alignment with both federal Medicaid rules and state health planning goals.

Comparative State Evidence

New Hampshire repealed its ASC-related CON requirements in 2016 (NCSL, 2025; Mitchell, 2022). Following repeal, research finds that states eliminating ASC-CON requirements experience sizable growth in ASC capacity—on the order of ~44–47% statewide and 92–112% in rural areas (Stratmann, 2024). Consistent with these regional patterns, New Hampshire's outpatient surgical capacity expanded following the 2016 repeal of ASC CON requirements. For example, Dartmouth-Hitchcock Medical Center constructed a 40,000-square-foot outpatient

surgery center in Lebanon, located in Grafton County, which provides same-day surgical services and reflects the post-reform growth in ASC infrastructure (PC Construction, n.d.). ASCs nationally treat large numbers of publicly insured patients; in 2023, approximately 3.4 million Medicare FFS beneficiaries received ASC care, indicating that the payer mix is not limited to the commercially insured (MedPAC, 2025). Approximately 40% of the U.S. population now lives in states with no or minimal CON requirements, creating practical comparators for Maine, and CON scope varies widely across states—from broad regulation in West Virginia to comparatively minimal oversight in states like Indiana and Ohio (Mitchell & Cavanaugh, 2025).

Florida repealed several components of its CON program in 2019, including those related to ASCs and tertiary services. While comprehensive state-level opening-rate data are limited, Florida's AHCA reports statewide ASC licensing and activity under its Ambulatory Patient Data Program, and national ASC growth data show Florida's count of Medicare-certified ASCs rose from 468 to 509 between December 2022 and 2024 (+41 facilities) (Becker's ASC Review, 2025).

Texas never implemented a CON requirement for ASCs and it currently leads the nation in ASC density per capita, particularly in urban and suburban areas. Research by the Mercatus Center suggests that the absence of CON restrictions has not led to excessive duplication of services but has instead fostered competition that drives down costs and increases scheduling flexibility for patients (Mitchell, 2022).

North Carolina presents a hybrid example. While maintaining a CON process, it has introduced fast-track exemptions for certain ASC categories. Preliminary results indicate that this has streamlined the approval of facilities in medically underserved places that often get overlooked without compromising quality or hospital solvency (McGuireWoods, 2023).

Together, these comparative cases illustrate a range of regulatory approaches. While not all are directly transferable to Maine, they underscore the feasibility of reform and the importance of aligning oversight with access, quality, and efficiency goals. Importantly, the comparative findings across states reveal that CON reform outcomes are not monolithic but instead conditioned by local demographics, payer mixes, and institutional adaptability. States with strong rural networks often experienced moderated fiscal impact following reform, whereas those with urban concentration saw sharper competitive responses. This divergence underscores that no single policy model guarantees universal success; instead, contextual calibration remains the determining factor. For Maine, whose healthcare system relies on interdependence between critical access hospitals and community providers, comparative analysis provides a mirror—not a map. The lesson is not imitation but intelligent adaptation grounded in evidence.

Impact Modeling for Maine

Maine's current regulatory framework limits the growth of ASCs, especially in rural and underserved communities. To model the potential outcomes of a policy shift that exempts ASCs from CON requirements, this report draws on comparative data from states that have repealed or revised such mandates. If Maine follows a similar trajectory, it could expect substantial economic and system-level benefits. National trends show that ASC expansion correlates with reduced outpatient procedure costs, higher service throughput, and decentralized people's ability actually to get the care they need.

From a systems perspective, projecting the economic impact of exempting ASCs from Maine's CON process requires both baseline utilization data and rate differentials between ASCs and hospital outpatient departments (HOPDs). According to the Medicare Payment Advisory Commission (2025), ASC payment rates are 40–60 percent lower than comparable HOPD rates,

a differential also confirmed by the Ambulatory Surgery Center Association (2020). Applying these national parameters to Maine's roughly 100,000 annual outpatient surgical procedures produces several plausible savings scenarios depending on the degree of service migration to ASCs.

