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State Strategies to Improve Health Care Market Oversight

A Peterson-Milbank Program State Health Policy Roundtable Convening Recap

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EXECUTIVE SUMMARY

The increase in health care consolidation and corporate control of health care has impeded the capacity of market forces, state cost growth target programs, and other initiatives to contain high and rising health care costs. Along with driving up health care prices, these market changes are threatening access to care, the quality of care, and the health care workforce.

In December 2025, policymakers and regulators from 12 states convened for a two-day roundtable sponsored by the Peterson-Milbank Program for Sustainable Health Care Costs. The roundtable, facilitated by Erin C. Fuse Brown, examined emerging challenges and policy strategies related to health care consolidation, corporatization, workforce pressures, and rising costs. Participants included officials from state health departments, Medicaid agencies, offices of the state attorneys general, insurance regulators, and health policy and affordability commissions.

The roundtable discussion occurred amid heightened fiscal uncertainty and increasing concern about affordability for households, employers, and public purchasers. Participants noted that recent and anticipated federal budget constraints affecting funding reductions for Medicaid and other public programs may intensify financial pressure on providers and accelerate consolidation, service line closures, and corporate investment—with disproportionate effects on safety-net providers. Against this backdrop, states assessed whether existing health system oversight tools are sufficient to protect access, affordability, and clinical capacity.

Across sessions, state officials identified key challenges and discussed a complementary set of policy responses, including transaction oversight, ownership transparency, corporate practice of medicine enforcement, regulation of provider–payer contracting, and price regulation. Participants emphasized the importance of incremental progress, peer learning, and sustained investment in data and institutional capacity.

KEY CHALLENGES

Consolidation and corporatization. Participants emphasized that consolidation and corporatization are reshaping health care delivery in ways that strain affordability, workforce stability, and public accountability. They were particularly focused on the impact of newer developments, such as the increase in private equity investors, vertically integrated insurers (which may own physician groups, home health agencies, a pharmacy benefit manager, and pharmacies), and large health systems.

Administrative fragmentation and complexity. State officials shared their challenges with the fragmented regulatory and payer landscape, including states' limited authority to oversee and regulate employer-based coverage that is self-insured. Participants emphasized a need to engage employers on issues of affordability and shine a light on the intermediaries (third-party administrators, pharmacy benefit managers, consultants, brokers, etc.) that may be contributing rising costs.

Lack of transparency. Currently, there is significant opacity regarding who owns or controls health care providers, especially among provider organizations. Officials identified the need for greater transparency about complex corporate ownership structures to better monitor and assess market dynamics across a state's health care system. Participants discussed strategies to use existing and new data resources to improve transparency of ownership, control, and the flow of funds between related parties within the health care system.

Provider sustainability and workforce. Consolidation and corporatization may be contributing to instability in the supply of health care providers. Private equity–backed hospitals and nursing home chains have declared bankruptcy or closed. Physician practices run by corporate entities may also close or lose providers to turnover, burnout, and leave. Participants highlighted growing concern over closures of service lines and physician practices and reductions in health facility capacity. State officials identified a need for further policy development to provide necessary capital supports and protect physician autonomy.

STATE STRATEGIES TO IMPROVE HEALTH CARE MARKET OVERSIGHT

Health Care Transaction Review

Policy approach

States are expanding notice and review requirements to cover a broader range of health care entities and transaction types and to prevent or oversee mergers and corporate health care transactions that may have harmful effects on patients and providers. Even in states with limited formal authority to block transactions, review processes can require disclosure of ownership structures, financial assumptions, workforce plans, and access commitments.

Why states are considering this

While traditional antitrust enforcement remains important, states increasingly view it as insufficient on its own to address serial acquisitions, corporate investment, vertical integration, and anticompetitive market conduct by already dominant actors.

State examples

- Oregon's Health Care Market Oversight program requires advance notice to the Oregon Health Authority (OHA) and approval for material change transactions involving health care entities, including hospitals, health plans, and provider organizations. With the attorney general's office, OHA has the authority to impose conditions or disapprove transactions.[1]
- Massachusetts' Health Policy Commission (HPC) conducts cost and market impact reviews of material change transactions involving a range of health care entities, including provider organizations, private equity investors, management services organizations (MSOs), and real estate sale-leasebacks. The HPC's review culminates in a public report assessing access, cost, competition, and public interest impacts. Though HPC lacks authority to block transactions, it can refer transactions to the attorney general so that office can take legal action.[2]
- California's health care market oversight program requires notice to the Office of Health Care Affordability (OHCA) of material change transactions involving health care entities, including hospitals, health plans, physician organizations, pharmacy benefit managers, and, as of 2025, MSOs operated by private equity or hedge funds.[3] Like Massachusetts' HPC, OHCA lacks the authority to block transactions but can report the review results to the state attorney general so they can take further action.

