The Source Roundup: July 2020 Edition

The Source continues to extend wishes of safety and good health to you and your loved ones. As the pandemic causes the healthcare industry financial tragedy, health law experts share important considerations for policymakers, providers, and payers. Many authors hope the pandemic will effect much-needed lasting improvements in the efficiency and efficacy of health care in the U.S.

Antitrust Experts Recommend More Rigorous Regulation of Healthcare Consolidation

In Preventing Anticompetitive Healthcare Consolidation: Lessons from Five States, published by the Source on Healthcare Price & Competition, authors Jaime King, et al. analyze how states could manage and prevent anticompetitive consolidation among healthcare providers and "rampant price increases." The authors studied statutes, regulations, and antitrust enforcement actions in all fifty states and identified five states with the strongest policy and enforcement frameworks: California, Connecticut, Massachusetts, Pennsylvania, and Rhode Island. The authors commend these states for the way they utilize antitrust enforcement tools including notice requirements, pre-transaction review and approval processes, and conditional approvals with post-transaction monitoring protocols. Based on best practices from these states, the authors urge policymakers to consider implementing a tiered framework that would require notice for all healthcare provider transactions and different levels of review for different types of transactions. In addition, they emphasize that states must pair clear statutory regulation with proper enforcement to effectively prevent the most vulnerable populations from the potential adverse effects of healthcare consolidation.

Another recent article published by *Washington Monthly* , Can COVID-19 Get Congress to Finally Strengthen U.S. Antitrust Law?, calls for increased federal oversight of anticompetitive mergers. Authors Robert H. Land and Sandeep

Vaheesan blame mergers for weakening both the nationwide response to COVID-19 and the economy's resilience. The authors claim consolidation tolerance stems from "myths," or common misconceptions about the benefits and need for mergers, which they attempt to refute. They cite examples in which the Department of Justice and Federal Trade Commission failed to preserve competition, including how hospital consolidation continues to escalate healthcare costs. They propose the federal government regulate acquisitions more stringently and provide aid for small or suffering business instead of continuing to allow market concentration.

Public Option Scenarios Could Impact Health Insurance Markets in Unexpected Ways

In Public Options for Individual Health Insurance, Jodi L. Liu et al. evaluated the effects four hypothetical federal public option health insurance plans would have on federal government spending, national overall coverage rate, individual market enrollment, and premiums. *RAND Health Care* published the study, which operated on assumptions including that the public option would have four tiers of coverage, providers would contract lower payment rates, adequate provider networks would form, etcetera. Their microsimulation predicted public option premiums between ten and twenty percent lower than their private market counterparts. In addition, all four options lowered federal government spending by $7 to $24 billion. One hypothetical scenario saw the uninsured rate decrease by 2.8 million people, compared to only a marginal decrease in another scenario, and 1.1-1.2 million decreases in the remaining two scenarios. While each model predicted modest decreases in the overall number of uninsured persons, making some individuals "better off," the study predicted a significant number of people would become "worse off" under each model. That is, currently insured individuals would either become uninsured or pay more for equivalent health insurance. Lastly, the study found higher-income individuals, who can fully finance insurance out of pocket, were more likely to benefit than lower-income individuals. The authors suggested the federal government could invest its savings to make the public option benefit lower-income individuals via tax credits or other incentives.

COVID-19 Treatments Will Cost Private Health Insurers Billions

As the pandemic persists, *Wakely Consulting Group, LLC* developed and published a report, COVID-19 Cost Scenario Modeling: Treatment, on the potential financial costs private domestic insurers will suffer from COVID-19. Though authors Michael Cohen and Julie Peper admit uncertainty remains surrounding long-term impacts, they assembled updated data as of May 10 from reputable public data sources including the Center for Disease Control and Prevention, the Kaiser Family Foundation, and the Centers for Medicare and Medicaid Services Medicare Advantage reports. They analyzed costs, utilization, and deferred care for commercial health insurers, Medicaid managed care organizations (MMCOs), and Medicare Advantage Organizations (MAOs) between 2020 and 2021 and used actual overall population infection rate instead of positive test rates. During the two-year period, the report estimates COVID-19 will cost private insurers between $30 and $546.6 billion and beneficiaries could pay out-of-pocket comprising $2.8 to $48.6 billion of the costs. The use of three unique possible infection rate scenarios – ten, twenty, and sixty percent – explains the large difference between the lowest and highest cost estimates. The authors also note these data will likely evolve quickly and insurers may save expenses on non-COVID-19-related treatments.