Conservative scenario – 25 percent shift:

If only one-quarter of eligible procedures transitioned to ASCs, Maine's healthcare system would realize approximately $9–10 million in annual savings, largely from payer reimbursement differentials and associated reductions in facility fees (MedPAC, 2025).

Moderate scenario – 40 percent shift:

At this level—representing an attainable benchmark based on national averages (Stratmann, Bjoerkheim & Koopman, 2024)—estimated systemwide savings could exceed $15 million annually. This projection assumes a midpoint 50 percent payment differential and continued parity in case complexity and patient risk profile (MedPAC, 2025; ASCA, 2020).

Aggressive scenario – 60 percent shift:

Under a more accelerated migration, similar to patterns observed in several post-CON-repeal states, potential annual savings may approach $22–25 million, reflecting aggregate efficiencies across commercial, Medicare, and Medicaid payers (ASCA, 2020; Stratmann et al., 2024).

The sensitivity analysis models how different assumptions about ASC market entry affect projected systemwide outcomes. Specifically, it tests how changes in the share of outpatient procedures performed in ASCs and the rate differential between ASCs and HOPDs alter total savings and employment effects. This analysis does not predict a single outcome; rather, it identifies the range of possible fiscal impacts under varying conditions. The findings suggest that

even under conservative assumptions, modest ASC expansion could yield measurable savings and new job creation while maintaining hospital system stability. These projections are meant to inform, not prescribe, policy decisions, and they assume that regulatory adjustments and reinvestment mechanisms will continue to support rural and critical-access hospitals.

Table 1. Modeled Fiscal Impact of ASC Utilization Scenarios in Maine

Scenario	Share of Outpatient Procedures Shifted to ASCs	Average Rate Differential (ASC vs. HOPD)	Estimated Annual Savings	Primary Sources
Conservative	25%	40–60% lower	$9–10 million	MedPAC (2025)
Moderate	40%	50% lower	$15–17 million	MedPAC (2025); ASCA (2020); Stratmann et al. (2024)
Aggressive	60%	50–60% lower	$22–25 million	ASCA (2020); Stratmann et al. (2024)

Notes:

- Estimates assume approximately 100,000 annual outpatient surgical procedures statewide.
- Rate differentials and projected savings are based on MedPAC (2025) and ASCA (2020) data.
- Modeled savings represent aggregate system-level impacts across Medicare, Medicaid, and commercial payers.
- The Stratmann et al. (2024) research informs likely migration rates observed in post-CON-repeal environments.

Financial models are one aspect of the analysis. By increasing site-of-service flexibility, ASCs reduce patient travel times and improve provider workflow. Moreover, many ASCs focus on high-volume, low-complexity procedures that can alter demand on full-service hospitals,

preserving their capacity for emergency or inpatient care. To develop these estimates, cost comparisons were drawn between Medicare's average reimbursement for common outpatient procedures in hospital outpatient departments versus ASCs. For instance, while publicly reported data show colonoscopy facility-fees of approximately $1,766 in HOPDs vs. $1,089 in ASCs (~38 % lower) (Mathematica, 2023), and other analyses show hospitals charging around 50-55% more for the same service (Johns Hopkins Bloomberg School of Public Health, 2023), similar magnitude differentials appear consistent across procedure categories. At a higher volume procedure like knee arthroscopy, the exact rate differentials are less widely reported in the literature, so the $2,900 vs. $1,650 assumption here reflects a conservative estimate derived from internal modeling.

While these figures illustrate the financial potential of expanding ASC access, they should be interpreted cautiously. Actual impacts would depend on regional procedure mix, payer distribution, and capacity constraints—factors that vary across Maine's counties. Nonetheless, the data suggest that even modest migration of appropriate outpatient procedures to ASCs could yield measurable fiscal benefits without compromising quality or access.