Key takeaways

Transaction review is expanding beyond nonprofit hospital mergers. States are broadening review authority to cover serial acquisitions, changes of control, physician acquisitions by corporate-backed MSOs, private equity investments, and real estate sale-leasebacks. Even when states lack authority to block transactions, review and public reporting have proven influential, as public scrutiny has prompted voluntary withdrawals from mergers.

Implementation capacity is critical. Sustainable market oversight requires dedicated staffing and specialized expertise. States report that small teams can function effectively—often supplemented by contractors, such as accountants, actuaries, and economists. However, staffing needs vary widely with transaction volume, and much of the work remains manual.

Defining the types of health entities and providers subject to review is a persistent challenge. States struggle to balance broad coverage with administrative feasibility. Even states with authority over hospital acquisitions may lack authority over transactions involving physician groups or MSOs. Long-term-care and skilled nursing facilities are a major point of divergence among states, and many states continue to refine definitions of covered entities through rulemaking to capture evolving private equity activity and prevent evasion, often using revenue or transaction-size thresholds to make review manageable.

Resources on Transaction Review and Market Oversight

- Comprehensive Consolidation Model Addressing Transaction Oversight, Corporate Practice of Medicine and Transparency
- Market Consolidation (The Source on Healthcare Price & Competition)
- The Corporate Backdoor to Medicine: How MSOs Are Reshaping Physician Practices (Milbank Memorial Fund)

Funding models vary and contain trade-offs. Transaction oversight capacity requires budgetary and other sources of funding for staff and outside experts to assist with review. Participants debated reliance on transaction review fees versus general fund appropriations. Experience suggests that fee-based models can be unstable due to unpredictable transaction volume, while general fund support raises political and budgetary challenges. States continue to experiment with ways to justify review costs relative to transaction size and market impact.

States are leveraging existing authority creatively. In the absence of explicit power to block transactions, states are using tools such as certificate of need programs, attorney general consumer protection authority, and health care affordability targets to influence market behavior and highlight transaction risks, demonstrating that meaningful oversight can occur even within constrained statutory frameworks.

Ownership and Financial Transparency

Policy approach

To address opacity of ownership and control structures, and financial relationships among health care entities, states are adopting ownership reporting requirements, provider registries, and enhanced financial disclosure requirements to illuminate corporate structures, management relationships, real estate holding companies, and related-party transactions.

Why states are considering this

Limited visibility into ownership, control, and financial relationships among health care entities constrains states' ability to understand market dynamics; allocate Medicaid and other public funds; ensure accountability; and anticipate closures, bankruptcies, or service reductions. Currently, there is no comprehensive federal database to track health care ownership structures and finances, and some states rely on expensive proprietary datasets to identify private equity ownership and difficult manual matching to trace corporate and financial relationships.

State examples

- Massachusetts' Registration of Provider Organizations requires provider organizations with more than $25 million in annual net patient service revenue to submit annual provider financial and organizational reports, including disclosure of corporate structure, governance, physician roster, contracting affiliates, and audited financial statements.[4]
- Indiana's HB 1666 (2025) established a health care entity ownership transparency requirement aimed at increasing state visibility into consolidation and corporate control. The law applies to hospitals, physician practices, insurers, pharmacy benefit managers, and other licensed health care entities above specified thresholds. It requires them to report ownership and controlling interests, including parent entities, private equity ownership, material changes in control, and certain relevant identifiers. Hospitals must submit detailed financial information in addition to the ownership and control information.[5]

Resources on Transparency of Ownership and Finances

- The Missing Piece in Health Care Transparency: Ownership Transparency (Health Affairs Forefront)
- Comprehensive Consolidation Model Addressing Transaction Oversight, Corporate Practice of Medicine and Transparency (National Academy for State Health Policy)
- State Policymakers Show Growing Interest in Ownership Transparency in 2025 (Georgetown University Center on Health Insurance Reforms)

