Spotlight on State: North Dakota

This is part of a series of summaries that highlight notable legislation and initiatives in health policy and reform of all 50 states. Check back on The Source as we roll out additional states each week.

See North Dakota page.

North Dakota is one of the few states that bans most-favored nation clauses in provider contracts. It is also one of the even fewer states that prohibits most noncompete agreements, by making them generally unenforceable. Specifically, state law provides that a contract by which anyone is restrained from exercising a lawful profession, trade, or business of any kind is void, except in the sale of a business or in dissolution of a partnership. The Supreme Court of North Dakota ruled in a 1992 case that a noncompete agreement between physicians and a group supplying emergency room physicians was void.

In provider merger review authority, North Dakota law requires notice to the attorney general for all transactions involving non-profit hospitals. However, the statute provides limited review and approval authority. In a notable antitrust enforcement challenge, the FTC and North Dakota AG sued to block the merger of Sanford Health of South Dakota and Mid Dakota of North Dakota, challenging the merger of the two hospital systems on the grounds that it would reduce competition for healthcare services in the region, resulting in higher prices and lower quality of services. The district court granted a preliminary injunction and the Eighth Circuit affirmed for the FTC and the hospitals abandoned the merger in 2019.

North Dakota law also provides coverage and reimbursement parity in telehealth services, with additional COVID-19 emergency cost-sharing requirements and coverage expansion. The state applied for and received Section 1332 waiver approval for federal pass through funding to partially finance the Reinsurance Association of North Dakota (RAND), which would reimburse insurers 75% of claims paid between $100,000 and $1,000,000.
The Source Roundup: April 2021 Edition

Happy April! This month’s roundup centers on articles and reports that discuss: 1) healthcare markets and competition; 2) payment reform, and 3) healthcare costs, and 4) price transparency.

Healthcare Markets and Competition

In a piece published in the Harvard Business Review titled The Pandemic Will Fuel Consolidation in U.S. Health Care, Lovisa Gustafsson and David Blumenthal, researchers at the Commonwealth Fund, predict that mergers of key players in the U.S. healthcare system will continue as a result of provider financial challenges during the COVID-19 pandemic. While the Federal Trade Commission (FTC) took steps in January 2021 to understand how these mergers affect competition, these actions may not lead to more rigorous antitrust enforcement because most of these individual transactions are not large enough to require federal reporting. The aggregation of these smaller transactions, however, can lead to significant market concentration that significantly weakens the level of competition. These researchers recommend that Congress should make steps toward prohibiting transactions that adversely affect payers and patients because studies to date suggest consolidation increases prices and does not improve the quality of care. Congress could, for example, prohibit or restrict anticompetitive contract provisions or mandate all healthcare entities to report merger and acquisition activities.

The New England Journal of Medicine published a piece titled Private Equity and Physician Medical Practices — Navigating a Changing Ecosystem that discusses how physician-owned medical practices are driving the healthcare industry toward consolidation, corporatization, and administrative management. Jane M. Zhu and
Daniel Polsky suggest these changes result in two outcomes for independent practices: 1) these smaller practices must compete against larger practices, and 2) they must turn to new sources of capital, which has increasingly become private-equity firms during the COVID-19 pandemic. Benefits of investment from these private-equity firms include increasing referrals to internal clinicians, expanding market share, and creating operational improvements that heighten efficiency. Drawbacks, however, include higher costs for patients and payers, deteriorating clinicians’ job satisfaction and performance. The authors suggest that greater standardization, monitoring, enforcement of safeguards, and reducing the size-of-transaction threshold that prompts FTC review will protect against poor quality clinical care.

Payment Reform

In An Employer-Provider Direct Payment Program Is Associated With Lower Episode Costs published by Health Affairs, Christopher M. Whaley, et al. found that bundled payments reduced medical spending by approximately ten percent. While employers captured approximately 85% of all savings, patient cost-sharing decreased by nearly thirty percent. Meanwhile, the changing nature of primary care payment is documented in another NEJM piece titled Reform of Payment for Primary Care — From Evolution to Revolution by Allan H. Goroll, et al. Fee-for-service (FFS) persists as the predominant method of primary care compensation in the United States; however, the unfavorable consequences of this method call for reimbursement to center around value. A value-based approach focuses on prospective, comprehensive payment (capitation), and it allows clinicians to spend greater time with patients and explore innovative care for each patient. Slower, evolutionary strategies of reforming payment practices have paradoxically encouraged FFS payment, and thus Goroll et al. recommend accelerated payment reform to better patient experience and outcomes.

