AARON M. FREY
ATTORNEY GENERAL

TEL: (207) 626-8800
TTY USERS CALL MAINE RELAY 711

STATE OF MAINE
OFFICE OF THE ATTORNEY GENERAL
6 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0006

REGIONAL OFFICES
84 HARLOW ST. 2ND FLOOR
BANGOR, MAINE 04401
TEL: (207) 941-3070
FAX: (207) 941-3075

125 PRESUMPSCOT ST., SUITE 26
PORTLAND, MAINE 04103
TEL: (207) 822-0260
FAX: (207) 822-0259

14 ACCESS HIGHWAY, STE. 1
CARIBOU, MAINE 04736
TEL: (207) 496-3792
FAX: (207) 496-3291

January 30, 2024

The Honorable Joseph M. Baldacci
The Honorable Michele Meyer
Committee on Health and Human Services
100 State House Station
Augusta, ME 04333-0100

Dear Senator Baldacci and Representative Meyer:

I am writing in response to your letter requesting my thoughts regarding the legality of capping executive pay at hospitals and the means by which such a cap could be enforced. As you note, last session the Committee on Health and Human Services considered L.D. 1321, "An Act to Address Income Disparity in Health Care by Limiting the Compensation of Hospital Executives." This bill would have limited hospital executive pay to no more than five times the median compensation of the hospital's full-time registered professional nurses. While the Committee voted "ought not to pass" on the bill, you indicate that the Committee may consider other legislation limiting hospital executive pay in the upcoming session. You ask for my opinion regarding the legality of capping executive pay at hospitals and how such a cap could be implemented and enforced.

With respect to the legality of capping executive pay at hospitals, the only reported decisions I am aware of relate to an executive order issued by New York's governor in 2012 directing the Department of Health ("DOH") and other state agencies to promulgate regulations requiring that at least 75 percent of state funds be used for direct care and prohibiting using state funds for executive compensation in excess of $199,000 per year. The DOH adopted regulations imposing these limits on health care providers. 10 NYCRR § 1002.3 (2013). The DOH regulations went beyond the executive order by capping executive compensation at $199,000 regardless of the funding source. *Id.* at § 1002.3(b). This cap could be exceeded, though, if 1) the compensation did not exceed the 75th percentile of the compensation provided to comparable executives in comparable facilities in the same geographic area, or 2) the compensation was reviewed and approved by the provider's governing body following an assessment of "appropriate comparability data." *Id.*

Various providers challenged the regulations in state court, alleging, among other things, that the DOH regulations violated the separation of powers principle and their due process rights.

The trial court dismissed the plaintiffs' due process claim because they were "unable to establish a 'vested property interest' in Medicaid reimbursements." *In re LeadingAge N.Y., Inc. v. Shah*, No. 5352-13, 2014 WL 4207061, at *6 (N.Y. Sup. Ct. Aug. 13, 2014). Subsequently, the trial court held that the DOH regulations limiting the use of state funds for executive compensation were valid but that the regulations limiting the use of both state and non-state funds for executive compensation were invalid because they were promulgated in excess of the DOH's statutory authority. *LeadingAge New York, Inc. v. Shah*, 56 Misc. 3d 594, 610, 53 N.Y.S.3d 804, 817 (N.Y. Sup. Ct. 2015). Subsequently, both the Appellate Division and the Court of Appeals affirmed. 153 A.D.3d 10, 58 N.Y.S.3d 651; 32 N.Y.3d 249, 114 N.E.3d 1032 (2018). Neither of the appellate courts addressed the due process claim, and it may be that the plaintiffs did not appeal the dismissal of that claim.[1]

The *LeadingAge* case is not particularly instructive because the primary issue litigated was whether a state agency had sufficient legislative authority to impose compensation caps. Here, on the other hand, any cap would be imposed directly by the Legislature and issues of agency authority would not be relevant.

Because you mention it in your letter, I also want to briefly discuss a citizen initiative in Los Angeles to cap hospital executive compensation. Essentially, under this initiative, the compensation of executives at hospitals and certain other healthcare facilities "shall not exceed the total compensation for the President of the United States, currently $450,000, as set forth in section 102 of Title 3 of the United States Code." The California Hospital Association filed a lawsuit to stop the initiative from being placed on the ballot, arguing that the initiative made a false statement regarding the amount of the President's compensation. The court rejected this argument. *California Hospital Assoc. v. Wolcott*, No. 23STCP00760 (Apr. 4, 2023, Cal. Sup. Ct., L.A. Cty.). It appears that the initiative will be placed on the March 5, 2024 ballot.[2]

Without any relevant legal precedent, it is impossible to assess with certainty the legality of legislation capping hospital executive pay. Although the providers in *LeadingAge* initially made a due process challenge to compensation limits, they apparently abandoned it after it was dismissed by the trial court. This may indicate that the providers did not see sufficient merit in bringing due process or other constitutionally-based claims. In any event, in the absence of any precedent clearly foreclosing legislation capping hospital executive compensation, it is my view that such legislation would be legally defensible.[3]

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[1] On October 8, 2021, New York's current governor issued an order discontinuing a number of prior executive orders, including the 2012 order limiting executive compensation

[2] On October 13, 2023, California's governor signed into law Senate Bill No 525, establishing a statewide minimum wage for covered healthcare workers and prohibiting local governments from enacting or enforcing ordinances limiting compensation at covered healthcare facilities through the end of 2029. So even if the Los Angeles initiative passes, state law may prevent its enforcement

[3] This assumes that any such legislation would be prospective only and would not apply to existing employment agreements Applying legislation limiting executive compensation to existing employment agreements could raise due process issues.

As to enforcement, there are at least three options. First, all hospitals in the state must be licensed by the Maine Department of Health and Human Services ("DHHS"). *See* 22 M.R.S. §§ 1811-1833. Compliance with compensations caps could be made a condition of licensure. This could be implemented by requiring hospitals to provide information about their executive compensation as part of initial licensure and all license renewal proceedings.

Second, hospitals could be required to comply with executive compensation caps as a condition of participating in the MaineCare program. To implement such a requirement, though, DHHS would likely need to update its "State Plan," and have the amendment approved by the federal Centers for Medicare & Medicaid Services. Further, while to my knowledge all hospitals in Maine currently participate in the MaineCare program, a hospital could potentially choose to end its participation to avoid imposition of compensation caps.

Third, the law could create a cause of action for violations of the compensation limits and authorize the Attorney General to bring enforcement actions in state court. The law could direct the court, if it finds a violation, to assess specific monetary penalties.

To be clear, I am not recommending that the Legislature impose caps on hospital executive compensation. In responding to your questions, I am simply expressing my opinion that the Legislature arguably has the authority to do so and outlining various enforcement options should the Legislature decide to limit hospital executive compensation.

I trust this information is helpful. Please let me know if I can be of further assistance on this issue.

Very truly yours,

Aaron M. Frey
Attorney General