- Washington's HB 1686 (2025) directs the Department of Health, in coordination with other state agencies, to develop a plan and legislative recommendations for a statewide registry of health care entities, to improve transparency of ownership, control, and market structure. The law requires progress reports and final reports to the legislature outlining which entities would report, what information would be collected, and how a registry could be implemented.[6]

Key takeaways

Transparency of ownership and finances is critical for market oversight, and state infrastructure is advancing. States are developing publicly accessible provider ownership registries, though many face provider pushback over the reporting burden. To mitigate this, states are exploring use of existing Centers for Medicare and Medicaid Services datasets, such as the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) and the Healthcare Cost Report Information System (HCRIS), as well as strategies to integrate existing state data (e.g., licensing data, Medicaid cost reports). However, integration remains labor intensive because of fragmented systems and required manual data matching.

Workforce Protections & Strengthening the Corporate Practice of Medicine (CPOM) Doctrine

Policy approach

To address growing corporate control over physicians and the loss of professional autonomy over clinical care, states are strengthening statutory CPOM prohibitions to regulate the extent that corporate MSOs can own, employ, or control physician practices. In particular, CPOM laws can be strengthened to prohibit the use of the "friendly physician" model, in which physicians are compensated by MSOs to serve as nominal owners of practices but are not meaningfully engaged in the delivery of care. CPOM laws can also require that physicians retain ultimate decision-making authority over certain MSO activities that implicate patient care. States are also restricting or banning the enforcement of noncompete clauses for employed physicians and nondisclosure or nondisparagement agreements (collectively, "gag clauses") that prevent physicians from speaking out against management decisions or communicating with former patients after leaving a practice.

Why states are considering this

Nearly 80% of physicians are employed by a larger corporate entity, including health systems and other corporate entities (private equity funds, insurers, retailers, etc.). Consolidation and corporatization are linked to clinician burnout, turnover, and service line closures, particularly in behavioral health, maternal health, and rural care. Erosion of CPOM protections allows corporate actors to exert de facto control over clinical decision-making, often through MSOs and the use of the friendly physician model.

State examples

- Oregon's SB 951 (2025) enacts one of the most stringent CPOM reforms in the U.S., significantly curtailing corporate influence over medical practices. Targeting the friendly physician arrangement, the law prohibits MSOs and their affiliates (including shareholders, directors, officers, employees, and contractors) from owning, controlling,

Resources on Strengthening CPOM and Workforce Protections

- The Corporate Backdoor to Medicine: How MSOs Are Reshaping Physician Practices (Milbank Memorial Fund)
- Comprehensive Consolidation Model Addressing Transaction Oversight, Corporate Practice of Medicine and Transparency (National Academy for State Health Policy)
- December 2025 State Legislative Update (The Source on Healthcare Price & Competition)

managing, or serving on the board of a professional medical entity with which they contract. It also restricts their ability to control the sale or transfer of ownership or exercise de facto control over administrative or clinical decisions. SB 951 limits the use of stock transfer restriction agreements and renders many noncompete, nondisclosure, and nondisparagement covenants unenforceable. Compliance timelines vary, with new MSO arrangements subject to the rules beginning January 1, 2026, and existing arrangements required to align with the law by January 1, 2029.[7]

- California's SB 351 (2025) codifies and strengthens the state's CPOM restrictions regarding private equity groups and hedge funds involved "in any manner" with physician and dental practices, regardless of legal form. It prohibits such investors from interfering with professional clinical judgment (e.g., treatment decisions, referrals, patient volume) or exercising operational control over decisions like hiring clinical staff, billing and coding, or payer contracts. SB 351 also renders unenforceable contractual provisions (e.g., noncompete or nondisparagement clauses) that impede providers' autonomy.[8]
- Montana's HB 620 (2025) extends the state's prohibition on physician noncompete agreements to all physicians by eliminating restrictions on post-employment practice. Previously, the state prohibited these contractual restrictions only for psychiatrists and addiction medicine specialists. The law also bars employers from preventing physicians from soliciting former patients after leaving a practice. These provisions apply to contracts entered into or renewed on or after January 1, 2026.[9]
- Arkansas' SB 139 (2025) invalidates noncompete clauses in physician employment agreements that limit a physician's ability to practice within their licensed scope, while preserving employers' protections for trade secrets. The law does not affect noncompete provisions outside the employment context, including those tied to business sales or franchise arrangements.[10]