Telehealth Consultations Between Physicians Benefit Everyone Involved

In Electronic Consultations (eConsults): A Triple Win for Patients, Clinicians, and Payers, published by *Milbank Memorial Fund*, Aasta Thielke and Valerie King report on the Medicaid Evidence-based Decisions (MED) Project findings. They analyzed the effectiveness of eConsults, a type of store and forward technology used by primary care clinicians and specialty clinicians to communicate with each other to provide coordinated care. The report found patient and clinician satisfaction increased, while use of resources were more productive. For example, when a primary care clinician turns to a specialist through an eConsult, they can perform any tests the patient may require prior to seeing the specialist. This saves time and costs for the patient and provider by reducing the number of specialist visits by at

least one. Studies estimated eConsults reduced total cost of care by up to eighty-three percent and average specialty-related episode cost of care by $82 per patient per month across four specialties. The authors presume that the widespread use of eConsults could increase access, resourcefulness, coordination, and satisfaction with specialty care as long as fee-for-service policies do not induce reimbursement misuse.

Germany's System Could Help the U.S. Learn How to Control Pharmaceutical Prices

The *New England Journal of Medicine* published Lower Prices and Greater Patient Access – Lessons from Germany's Drug-Pricing Structure, in which James C. Robinson examined pharmaceutical price discrepancies between two countries despite their numerous other similarities. He highlights that the U.S. and Germany enjoy similar average household incomes, rely on both private and public health insurance plans, prefer negotiation instead of regulation, and determine new drugs' prices with similar uses of clinical assessments. Important differences between the two systems emerge *after* new drugs initially enter the markets. First, regulation in the U.S. allow manufacturers to increase prices as often as twice per year, while the German system prohibits unilateral price increases after the original clinical assessments and price negotiations. Second, while a small population of very sick patients who require high-cost drugs comprise most of the pharmaceutical spending in both countries, patients and health plans experience disparate costs. Insurers in the U.S. try to administratively avoid enrollees from this expensive population, whereas Germany protects these patients by statutorily capping cost-sharing at about $11 per prescription. Robinson suggests the U.S. learn from the negotiation processes between competing health insurance plans and ample statutory structure Germany uses to construct a more socially and economically respectable system for drug-pricing.

If you find additional articles that you would like us to include in the monthly roundup, please send them our way! The Source team hopes you stay safe and healthy in the upcoming month.

Federal Telehealth Waivers Provide Flexibility During the COVID-19 Crisis to Expand Coverage and Access to Healthcare

By: Megan Pham, Student Fellow

COVID-19 has upended the way individuals across the country access medical care and has made doctors' offices and hospitals high-risk grounds for transmission. This leaves the elderly and immunocompromised who seek care especially vulnerable. In response, the U.S. Department of Human and Health Services (HHS) and Centers for Medicare and Medicaid Services (CMS) have adopted a series of waivers to allow increased access to and coverage of healthcare services through telehealth.

PRE-PANDEMIC TELEHEALTH

Telehealth is "the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance."[1] Telehealth serves to help improve health care access, meet patient demand, reduce costs, and improve the quality of health care services. However, the tradeoff of these benefits often comes in the form of a limited scope of service and numerous administrative requirements for health care providers. According to an American Medical Association (AMA) survey, the percentage of physicians using virtual patient visits doubled between 2016 and 2019; however, adoption remained low with only 28% of physicians reporting use of virtual visits.[2] Additionally, only 9.6% of Americans have used telehealth services,

and nearly three-fourths (74.3%) say they either do not have access to or are unaware of telehealth options.[3] Many qualifying patients are reluctant to adopt telehealth for reasons such as unfamiliarity with telehealth apps and platforms[4], confusion about insurance coverage and payments, and skepticism surrounding safety, security, and effectiveness.[5]

COVID-19 TRIGGERS FEDERAL RESPONSE

As the COVID-19 crisis continues to unfold, federal agencies have adopted waivers to expand access to telehealth and ease legal requirements for its utilization. Prior to the adoption of these waivers, administrative burdens prevented practitioners from offering care online. Medicare could only pay for telehealth on a limited basis, and HIPAA regulations limited the types of technology permitted to deliver services.[6] Now, federal waivers allow for expansion of service coverage and access, flexibility for patient cost-sharing, establishment of payment parity, and discretional enforcement of HIPAA regulations.