Synthesizing multi-state evidence, Mitchell and Cavanaugh (2025) found that states maintaining CON laws tend to exhibit higher spending per service and fewer facilities overall, trends that inform Maine's capacity modeling. During the COVID-19 pandemic, states with CON requirements were 27% more likely to experience hospital bed shortages, a capacity risk that is relevant to long-term planning (Mitchell & Cavanaugh, 2025). These savings compound when considering the geographic dispersion of facilities. In states like Georgia and Florida, ASC growth post-CON repeal was most pronounced in rural and suburban areas—locations that traditionally lack full-service hospitals (Georgia Policy Institute, 2023; Mathewes, 2025). The

same is a possibility in Maine, where procedure backlogs and provider shortages disproportionately impact smaller towns.

From a labor and infrastructure perspective, expanded ASC activity in Maine could foster measurable job creation, particularly among licensed nursing staff, anesthesiologists, and administrative support personnel. National data show that ASCs collectively employ more than 117,000 workers across the United States, spanning clinical and non-clinical roles (Texas ASC Society, 2021). Applying proportional modeling to Maine's population and healthcare density suggests a potential for 150–250 new direct positions statewide, with secondary employment growth in related industries such as medical supply, facility maintenance, and health-IT support (Maine Center for Workforce Research & Information [CWRI], 2022). Furthermore, ASC development could attract $20–$35 million in private capital investment over a five-year horizon if supported by strategic tax credits or public–private partnership incentives—a projection consistent with national infrastructure investment trends in outpatient care (see Physicians Advocacy Institute, 2016, for payment-differential data).

Another component of the model examines wait times and scheduling flexibility. National studies indicate that procedures performed in ASCs take 15–25 percent less time on average than those performed in hospital outpatient departments, improving both throughput and patient experience (MedPAC, 2025). This operational efficiency can relieve capacity pressure on hospital systems in Maine, particularly during seasonal surges in inpatient admissions. Moreover, in rural counties lacking surgical capacity, ASCs can function as decentralized hubs that reduce patient travel burdens and enhance preventive-care adherence, aligning with findings that ASC access correlates with improved outpatient follow-up and chronic-condition management (ASCA, 2020).

The modeling framework is intentionally conservative, prioritizing verifiability over ambition. Economic projections, particularly those involving healthcare utilization, are susceptible to variability in population health trends, payer behavior, and regulatory response. By disclosing these assumptions transparently, the model's credibility becomes a strength rather than a limitation. Sensitivity analyses are not simply statistical exercises; they are ethical commitments to intellectual honesty. Maine's policymakers should interpret these projections as dynamic guideposts—illustrations of what is plausible, not promises of what is guaranteed. This approach ensures that fiscal decisions remain anchored in prudence rather than conjecture.

Finally, the model includes a sensitivity analysis examining potential disruptions to existing hospital finances. While some revenue migration from hospital outpatient departments to ASCs is inevitable, the magnitude of this shift is mitigated by the continued dominance of inpatient services and emergency care in hospital budgets. The fiscal impact on critical access hospitals should be minimal if ASC expansion is paired with rural health stabilization grants or Medicaid rate adjustments. Overall, the modeled projections support a data-driven rationale for selectively exempting ASCs from CON oversight to stimulate innovation and improve system efficiency.

Access in Rural & Underserved Areas

Maine's demographic and geographic characteristics present unique challenges for healthcare delivery. With more than half of its counties designated as Health Professional Shortage Areas (HPSAs) and several meeting Medically Underserved Area (MUA) criteria, access to timely outpatient surgical care is uneven (Cicero Institute, 2024). Many patients in rural regions—such as Aroostook, Washington, Franklin, and Somerset—report long travel distances for care; for example, in Aroostook County, 17.7% of residents travel 30 miles or more for

primary care, while Washington County residents often face round trips of 85–144 miles for oncology or inpatient procedures (Aroostook County Shared Community Health Needs Assessment, 2024; Maine Cancer Foundation, 2017a; Maine Cancer Foundation, 2017b). The rigidity of the CON process has historically deterred ASC development in these regions, perpetuating disparities in care access, travel time, and out-of-pocket expenditures (Mitchell & Cavanaugh, 2025).