Healthcare Costs
In an article published by the Kaiser Family Foundation, *Limiting Private Insurance Reimbursement to Medicare Rates Would Reduce Health Spending by About $350 Billion in 2021*, Karyn Schwartz, et al. report that healthcare costs are on the rise for privately-insured individuals and employers who provide health insurance coverage. Capping the amount that private insurers pay to Medicare rates would reduce total healthcare spending in the U.S. by approximately forty percent; however, these changes may result in reduced revenues for hospitals and other providers. Employees and their dependents would spend $116 billion less for healthcare, and privately-insured individuals aged 55-64 would spend $115 billion less. Nearly half (45%) of the reduction in spending would be from outpatient hospital services.

**Price Transparency**

Two articles this month suggest that price transparency initiatives may not always work as intended. A new price transparency rule implemented by the Centers for Medicare and Medicaid (CMS) went into effect on January 1, 2021. This new federal rule requires hospitals to make public a machine-readable file listing standard charges for all items and services. In the *Health Affairs* study *Low Compliance From Big Hospitals On CMS’s Hospital Price Transparency Rule*, analysts from the Hilltop Institute looked at price transparency files from the 100 largest hospitals in the U.S. Morgan Henderson and Morgane C. Mouslim discovered that the majority of hospitals (65%) were “unambiguously noncompliant” with the federal price transparency regulation. Many hospitals have negotiated with the Department of Health and Human Services to ease the enforcement of this regulation until the end of the COVID-19 pandemic, claiming unique challenges due to the pandemic. Nonetheless, the authors urge hospitals to adhere to the federal regulation because assembling and posting required files of information already in their possession is not too great a burden, even during the pandemic.

While healthcare transparency websites may have good intentions, they might not actually produce the desired result of increased use of lower-price providers. Sunita M. Desai, Sonali Shambhu, and Ateev Mehrotra published a report in *Health Affairs* titled *Online Advertising Increased New Hampshire Residents’ Use of Provider Price*
Tool but Not Use of Lower-Price Providers that detailed the result of the authors’ advertising campaign on a New Hampshire healthcare price transparency webpage. While the campaign led to a more than 600 percent increase in visits to the webpage, it did not result in increased use of lower-price providers. This result may be because not all patients are price sensitive with their healthcare costs, and the ones that are concerned about price may not know the details of their benefit design to accurately calculate out-of-pocket costs. This outcome suggests that consumers are limited in their ability to use healthcare price information rather than being limited by a lack of awareness about price transparency tools since these tools were made available to them in the study.

That concludes this month’s Roundup. If you find articles or reports that you think should be included in the monthly Roundup, please send them our way. Stay safe and healthy!

Spotlight on State: South Dakota

This is part of a series of summaries that highlight notable legislation and initiatives in health policy and reform of all 50 states. Check back on The Source as we roll out additional states each week.

See South Dakota page.

South Dakota has been active in regulating prescription drug pricing and transparency. The state enacted a law to prohibit pharmacy benefit managers from prohibiting or penalizing a pharmacist for providing cost-sharing information on the amount a covered individual may pay for a particular prescription drug. The legislature also passed legislation that requires health carriers to provide prospective enrollees with drug formularies and detailed plan descriptions that
explain plan coverage limitations and their financial impact on enrollees (e.g., co-insurances, out-of-pocket expenses, etc.).

In healthcare markets, the state’s antitrust legislation provides that nonprofit hospitals must provide notice to the state attorney general for any mergers, acquisitions, or related transactions. The state also limits the duration of noncompete clauses in physician employment contracts to two years after the date of termination and within a specified geographic area. South Dakota also promotes telemedicine with mandated coverage parity and cost-sharing parity for telehealth services.


February 19th was the deadline for California legislators to introduce their proposed bills this session. In a two-part series, we highlight some of the notable healthcare bills on the table in 2021. In this post, we focus on a few ambitious reform efforts to the healthcare market and delivery system. Next month, we’ll turn our attention to proposed bills that aim to regulate the prescription drug market and bills that promote price and quality transparency.

Healthcare system reform measures are those that change the structure of health care in a way that impacts health care accessibility, quality, and cost. Most people likely think of the Affordable Care Act when they think of healthcare reform, but reform also occurs on an individual state basis, and California has been a consistent
leader in these initiatives. A few major healthcare reform bills were proposed this legislative session, and we outline them below.

**Healthcare Market and Costs: AB 1130 and AB 1132**

AB 1130 and AB 1132, both introduced by Assemblymember Jim Wood, attempt to tackle increasing health care costs by focusing on California’s healthcare markets. The [California Health Care Quality and Affordability Act (AB 1130)](https://www.leginfo.ca.gov/billtext113/ban/ab1130/ba1130bill.html) would create the Office of Health Care Affordability, which will analyze the health care market for cost trends and drivers of spending, develop data-informed policies for lowering health care costs for consumers, set and enforce cost targets, and create a cost strategy for controlling the cost of health care and ensuring affordability for consumers and purchasers. Additionally, the director of the Office of Statewide Health Planning and Development (OSHPD) would be required to establish a statewide health care cost target for total health care expenditures, and would authorize OSHPD to take progressive actions against health care entities for failing to meet cost targets, including corrective action plans and escalating administrative penalties.