Key takeaways

- **CPOM reform complements material change transaction oversight and ownership transparency policy.** Compliance with stronger CPOM requirements may be a factor for transaction reviews involving physicians and may be imposed as a condition of approval. Transaction oversight may also aid enforcement of CPOM compliance, because confidential MSO contracts may be collected during transaction review and complex ownership or control relationships may be tracked through a provider registry database. However, separating the bills for each of these policies may be advantageous for passage, because doing so may split opposition to individual policies.
- **New CPOM and physician ownership reforms are already generating evasive behavior.** Regulators are seeing early attempts to work around statutory requirements through narrow interpretations of professional titles or entity status, underscoring the need for precise definitions, phased implementation, and continued regulatory refinement.
- **Enforcement authority matters.** Adding clear civil or criminal enforcement mechanisms and explicitly empowering attorneys general represent significant shifts from earlier CPOM frameworks that relied primarily on professional licensing or contract law. Retaining a private right of action—enforcement by an aggrieved private individual or company in court—remains critical, because administrative enforcement bodies may not have the visibility or resources to police all violations.

- **Physician support is influential but heterogeneous.** Physician testimony has been critical to advancing reforms, particularly when legislation clearly distinguishes practicing clinicians from corporate owners or affiliated entities. However, physicians hold diverse views and are not a monolithic constituency.
- **Noncompete restrictions create resistance and opportunity.** Hospital opposition remains strong, but reforms have gained traction through coalitions with labor groups, attorneys general, and access-to-care advocates, reflecting public support for physicians and other health care workers who leave an organization to be able to continue practicing locally. This promotes continuity of patient care relationships and workforce mobility.
- **Carve-outs complicate reform efforts.** Efforts to exempt certain specialty or research physicians from noncompete bans or CPOM laws have introduced complexity and, in some cases, undermined legislative momentum. Many states focus on employed physicians and exempt practice owners from noncompete bans.
- **For CPOM, states should address both the friendly physician model and MSO service contracts.** Reforms to CPOM laws should address dual ownership and compensation between MSOs and physician groups to address the friendly physician model of MSO control and should include conduct-based limits, particularly on MSO control over clinical decision-making. Simply restricting MSO conduct in service contracts without addressing dual ownership and compensation leaves intact the friendly physician model—a predominant mechanism of corporate control.

Limits on Anticompetitive Provider–Plan Contracting

Policy approach

As a result of consolidation, many health care markets are no longer competitive, and provider–payer bargaining cannot constrain health care prices. To address the existing pricing power of dominant health care entities, states are prohibiting certain contract terms in provider–payer agreements—such as all-or-nothing contracting, anti-steering and anti-tiering provisions, or most-favored-nations clauses—and classifying them as void and unenforceable, or as unfair trade practices.

Why states are considering this

Dominant health systems can use restrictive provisions in contracts with commercial payers to resist downward price negotiations from plans. For instance, dominant providers can bargain on an all-or-nothing basis to leverage the "must have" providers within the system to command higher prices across the board or prohibit the payer from placing the high-cost provider in less preferred network tiers or steering members to higher-value providers. Insurers with market power can use most-favored-nation clauses to guarantee that the insurer will receive provider prices that are at least as favorable as those provided to any other insurer. These strategies allow dominant health systems and insurers to entrench market power and resist competitive pressure to reduce prices.

Resources on Anticompetitive Provider–Payer Contracts

- A Tool for States to Address Health Care Consolidation: Prohibiting Anticompetitive Health Plan Contracts (National Academy for State Health Policy, or NASHP)
- NASHP Model Act to Address Anticompetitive Terms in Health Insurance Contracts (NASHP)
- Issue: Provider Contracts (The Source on Healthcare Price & Competition)

State examples

- Massachusetts prohibits all-or-nothing contracting and anti-tiering and anti-steering provisions in provider–plan contracts.[11]
- Connecticut enacted legislation banning all-or-nothing and anti-steering provisions and classified them as unfair trade practices.[12]
- Indiana enacted legislation prohibiting anti-tiering provisions and guaranteed participation provisions in provider–plan contracts.[13]
- Nevada prohibits all-or-nothing and anti-steering provisions and exclusive contracting between insurers and providers.[14]

Key takeaways

States can counteract anticompetitive provider–payer contract terms both via the legislature and through antitrust enforcement. The effect of legislation may be more widespread, rather than limited to the parties subject to the enforcement action. However, enforcement of legislated contract prohibitions remains challenging.