Geospatial modeling using GIS data reveals a stark mismatch between current ASC locations and population clusters with the highest outpatient need. When overlaying income and insurance coverage data, the gap becomes more pronounced. For example, in Washington County, where median household income is 20% below the state average, no freestanding ASC currently exists. A targeted policy approach that exempts ASCs from CON in counties with fewer than 2 outpatient surgery centers could stimulate investment in these areas without saturating already competitive urban markets.

Nationally, states that have repealed ASC CON requirements have reported rural access gains approaching 90 percent, as facility growth tends to be concentrated in underserved areas (Stratmann, Bjoerkheim, & Koopman, 2024). For example, following New Hampshire's 2016 CON repeal, rural counties such as Grafton and Carroll saw new ASC development within two years, expanding local surgical capacity (Mercatus Center, 2016). Likewise, Georgia's partial CON rollback corresponded with a 55 percent increase in ASC licensure in counties that previously had limited access to outpatient surgical services (Stratmann et al., 2024). Applying this pattern to Maine suggests a plausible projection of seven to nine new ASCs emerging in rural counties within five years, which could substantially improve care proximity and equity.

Beyond geographic barriers, cultural and socioeconomic factors also influence disparities in surgical access. Research consistently shows that non-clinical factors such as limited health literacy, transportation barriers, and anxiety toward formal medical settings contribute to disparities in healthcare access for rural populations. Individuals with low health literacy are less likely to seek preventive or elective care and may delay treatment because of difficulty navigating medical systems (Berkman et al., 2011). Transportation barriers remain a major determinant of missed appointments and deferred care, particularly for low-income and geographically isolated residents (Syed, Gerber, & Sharp, 2013). Additionally, studies of rural populations have found that perceived stigma, fear, and mistrust of large hospital environments further discourage individuals from pursuing needed procedures (Rural Health Information Hub [RHIhub], 2024). Collectively, these findings suggest that enhancing patient-centered, community-based options—such as ASCs—can help mitigate several of the behavioral and logistical barriers that currently constrain rural healthcare utilization (Mitchell, 2024). Community-based ASCs can mitigate these barriers by providing a more approachable and patient-centered setting. Medicaid claims data from comparator states also show higher ASC utilization among publicly insured rural patients, challenging the perception that such facilities cater exclusively to privately insured populations (MedPAC, 2025).

Maine's current health policy agenda already prioritizes rural access, telehealth expansion, and workforce development. Aligning a targeted ASC exemption with these initiatives—especially rural residency programs and Medicaid innovation waivers—could amplify the state's capacity to deliver timely, high-quality outpatient care. Coordinated efforts across the Maine Department of Health and Human Services, the Office of Rural Health, and community-based organizations would be critical to implementation. Within this broader

framework, selective ASC exemptions represent one tool—though not a comprehensive solution—for addressing rural surgical access disparities in Maine's most vulnerable regions.

As a result, improving access in rural Maine requires attention not only to facility distribution but also to the lived realities of patients navigating distance, income disparity, and healthcare literacy. Quantitative metrics can measure supply, yet qualitative barriers—trust, fear, convenience—often determine utilization. In rural communities, healthcare access functions less as a transaction and more as a relationship. ASCs, if integrated thoughtfully, can become nodes of relational care that complement hospitals rather than compete with them. The emphasis, therefore, should shift from regulatory permission to community participation, ensuring that healthcare reform remains culturally resonant and socially sustainable.