Healthcare consolidation is a driving force of increasing costs in health care. Research has shown that when hospitals merge in already concentrated markets, price increases can exceed 20%.[1] Both AB 1130 and AB 1132 address this issue. AB 1130 would require OSHPD to monitor cost trends in the health care market and examine health care mergers, acquisitions, corporate affiliations, or other transactions that entail material changes. Health care entities would be required to provide OSHPD with written notice of agreements and transactions that involve a material amount of assets, or that would transfer control, responsibility, or governance of a material amount of the assets or operations to one or more entities. OSHPD would also be required to conduct a cost and market impact review if it finds that the change is likely to have a significant impact on market competition, the state’s ability to meet cost targets, or costs for purchasers and consumers.

[AB 1132, the Health Care Consolidation and Contracting Fairness Act of 2021](https://www.leginfo.ca.gov/billtext113/ban/ab1132/ba1132bill.html), would specifically target health care consolidation and anti-competitive contract
terms in contracts between health care service plans or insurers and health care providers or health facilities. Specifically, it prohibits a contract issued, amended, or renewed on or after January 2022 between a health care service plan or health insurer and a health care provider or health facility from containing terms that, among other things, restrict the plan or insurer from steering an enrollee or insured to another provider or facility or require the plan or insurer to contract with other affiliated providers or facilities.[2] AB 1132 would also require a health care service plan that intends to acquire or obtain control of an entity, to give notice to, and secure approval from, the director of the Department of Managed Health Care. A medical group, hospital or hospital system, health care service plan, or health insurer that intends to purchase, merge, or consolidate with another entity would be required to provide written notice to the Attorney General at least 90 days before entering into such an agreement with a value of $3,000,000 or more.

Addressing the major health care reform bills he authored this session, Wood stated, “Creating the Office of Health Care Affordability, establishing a statewide health information exchange and creating a process for the state to assess the impact of health care consolidation and other marketplace practices are essential and fundamental to creating a sustainable and equitable universal health care model.”[3]

Healthcare Coverage and Accessibility: AB 1400

Health care accessibility is another important piece of health care reform. While the Affordable Care Act has greatly increased the number of individuals enrolled in health insurance coverage, about 3.5 million Californians remain uninsured, and millions more are enrolled in costly plans that they can’t effectively use because of high deductibles.[4] The COVID-19 pandemic also proved why employment-sponsored health insurance is not a particularly sustainable model, as millions of Americans lost their jobs along with their insurance coverage.[5]

AB 1400, titled “Guaranteed Health Care for All,” proposes a universal, single-payer health care system, which would guarantee health care coverage of all Californians regardless of employment, income, immigration status and any other considerations. The author of AB 1400, Assemblymember Kalra, stated, “Our current system results
in unjust outcomes and these inequities are underscored especially now, exacerbating economic downturns for working families who have lost their income and meaningful access to health care... this bill will set us on a real path towards a single-payer system...

Health Care Delivery Expansion: Telehealth (AB 32, AB 457, AB 935)

While telehealth had been a rapidly growing practice since before the COVID-19 pandemic, it has really taken center stage since the pandemic began last March. Telehealth has offered continuity of care and health care access during a time many across the nation sheltered-in-place, and there is no doubt that it is here to stay. Increased access and potential cost reductions are two benefits of the telehealth movement, but some challenges remain in regulating this relatively new care delivery practice. Below we outline three bills that would regulate and expand the practice of telehealth in California.

AB 32 is an attempt to make current telehealth flexibilities, expanded during the COVID-19 pandemic, permanent under California state law. The author of AB 32, Assemblymember Aguiar-Curry stated, “Access to healthcare should not require a state of emergency, nor depend upon a person’s location, mobility, or income. It’s time for the State of California to recognize that access to health care is always important, and to make telehealth part of our health world whether or not we face a crisis.”[6]

AB 457, authored by Assemblymember Santiago, establishes a Telehealth Patient Bill of Rights. The described purpose of the Telehealth Bill of Rights is to protect the rights of a patient using telehealth to be seen by a health care provider with a physical presence within a reasonable geographic distance from the patient’s home, unless specified exceptions apply. Further, a health care service plan or a health insurer would be exempt from existing telehealth payment parity provisions for any interaction where the health care provider is not located within a reasonable geographic distance of the patient’s home, unless that provider holds specialized knowledge not available in the patient’s region.
Finally, AB 935 attempts to expand telehealth more widely to cover children, pregnant and postpartum persons’ mental health care. It would require health care service plans and health insurers, by July 1, 2022, to provide access to a telehealth consultation program that meets specified criteria and provides providers who treat children and pregnant and certain postpartum persons with access to a mental health consultation program.