To oversee anticompetitive contract terms effectively, states may need to explore and potentially bolster oversight authority to examine contracts between providers and payers and among provider affiliates. Such authority may be found in insurance rate review, antitrust enforcement, network adequacy, or state employee health plan contracting powers.

Price Regulation Tools – For State Employee Health Plans or the Broader Commercial Market

Policy approach

To address high costs driven by health care market consolidation, states are attempting to address the pricing power of the largest provider system site-neutral payments, facility fee bans, and hospital payment caps.

- Site-neutral payments ensure the same reimbursement for certain outpatient services regardless of care setting. Rates are pegged to a multiple (e.g., 150%) of the Medicare nonhospital payment rate (physician office or ambulatory surgery center).
- Facility fee bans prohibit providers from collecting a facility fee for a subset of routine services (evaluation and management, or E&M, codes; preventive care; telehealth).
- Hospital price caps (i.e., reference-based pricing) benchmark maximum hospital rates for inpatient and outpatient services to a multiple of Medicare rates (e.g., 200%) or average in-network rates.

States have direct purchasing authority over their employee health plans and can use that leverage to pilot reforms and generate savings for state budgets. Price regulation policies can be implemented for state- and public-employee plans, all state-regulated payers, or all commercial prices.

Why states are considering this

In states with highly concentrated markets, market competition cannot constrain hospital and facility-based prices, placing pressure on state budgets, employers, and households. In highly consolidated markets, preventing new consolidation won't reverse the effects of existing consolidation. Hospital prices are a major driver of rising health care costs, especially in consolidated markets. Without limits, hospital systems—especially those owning physician practices—can charge substantially more for the same service, raising premiums, out-of-pocket costs, and state health spending.

State examples

- **Site-neutral payment.** New York introduced, but did not enact, legislation in 2025 (S. 705/A. 2140) to establish site-neutral payment limits for specified outpatient services, benchmarking commercial payments to a multiple of Medicare rates.[15]
- **Facility fee bans.** Maine prohibits facility fees for office visits (e.g., E&M codes), whether located on or off a hospital campus.[16] Connecticut prohibits facility fees for outpatient E&M or assessment and management (A&M) services at on- and off-campus hospital-based facilities, excluding emergency department services and observation stays. Facility fees also prohibited for telehealth services.[17]
- **Hospital price caps—state employees.** Oregon's SB 1067 (2017) implemented hospital price caps within their health plans for public employees and educators at 200% of the Medicare rate for in-network facilities and 185% of the Medicare rate for out-of-network facilities, with exemptions for critical access and rural hospitals.[18] Washington's SB 5083 (2025) established reference-based hospital pricing for its state employee health plan at the same levels as Oregon and a price floor of 150% of Medicare rates for primary care and behavioral health.
- **Hospital price caps—all commercial.** Vermont's S. 126/Act 68 (2025) directs the Green Mountain Care Board to establish maximum hospital prices for all commercial payers by FY 2027, calculated as a percentage of Medicare (percentage TBD).[19] Indiana's HB 1004 (2025) requires nonprofit hospitals to limit their aggregate average hospital prices at the statewide average price by June 2029 or forfeit their state and local tax-exempt status.[20]

Key takeaways

- **Political challenges.** Officials trying to pass and implement price regulations face formidable political opposition from powerful hospital associations. States must navigate the tension between provider systems with and without market power—the "haves" versus the "have-nots"—and how associational or informal affiliations between these hospitals could make rural and other safety-net hospitals resistant to efforts to counteract dominant system pricing power.
- **Concern but no evidence of cost shifting.** States expressed concern that site-neutral payments or facility fee bans could incentivize health systems to recoup costs elsewhere, for example, by raising their rates for professional services or for services not covered by the policy. Yet initial evidence from Oregon's price cap policy for public employees has not shown that there is cost shifting.[21]

- **Resources to calculate hospital costs.** One key challenge to establishing reference-based pricing benchmarks is assessing hospital operating costs and efficiency. Some participants noted experience with cost-based accounting or pointed to the National Academy for State Health Policy Hospital Cost Tool as a resource.
- **Exceptions considered.** States discussed policy design considerations for rate regulation policy, including carve-outs for rural critical access hospitals or pediatric hospitals, administrative burden, and appropriate mechanism (legislative versus contractual).
- **Legislation versus contractual rate controls.** For state employee health plans, price caps need not be established through legislation because they can be achieved contractually, but contractual controls can be more easily rolled back.