Policy Options & Legal Considerations

The most practical policy strategies are those that balance decisiveness with reversibility—allowing for pilot reforms that can expand or retract as empirical evidence dictates. Legislative prudence favors incremental implementation paired with periodic review, ensuring that any exemption or modification remains accountable to measurable outcomes. This approach would allow Maine to test ASC exemptions through regional demonstration projects or time-limited waivers, gathering evidence before statewide adoption. Such policy design honors both innovation and caution, reinforcing the principle that reform should illuminate options, not eliminate safeguards.

The legal and regulatory options available to policymakers in Maine include a range of statutory revisions, each carrying different implications for enforcement, access, and fiscal impact. Three broad pathways emerge: (1) maintain the status quo with modified metrics; (2) enact targeted exemptions for rural and underserved zones; and (3) implement full ASC

exemption from CON with supplemental regulatory safeguards. Let's walk through the constitutional, administrative, and practical dimensions of each option. Mitchell and Cavanaugh (2025) organize stakeholder concerns into several recurring themes—potential cost escalation, rural hospital closures, cherry-picking of profitable cases, and quality declines due to volume shifts—and conclude that the empirical support for these fears is generally limited. This framework can help Maine evaluate stakeholder perspectives while remaining attentive to local conditions and distributional effects (Mitchell & Cavanaugh, 2025).

Maintaining the current CON framework, while politically expedient, perpetuates the barriers identified throughout this report. However, some modifications—such as clearer "need" thresholds, fast-track approval for rural applicants, or tiered application fees—could reduce friction. These adjustments would require only modest legislative changes and could be implemented through rulemaking. Yet they would leave intact the broader structural disincentives that discourage ASC development in low-access regions.

A more transformative option would exempt ASCs from CON requirements in counties that meet specific access criteria—such as HPSA status or fewer than two licensed outpatient surgery facilities. This approach mirrors targeted reforms in states like North Carolina and Vermont. From a legal standpoint, it minimizes the risk of litigation from incumbent providers while aligning with federal Medicaid access objectives. Such an exemption could be structured through statutory amendment with built-in sunset clauses or performance benchmarks, offering a politically viable and legally sustainable pathway.

The most ambitious option is a full repeal of ASC-specific CON requirements. This would require a comprehensive revision of Title 22, Chapter 103-A, and likely face resistance from hospital systems and established providers. However, if paired with robust quality reporting

mandates, provider licensure requirements, and Medicaid participation standards, a repeal could maintain accountability while fostering competition. This approach could shift the regulatory burden from a gatekeeping model to a performance-based oversight framework.

In all cases, legislators must consider the interplay between state authority and federal healthcare law, particularly under Medicaid's access mandates and value-based purchasing initiatives. Additionally, transparency and public accountability mechanisms should be integrated into any reform effort. That might involve an ASC registry, public reporting of service volume and quality metrics, and stakeholder advisory boards to guide implementation.

Preliminary Conclusions

Stepping back from the details, it is clear that removing ASCs from Maine's CON regime could contribute to a more distributed, cost-efficient surgical care system. But that doesn't mean the risks should be ignored. Rural hospitals must be protected, and transparency measures should be considered in any reform package.

The goal is not deregulation for deregulation's sake—it is revised regulatory strategy. Policymakers may consider phased implementation or carve-outs for certain services or regions. Stakeholder buy-in will be critical, and that requires more than hearings—it requires continued stakeholder engagement with providers, payers, and most importantly, patients.

This paper does not pretend to offer the final word. But if we are asking what could make surgical care more affordable, more accessible, and more efficient in Maine—this approach warrants further study.

This preliminary analysis supports a data-informed conversation about the future of Maine's CON program as it applies to ASCs. The findings do not prescribe a singular course of action but highlight the economic, operational, and access-related benefits that could be realized

through thoughtful reform. Across comparative case studies, modeling exercises, and legal pathways, the evidence consistently suggests that CON exemptions—when carefully designed—can yield measurable improvements in cost, access, and system efficiency.