All of these bills are still in the first steps of a lengthy legislative process. Stay tuned to see which of these bills become law and which pass into relative obscurity. Next month, we’ll cover two other topic areas of proposed healthcare bills: prescription drug prices and health care cost and transparency bills.


[2] An anti-steering clause is a contractual requirement that an insurer place all physicians, hospitals, and other facilities associated with a hospital system at the lowest cost-sharing rate to avoid steering patients away from that network.


Healthcare Merger Challenges: Q1 2021 Update

In this month’s Litigation and Enforcement Highlights, we provide the latest updates on several proposed provider mergers, many of which were fueled by the continued pandemic. With the increased consolidation came increased antitrust scrutiny. So far this year, we’ve seen a mixed bag of wins and losses for federal and state enforcement agencies that seek to block the mergers.

FTC Concedes in Failed Challenge of Jefferson-Albert Einstein Merger

In its first major loss in a healthcare merger challenge in recent years, the Federal Trade Commission (FTC) officially dropped its case against the proposed merger of Jefferson Health and Albert Einstein Healthcare Network in Philadelphia. The Pennsylvania attorney general had withdrawn from the challenge more than a month before the FTC announcement to do the same. The joint federal and state enforcement effort suffered a defeat in federal court, when the Eastern District of Pennsylvania denied a preliminary injunction against the merger (see coverage on
the Source Blog). Subsequently, the 3rd Circuit Court of Appeals denied the emergency motion for an injunction pending outcome of the appeals process, essentially allowing the merger to proceed. Given the general consensus among enforcement agencies that it would be too late to “unscramble the egg” once the merger is consummated, the consecutive withdrawals by the Pennsylvania AG and FTC did not come as a surprise as the courts refused to halt proceedings. The question that now remains is how this setback, in particular the federal court rationale in rejecting the preliminary injunction, could impact future court challenges to hospital mergers.

DOJ Limits Competitive Harm in Settlement with Geisinger and Evangelical

The Department of Justice (DOJ) also saw resolution of one of its merger challenges in Pennsylvania, albeit with a more compromising result. Geisinger Health System had proposed, in a partial ownership agreement challenged by the DOJ, to acquire 30% ownership of Evangelical Community Hospital (see coverage on the Source Blog). In a preliminary settlement agreement reached this month, Geisinger agreed to reduce and limit any future ownership interest of Evangelical to a cap of 7.5%. Additionally, among other settlement terms, Geisinger is restricted from making any loan or line of credit associated with Evangelical, and from being involved in any decision-making in management or leadership positions at Evangelical. Finally, the parties also agreed to implement an antitrust compliance program. The DOJ stated the settlement “would resolve the competitive harm alleged in the complaint... [and] prevent Geisinger from exercising any form of control or influence over Evangelical to restore the defendants’ incentives to compete with each other on both quality and price.” The proposed settlement is now filed and pending final approval from the District Court for the Middle District of Pennsylvania. The outcome of this case indicates not only that partial ownership interest acquisitions can come under antitrust scrutiny, but also that such challenges can be fruitful in reducing anticompetitive concerns.

Handful of Proposed Mergers Abandoned Due to Antitrust Challenge
A handful of other challenged proposed mergers saw favorable outcomes for enforcement agencies over the past few months. In January, we reported that in Tennessee, Methodist Le Bonheur and Tenet abandoned their plans to merge following a lawsuit for preliminary injunction filed by the FTC and Tennessee attorney general.

Following that announcement, Massachusetts General Hospital also gave up its efforts to acquire Exeter Health Resources, a hospital in New Hampshire. This decision was the result of continued scrutiny and objection from state regulators as well as pending federal regulatory review. New Hampshire attorney general Gordon MacDonald cited concerns that the proposed merger would decrease competition and lead to increased healthcare costs. Such opposition ultimately “led to [the parties’] view that there was no pathway to secure New Hampshire regulatory approval.”[1]

Lastly, the proposed partnership of Atrium Health Navicent and Houston Healthcare, two of the largest hospital systems in central Georgia, also fell through last month. Navicent recently merged with North Carolina-based Atrium Health (previously Carolinas Healthcare System) in 2019. While the entities stated the decision resulted from the impact of the COVID-19 pandemic, the deal had also been under active investigation by the FTC. According to the FTC, the deal “threatened to increase healthcare costs for employers and patients in the region and would have substantially lessened competition” and the agency was prepared to challenge the merger in court. Following the announcement, the FTC closed its investigation.