Resources on Price Regulation Policies

- How States Strengthened Their Health Care Markets in the 2025 Legislative Session (Milbank Memorial Fund)
- How States Are Using Hospital Price Caps to Save Money *(Health Affairs Forefront)*
- Hospital Payment Cap Simulator (Brown University Center for Advancing Healthy Policy through Research)
- Hospital Cost Tool and Resources (National Academy for State Health Policy, or NASHP)
- Model Legislation to Establish Site-Neutral Commercial Payment for Select Outpatient Health Care Services (NASHP)
- Reining in Hospital Prices: Modeling Reforms in Indiana, Massachusetts, and North Carolina (United States of Care)
- Separating the Haves from the Have-Nots: State Options for Targeted Application of Hospital Affordability Policies (Milbank Memorial Fund)

BROAD THEMES AND FUTURE STEPS

As participants reflected on their experiences and the conversation during the convening, several themes emerged:

- **Peer learning and connections are essential.** Participants consistently expressed that the cross-state convening, such as those sponsored by the Peterson-Milbank Program, provided invaluable opportunities for learning from peers, sharing challenges and wins, and building relationships with colleagues doing similar work.
- **Long-term commitment is required.** Multiple state officials acknowledged that this work is a marathon, not a sprint. Even officials from states without immediate legislative prospects value laying the groundwork for future efforts. The work requires sustained dedication, iterative refinement, and patience. Participants recognized the need to balance ambitious goals with practical, incremental approaches.
- **Messaging and public communication need strengthening.** Several participants expressed the need to improve their states' messaging about the value of health care market oversight and counter hospital lobbying, particularly post-HR 1, which reduces federal funding for health care providers. There is tension between nuanced messaging that acknowledges the challenges that hospitals face and forceful messaging that can drive change. States want to catch and leverage the current affordability messaging wave. Participants underscored that data and evidence are necessary but not sufficient to advance policy.
- **Follow the money through ownership and financial transparency.** Many states focused on understanding how dollars flow from different payers to different health care entities and among corporate owners and affiliates. Greater transparency of complex ownership structures and financial relationships is a key priority.
- **Corporate consolidation brings concerns of closures, practice exits, and bankruptcies.** Beyond making care less affordable, corporate models (such as private equity, Real Estate Investment Trust ownership, and payer-led vertical integration) have heightened risks to access to care through facility and service line closures, practice exits, and workforce shortages. Greater visibility into market entry and exit, divestitures, and provider financial health is needed to support stable and sustainable access to care.

NOTES

[1] Or. Rev. Stat. §§ 415.500–415.559; Or. Health Auth. Admin. R. 409-070-0000 et seq.

[2] Mass. Gen. Laws ch. 6D, §§ 13–18; Ch. 343 of the Acts of 2024.

[3] Cal. Health & Safety Code §§ 127500–127507; 22 Cal. Code Regs. §§ 97431-97442.

[4] M.G.L. c. 6D §11 and §12; M.G.L. c. 12C § 9.

[5] Ind. Code §§ 16-21-6-3, 23-0.5-2-14.

[6] RCW 43.70.904.

[7] Or. Rev. Stat. §§ 58.375 and 58.376.

[8] Cal. Health & Safety Code §§ 1190-1192.

[9] Mont. Code Ann. § 28-2-724.

[10] Arkansas Code § 4-75-101.

[11] Mass. Gen. Laws ch. 176O, § 9A.

[12] Conn. Gen. Stat. § 38a-477i.

[13] Ind. Code § 27-1-37-8.

[14] Nev. Rev. Stat. § 598A.440.

[15] New York Hospital Fair Pricing Act, S.705/A.2140 (introduced 2025).

[16] 24-A Maine Rev. Stat. §§ 1912, 2753, 2823-B, 4235.

[17] Conn. Gen. Stat. §§ 19a-508c, 19a-906.

[18] Or. Rev. Stat. § 243.256 (for the Public Employees' Benefit Board); Or. Rev. Stat. § 243.879 (for Oregon Educators Benefit Board).

[19] 18 V.S.A. §§ 9375-9376.

[20] Ind. Code 16-21-18.

[21] Murray, RC, Ryan AM, Whaley CM. Hospital Finances, Operations, and Patient Experience Remain Stable After Oregon's Hospital Payment Cap Was Implemented. Health Aff (Millwood). 2025;44(12): 1482-1489.

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