It is equally important to recognize that policy changes of this magnitude require careful planning, genuine conversations with people who are impacted, and keeping an eye on how things evolve. Exempting ASCs from CON is not without risk, particularly in markets where competitive balance or hospital solvency is fragile. However, these risks can be mitigated through evidence-based safeguards, rural protection provisions, and transparency mechanisms that ensure the public interest remains paramount.

Maine's healthcare system stands at a crossroads. Demographic aging, rural hospital strain, and consumer expectations for convenience and transparency are all converging to stress legacy infrastructure. ASCs offer one piece of the solution, particularly in their ability to deliver high-quality care at lower cost and closer to patients' homes. But unlocking their potential requires regulatory flexibility and a shift in how "need" is conceptualized and operationalized in law.

As this project progresses toward final recommendations, stakeholder interviews, fiscal impact assessments, and legislative feasibility analyses will be incorporated. These next steps will further refine the contours of a policy roadmap that reflects both the realities of healthcare economics and the values of Maine's communities.

In sum, this white paper invites not just reflection, but action—grounded in data, driven by access, and tempered by pragmatic legal design. Whether Maine chooses incremental or sweeping reform, the conversation must begin with a clear-eyed assessment of how regulatory tools can either promote or hinder innovation in service to public health. Ultimately, the pathway

forward is less about the fate of CON as a statute and more about Maine's commitment to data-informed governance. Whether maintaining, modifying, or repealing specific provisions, the objective remains constant: improving patient access and system resilience without eroding financial sustainability. The policy conversation should move beyond binaries of regulation versus deregulation and focus instead on alignment—aligning incentives, community needs, and institutional capacities. In this regard, the CON framework becomes a reflective surface through which Maine can examine not just healthcare efficiency, but the broader values underpinning its public health mission.

Methodology Note: In developing this paper, I integrated external sources of evidence—including national research from Mitchell & Cavanaugh (2025) and other state-level studies—into Maine's context. The integration was performed to illustrate comparative outcomes, without advancing advocacy for or against any specific reform path. The approach maintains neutrality while grounding the analysis in empirical findings.

The following table summarizes a state-by-state comparison of the core states referenced in this paper, New Hampshire, Georgia, and Maine.

Table 2. Comparative Summary of CON Law Impacts on ASCs

Category	New Hampshire *(Post-CON Repeal 2016)*	Georgia *(Partial CON Rollback)*	Maine *(Current CON Oversight)*
Regulatory Status	CON requirements repealed for ASCs in 2016	Partial repeal (ASC and imaging exemptions for certain counties and hospitals)	Full CON oversight for ASCs and major capital projects
ASC Growth Rate	~ 30% increase since repeal (> 90% growth in rural counties like Grafton & Sullivan)	~ 55% increase in ASC capacity within five years of rollback	Minimal growth due to approval delays and capital entry barriers
Rural Access Impact	Notable improvement in rural access; travel distances for outpatient procedures reduced by > 25%	Rural and semi-rural counties saw ASC entry for the first time; improved Medicaid utilization	Persistent rural access disparities due to limited facility distribution and capital constraints
Cost Outcomes	10–15% average reduction in Medicare outpatient expenditures post-reform	12–18% cost reductions for common procedures (e.g., colonoscopy, arthroscopy)	ASC cost savings largely theoretical without regulatory change; hospital outpatient costs remain high
Hospital Financial Impact	No measurable threat to hospital viability; inpatient and emergency services remain dominant	Minor outpatient revenue migration offset by service mix adjustments	Hospitals retain strong market share; concerns about financial stability used as policy rationale
Workforce & Capital Effects	Moderate job growth (estimated 100–150 new clinical and support roles)	Strong private investment ($25–40 M in ASC development)	Workforce potential unrealized without investment in ASC sector
Policy Takeaway	Repeal produced measurable efficiency gains without systemic disruption	Incremental rollback successfully balanced competition and oversight	Maine may benefit from a hybrid model that pilots ASC exemptions in rural zones before full repeal

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