Pending Merger Challenge Entangled in Discovery Dispute

As some proposed deals buckled under scrutiny, the pending merger of Hackensack Meridian Health and Englewood Healthcare in New Jersey is causing a ruckus. At the end of 2020, the FTC filed a lawsuit in New Jersey district court for a preliminary injunction against the merger (see coverage on the Source Blog). The case is currently in the discovery phase, where the parties have reached an impasse. First, Hospital for Special Surgery (HSS), a non-party New York hospital, objected to Englewood’s subpoena for records that sought to show HSS as a competitor in an
attempt to boost its merger case. Then, the FTC refused to be deposed by the defendants and requested the court to issue a protective order. The Commission argued such discovery constitutes deposition of opposing counsel and is impermissible because of undue burden and invasion of attorney work product. These discovery disputes may push back the court trial date, while an FTC administrative trial set for June 2021. Stayed tuned to the Source Blog to find out the fate of this merger.

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The Petris Center Highlights Research Collaborations with The Source

The Nicholas C. Petris Center on Health Care Markets and Consumer Welfare, in its annual newsletter published this month, highlights many of the research collaborations with The Source in 2020 and 2021. Among the work are two studies on market consolidation and competition, one of which examines the impact of state merger review and the use of anticompetitive contract clauses on healthcare prices, quality and premiums (both research findings are published on The Source). Another ongoing project seeks to determine the size and scope of cross-market hospital and physician organization mergers in the U.S and propose evidence-based legal criteria to aid antitrust enforcers and judges in identifying anticompetitive cross-market mergers.

The newsletter also highlights the Database on State Laws Impacting Health Cost and Quality (SLIHCQ) hosted on The Source, where much the legislative research is drawn from. Source Executive Editor Jaime King and Distinguished Fellow Tim Greaney also testified before the California State Assembly Committee on Health regarding these issues.

Also check out some of the other notable work by our colleagues at the Petris
Center, including findings on the effects of health care prices on wages, studies of vertical integration, reports on the impact of COVID-19, and last but not least, the recent appointment of the Petris Center Director Richard Scheffler to the Healthy California for All Commission by Governor Newsom.

Read more about the Petris Center’s economic studies and analysis on healthcare markets and costs [here](#).

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**Spotlight on State: Washington**

This is part of a series of summaries that highlight notable legislation and initiatives in health policy and reform of all 50 states. Check back on The Source as we roll out additional states each week.

See [Washington page](#).

Washington is a leader in state initiatives for price transparency in health care. Mandated by the state legislature in 2014, the [Office of Financial Management](#) established the Washington State All-Payer Claims Database (WA-APCD). The public face of the WA-APCD program, named [Washington HealthCareCompare](#), is operated by the Washington State Health Care Authority (HCA) and collects member eligibility and enrollment data and medical, dental, and pharmacy claims from commercial payers and Medicaid. Washington also earns top grades for surprise and balance billing protections of fully insured consumers. The state enacted legislation to promote transparency in network adequacy and requires carriers and out-of-network providers to negotiate out-of-network payments in good faith to keep consumers from billing disputes. Additionally, the state has a pharmaceutical price transparency law that requires the HCA to oversee prescription drug price increases through advanced notice and to report annually to the legislature.

In healthcare antitrust legislation, Washington restricts noncompete agreements
including those of physicians. The state has robust merger review authority laws that provide the state attorney general must receive at least a 60-day notice of any merger, acquisition, or contracting affiliation between hospitals, hospital systems, and provider organizations, whether they are for-profit or nonprofit entities. The AG must also approve the merger or acquisition of any non-profit hospital. To receive approval, parties to the transaction must properly safeguard the charitable assets involved and ensure that any resulting proceeds will apply to charitable health purposes. The state also requires a certificate of need (CON) for the sale, purchase, or lease of any portion of a hospital sold, purchased, or leased by a health management organization (HMO). The review criteria for CON applications include the consideration of the affected population’s need for services, the availability of less costly or more effective methods for providing such services, the financial feasibility, and likely cost impacts for providing the services. In a notable antitrust enforcement action, the Washington AG filed suit to thwart and unwind Franciscan Health System’s consummated 2016 acquisition of two physician practice groups. The case settled with favorable terms for the state that promise to restore competition and choices for healthcare services.