The Secretary of the Department of Health and Human Services (HHS), using Section 1135 of the Social Security Act (SSA) can modify or waive certain Medicare (Parts A and B), Medicaid, and HIPAA requirements. This includes the ability to establish waivers under those programs to expand access to care during emergencies. Additionally, the Office for Civil Rights (OCR) at HHS is responsible for enforcing certain HIPAA regulations. Thus, HHS has the authority to remove procedural barriers for practitioners by allowing discretional enforcement of regulatory requirements.[7] Under the Coronavirus Aid, Relief, and Economic Security (CARES) Act, CMS also waived requirements of Section 1834(m)(4)(E) and 42 CFR § 410.78(b)(2), which in turn expands the types of services that may be provided through telehealth and eligible for billing to Medicare Parts A and B.[8] Altogether, the HHS and CMS are responsible for blanket healthcare waivers affecting Medicaid and Medicare services and coverage.[9]

While the federal waivers provide regulatory flexibilities beyond just telehealth, this post focuses on how barriers to telehealth have eased for insurers, providers, and patients. Additionally, while these waivers apply to both Medicare and Medicaid, we

discuss here primarily the effects on Medicare, as Medicaid plans are subject to variation from individual state regulation.

1. Expansion of Telehealth Services

Waivers issued by CMS help ease telehealth barriers by expanding coverage of telehealth services to benefit both health care providers and patients. Providers can now provide telehealth services that they could not previously, and patients can access a greater number of services that were unavailable prior to the pandemic.

Prior to the waivers, Medicare would only cover telehealth services for beneficiaries located in certain originating sites of care in qualifying rural areas. Under the waivers, coverage is now expanded for office, hospital, and other visits furnished via telehealth from a patient's place of residence. Medicare will now cover any service that is certified as deliverable through telehealth platforms, as well as monthly remote care management and monthly remote patient monitoring.[10] Additionally, CMS published a final rule of revised regulations for Medicare Advantage that strengthens network adequacy rules. Distance and residential requirements are now eased so that more beneficiaries can access telehealth. Medicare Advantage plans now have more flexibility to provide telehealth services in specialty areas. This change is meant to provide patients with more health care choices, especially for those residing in rural communities.[11]

The CMS waivers also expand coverage of specific types of services and practitioners. Previously, services provided through telehealth included remote evaluations, virtual check-ins, behavioral health services, education services, and remote patient monitoring. Eligible telehealth practitioners were limited to doctors, nurse practitioners, physician assistants, certified registered nurse anesthetists, certified nurse midwives, clinical social workers, clinical psychologists, and registered dietitians. With the federal waivers in place, nearly any service can be delivered through telehealth if there is a medically appropriate way to do so. Over 100 services have been temporarily added through the waivers. Notable additions include brief emotional or behavioral assessment, prosthetic training, speech therapy, and acute nursing facility care.[12]

2. Payment Flexibility and Reimbursement Parity

Along with expanded coverage of services, CMS waivers allow for Medicare Parts A and B to exercise reimbursement parity and bill telehealth services as if they were provided in person. Specifically, telehealth services previously billed by Medicare Parts A and B between $14-$41 are now billed by at $46-$110.[13] Medicare reimbursement parity is retroactive to March 1, 2020. Moreover, no federal approval is needed for state Medicaid programs to reimburse providers for telehealth services in the same manner or at the same rate as face-to-face services.[14]

Furthermore, HHS has provided flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs, including Medicare, Medicaid, and CHIP, without being subjected to administrative sanctions.[15] Ordinarily, if physicians or practitioners reduce or waive costs owed by federal health care program beneficiaries including cost-sharing, coinsurance, and deductibles, they could potentially implicate 42 USC § 1320a-7b, the federal Anti-Kickback Statute. The statute prohibits the exchange of anything of value, to induce or reward the referral of business reimbursable by federal health care programs.[16] Restrictions are meant to deter overutilization and the resulting increase cost of healthcare services.