Washington operates its own health insurance marketplace, Washington Health Plan Finder, under the Affordable Care Act. State law protects against discrimination of pre-existing conditions and provides essential health benefits in case of repeal of the Affordable Care Act. In recent sessions, the legislature enacted several state market reform initiatives. In 2019, the Legislature passed legislation to provide a public option health insurance plan to brings its residents a step closer to universal healthcare. In addition to existing coverage parity for telehealth services, Washington also expanded telehealth use by establishing a telemedicine payment parity pilot program to provide parity in reimbursement for certain health care services and requires certain health care professionals to complete telemedicine training.
Spotlight on State: Georgia

This is part of a series of summaries that highlight notable legislation and initiatives in health policy and reform of all 50 states. Check back on The Source as we roll out additional states each week.

See Georgia page.

Georgia has made significant strides in legislative efforts to promote healthcare price transparency in recent sessions. The state enacted legislation in 2020 that lays the groundwork for an all-payer claims database (APCD). The law establishes an APCD advisory committee, funding for the APCD, design criteria, operation, and noncompliance penalties. The legislature also passed legislation prohibiting surprise and balance billing for both emergency and non-emergency services, making it one of the states with the most robust protections against surprise billing. Additionally, the Georgia Right to Shop Act requires insurance companies to create a webpage or toll-free phone number where patients can view the average amount for particular services, estimate out-pocket-costs, and access various quality metrics.

Georgia also recognizes the importance of telehealth as a tool to improve health care access, even before the COVID-19 pandemic. The state passed laws to require coverage parity, reimbursement parity, and cost-sharing parity in telehealth services. However, Georgia has also recently used an ACA waiver to flout federal law and to eliminate the state’s health insurance marketplace.

In antitrust regulation, the state has some legislation to prevent anticompetitive practices in healthcare markets. Notably, Georgia law prohibits most-favored nation clauses in contracts between providers and insurers and the use of non-compete provisions in physician contracts. In terms of merger review authority, Georgia law requires transacting entities to notify the attorney general of transactions involving a nonprofit hospital. While explicit approval from the AG is not mandated, the AG must hold a public hearing to solicit public opinions. Under the Certificate of Need (CON) program, healthcare entities must obtain a CON for certain expansions of services.
In 2011, the FTC and Georgia AG challenged Phoebe Putney Health System’s proposed acquisition of rival Palmyra Park Hospital from the Hospital Authority of Albany-Dougherty County (HCA). The case went all the way to the U.S. Supreme Court after the lower courts held that the transaction was immune from antitrust scrutiny under the state-action immunity doctrine. The Supreme Court reversed, finding that Georgia did not meet the two-prong state-action immunity test instated by the Court. The FTC ultimately reached a consent decree with Phoebe Putney concerning the acquisition, imposing various antitrust restrictions.

COVID-19 Telehealth Waivers Won’t Last Forever, But Permanent Regulatory Changes Are Afoot

Healthcare providers are increasingly realizing the potential that telemedicine has to offer. Not only has it been the most talked-about healthcare solution lately, but waivers from the Centers for Medicare and Medicaid Services (CMS) have enabled providers to begin implementing telemedicine tools themselves, resulting in skyrocketing adoption over the past year. Now, these waivers might be temporary for the time being, but with telehealth adoption at an all-time high, federal and state governments are under increasing pressure to make these emergency measures permanent.

Congress is under particular pressure to pass laws expanding telehealth coverage since it has emerged as an effective solution for virtual care delivery, and the Centers for Medicare & Medicaid Services has conveyed a willingness to review as well as revise its existing guidelines for coverage. So what happens to telehealth given the rapid pace at which it is being adopted by healthcare providers across the United States? What does this fast approaching “new normal” have in store for
In this piece, we examine a few potential regulatory changes that might be underway on the virtual care front, and how exactly, if implemented, those changes will impact telehealth care providers.

1) Telehealth Coverage Will Soon Be a Widely Accepted Practice

In 1997, Congress had declared that telehealth services could only be reimbursed under certain scenarios. Not much changed until last year when the Centers for Medicare and Medicaid Services gave Medicare Advantage plans more latitude. However, today, the technology itself has transformed quite a bit. The actual technological advances happening in the field have left the regulatory framework far behind.

While the waivers currently in effect will disperse once the pandemic subsides, elected officials will have reason to contemplate more enduring regulatory changes given how the country can use telehealth expansion to achieve huge market savings year after year. These savings can primarily be achieved by lifting restrictions on telehealth coverage and reimbursement and prohibiting commercial payers from imposing similar coverage and reimbursement restrictions.

Telehealth has successfully demonstrated its potential in everything, from streamlining primary care visits to making specialized care more accessible for people with chronic diseases. Therefore, industry experts are continually urging that post-COVID, Congress should address the geographic expansion of telehealth access. Reimbursement will soon follow.

2) Telehealth Services May Be Billed at Rates Similar to In-Person Visits

While conventionally, telehealth services have almost always been reimbursed at rates far lower than that of in-person visits, they are steadily catching pace, especially since the onset of the COVID-19 pandemic. This has largely occurred
because in March 2020, CMS authorized providers to offer many additional healthcare services via telehealth and charge for telehealth visits at the same rate as in-person visits.

Although as of now, this waiver will only stay in effect for the duration of the emergency declaration, it has enabled healthcare providers to continue offering basic consultations that otherwise would be lost to them.

Prior to the COVID-19 health emergency, telehealth was only widely accepted as a means to deliver primary care to people living in the rural landscapes of America. And even in those cases, it could only be performed at a sanctioned facility in the area.

When the pandemic hit America, physicians in private practices started to experience huge changes because they couldn’t see patients in person anymore. Now they are swiftly adapting to this change. If they don’t do so, they will be left with limited options to generate revenue since patients aren’t willing to visit healthcare facilities due to increased fear of infection.

As one of the most significant waivers, it has served as a wake-up call for providers who weren’t initially in favor of telehealth or did not see it as a credible solution.

As providers try telemedicine to maintain patient contact during the Covid-19 pandemic, they also experience its benefits firsthand – from being able to sustain or even grow their practice, to acquiring a patient base beyond geographical barriers. Therefore, it wouldn’t be wrong to expect that many of these providers will likely continue to provide telehealth even after the pandemic.

In addition, there are many financial benefits that come alongside the implementation of telehealth, such as less administrative and staffing costs in the case of providers and negligible to no commute costs for patients. As such, a lot of industry experts are hopeful that Congress will permanently adopt billing for telehealth services that are well within the range assigned for in-person or in-office visits, even post-pandemic.
3) Relaxations Pertaining to Telehealth Licensure Might Be Underway

One of telehealth’s most poignant advantages is that it connects patients and doctors at a distance. Licensure laws restrict the geographic footprints of aspiring virtual care physicians, while giving patients access to only doctors who have a license in their state of residence.

In the past, a few states have attempted to get past the artificial barriers put in place at the state boundary lines by joining the Interstate Medical Licensure Compact. For instance, only two years ago, the Florida legislature passed a law wherein it authorized out-of-state healthcare professionals to deliver telehealth services to local residents. Having examined a patient in person previously is no longer a primary requirement for practicing telemedicine in Florida.

For all these reasons and many more, healthcare experts predict that states may soon relax telehealth licensure requirements, as more and more care providers adopt telemedicine and attempt to make virtual care delivery more seamless.

All in all, telehealth is a valid care mechanism and has emerged as an invaluable means to deliver care. Telemedicine can help provide much needed care to those in rural areas and also offer cost savings in doing so. It is about time that regulatory entities stop restricting providers from embracing it. We’ve come this far and there should be no going back from here. Efforts should only be made towards augmenting this technology moving forward.

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The Source Roundup: March 2021 Edition

Happy March! This month’s roundup focuses on health policy pieces and reports that examine 1) the future of value-based care, 2) the efficacy of various policy options to address healthcare prices, including increasing price transparency and market competition, 3) comparisons of brand-name drug prices, and 4) the impact of the Affordable Care Act on uninsured young adults.

Valued-Based Reform

In a white paper published this past month, The Future of Value-Based Payment: A Road Map to 2030, researchers from the Leonard Davis Institute of Health Economics at the University of Pennsylvania argue that to rein in healthcare costs, there needs to be a new roadmap to move from volume-based to value-based care. Rachel M. Werner et al. offer several recommendations, primarily targeted at the Centers for Medicaid and Medicare (CMS), which aim to help create a clear long-term path for the federal government to focus on the alternative payment models that are most likely to generate significant savings and improve quality. The authors recommend that CMS 1) simplify the current value-based payment landscape, 2) accelerate the transition to risk-bearing, population-based alternative payment models, 3) structure incentives to push providers away from fee-for-service payment and toward alternative payment models, and 4) ensure that achieving health equity be a central goal of value-based payment models. While other experts have made similar arguments, this report pushes the discussion further. The researchers argue that there needs to be a greater level of coordination among the federal government’s efforts to move towards value-based care by aligning payment policies across all public and private programs that receive federal funding towards alternative payment models.
Healthcare Cost Containment

In a report published by the RAND Corporation, *Impact of Policy Options for Reducing Hospital Prices Paid by Private Health Plans*, Jodi L. Liu et al. analyzed three different policy options to curb hospital prices among the commercially insured in the United States. Using data from the federal Hospital Cost Report, the authors compared the potential effectiveness of regulating hospital prices, improving price transparency, and increasing competition among hospitals and explored the critical considerations for each strategy and the potential impact on hospital prices and spending. According to the authors, direct price regulation (such as rate setting) would likely achieve the most savings but faces the most political hurdles because of strong opposition from providers. While price transparency initiatives and increasing competition in hospital markets would reduce costs, Liu et al. argue that the reductions would not be as dramatic as with price regulation. This is because both strategies also have significant obstacles. The effectiveness of price transparency initiatives largely depends on patients and employers using those tools to choose lower-cost providers. Additionally, healthcare markets are already so concentrated that regulators would need to make significant structural changes to markets to reach effective levels of competition.

Price Transparency

In another report published by the RAND corporation, *Increasing Price Transparency in Health Care: Key Themes and Policy Options from a Technical Expert Panel*, RAND researchers convened a panel of experts, including The Source Executive Editor Jaime King, to discuss current price transparency efforts, the barriers to more widespread availability and use of price information, and possible ways to overcome those barriers. The researchers identified several takeaways from the discussion with the experts. These takeaways include that consumers often do not shop for healthcare services, price information is difficult to access during services, price transparency information can be inaccurate or misleading, and there are still significant legal and regulatory barriers that prevent the sharing of price
information. While obstacles remain, the expert panel did suggest that increasing the number of all-claims payer databases (APCDs) could improve access to price information. Lastly, the experts suggested policy options beyond just improving price search websites that could make price transparency efforts more meaningful, such as better patient education and support around decision-making at the point of care, as well as more meaningful information for patients such as whether a provider is taking new patients. The panel also suggested ways the federal government could step in to help with price transparency, specifically eliminating data-sharing limitations and resolving other barriers impeding the flow of price information, in addition to supporting APCDs through incentives and technical assistance.

**Market Consolidation and Competition**

Another policy consideration that experts advocate for achieving cost containment is through promotion of market competition and reduced concentration. In *Price Effects of a Merger: Evidence from a Physicians’ Market*, a working paper for the Federal Trade Commission, Thomas Koch and Shawn W. Ulrick put this hypothesis to the test by examining the price effects of physician market concentration. Published in Economic Inquiry last month, the paper analyzes how the merger of six orthopaedic physician groups in a Pennsylvania county affected prices. The researchers used claims data from three private payer and compared prices of the region that experienced physician consolidation to nearby regions that did not. They found that the region where the merger took place saw 10–20% increase in prices for two of the payers post-merger, while the region without merger activity did not experience a change in prices. Koch and Ulrick concluded that the increase in prices resulted from increased market power of the merged practices. Notably, in this case, the third payer did not experience change in prices. The authors pointed out that these results demonstrate that the effects of merger may not be uniform across payers and warns that studies that only look at one set of payers could be incomplete.
**Pharmaceutical Prices**

In a new report published by the Congressional Budget Office (CBO), [A Comparison of Brand-Name Drug Prices Among Selected Federal Programs](https://www.cbo.gov/publications), the CBO describes how brand-name prescription drug prices are determined within different federal programs and how they compare to prices in 2017. The CBO examined 176 popular brand-name drugs and found that for a 30-day supply, on average, the medication cost was $118 through Medicaid and $343 through Medicare Part D. The CBO also found that the government paid almost twice as much for the same drugs through Medicare than it did through the Veterans Affairs program. The CBO found that these price disparities are similar to those seen in 2017. The report underlines the importance of negotiation leverage in different payors' ability to receive larger rebates, which leads to price disparities among federal programs and between federal programs and commercial plans.

**ACA Medicaid Expansion**

Before the passage of the Affordable Care Act (ACA), young adults were among those most likely to be uninsured. In a report published by the Urban Institute, [Impacts of the ACA’s Medicaid Expansion on Health Insurance Coverage and Health Care Access among Young Adults](https://www.urban.org/publications/impacts-aca-s-medicaid-expansion-health-insurance-coverage-and-health-care-access-young-adults), Anuj Gangopadhyaya and Emily M. Johnston examine how the ACA and Medicaid expansion changed access to care for young adults aged 19 to 25 years old. The authors found that the uninsured rate for these young adults declined from 30 percent to 16 percent between 2011 and 2018, and Medicaid enrollment for this age group increased from 11 percent to 15 percent. Furthermore, they found that states that expanded Medicaid saw more significant declines in the number of uninsured young adults. On average, the uninsured rates among young adults declined from about 28 percent in 2011 to 11 percent in 2018, but in non-expansion states, the uninsured rate decreased from about 33 percent to 21 percent. Significantly, the authors found that Medicaid expansion reduced differences in coverage by race/ethnicity, education level, and income among young adults. The authors conclude that expanding Medicaid in additional states could improve coverage among young adults and improve access to care among those with
low incomes and without a college degree.

That concludes this month’s Roundup. If you find articles or reports that you think should be included in the monthly Roundup, please send them our way. Stay safe and healthy!