Waived cost-sharing allows patients to seek telehealth care without incurring out-of-pocket expenses for their visits. Since the rest of the cost will be absorbed by Medicare, Medicaid, or CHIP, beneficiaries are encouraged to make appointments and seek the appropriate health care they need. Consequently, health care providers can expect more patients and business due to HHS waivers.

3. Fewer Restrictions to Telehealth Delivery and Access

To further encourage the use of telehealth, HHS' Office of Civil Rights (OCR) stated that it will exercise enforcement discretion and not impose penalties for violation of certain provisions of HIPAA, so long as telehealth services and technology usage are

made in good faith. OCR's enforcement discretion expands the delivery of telehealth to platforms that would not otherwise comply with HIPAA's regulations. Practitioners may now communicate with patients using non-public facing communication apps such as WhatsApp, Zoom, Skype, FaceTime, and iMessage.[17] However, public-facing video communication applications such as Facebook Live, Twitch, and TikTok should not be used in the provision of telehealth by covered health care providers. Since HIPAA expansion under HHS' waiver does not have an expiration date, telehealth services can be carried out on permitted platforms indefinitely.[18]

Consistent with service expansions, federal telehealth waivers also broaden the modalities through which telehealth services can be delivered. Previously, video technology was required to deliver telehealth services. CMS waivers discarded video requirements, allowing for audio-only evaluations when appropriate. CMS has provided a list of reimbursable audio-only services.[19] The change is meant to encourage telehealth use among the elderly and low-income populations who might have difficulty securing and using video technology.

4. Fewer Administrative Barriers for Providers

In addition to the expansion of telehealth in terms of service, delivery, and access, the federal waivers seek to lessen administrative burdens and encourage providers to adopt telehealth. CMS created the "Patients Over Paperwork" initiative to remove paperwork barriers that previously prevented certain practitioners from offering their services virtually.[20] The initiative expands caregivers' abilities to administer therapy, improves reporting systems, and reduces psychiatric hospital burdens with a new survey process.[21]

WHAT THE FUTURE HOLDS FOR TELEHEALTH

As the country works to lower the COVID-19 infection rate and prepare for a potential second wave as states start to reopen, the healthcare system will continue to rely heavily upon telehealth to ease healthcare burdens. Since federal telehealth

waivers have been instituted, the demand for telehealth has surged dramatically. AllyHealth, a telehealth platform, reported a 150% increase in Virtual Urgent Care utilization between January 2020 and April 2020.[22]

The overwhelming adoption of telehealth by beneficiaries since the pandemic makes clear that telehealth is here to stay, and any legislative pushback may be seen as unnecessarily restricting access to essential health care. Experts expect that even when the pandemic subsides, CMS and HHS will maintain much of the flexibilities provided by their waivers in terms of expanded service and access.[23] Moreover, high demands for telehealth have put pressure on Congress to advance telehealth reform through formal regulatory changes, especially concerning payment parity and rural area funding.[24] While it is unfortunate that it took a pandemic to accelerate the development of telehealth and broaden its coverage and access, the resulting desire and urgency for telehealth reform will undoubtedly be, if not already, on the forefront Congress' mind.

	CMS WAIVER	HHS WAIVER	INSURANCE

SERVICES	Adds 100+ new services to the list of Medicare services that may be furnished via telehealth: group psychotherapy, eye exams, speech/hearing therapy, cochlear implant follow up exam, brief emotional/behavioral assessment, etc. Waives limitations on the types of clinical practitioners that can furnish Medicare telehealth services. Hospitals may bill as the originating site for telehealth services furnished to patients registered as hospital outpatients, including certain partial hospitalization services and when the patient is located at home. *Patients in rural areas benefit from network adequacy requirements. (M.A. only)		Medicare Parts A and B *Medicare Advantage

PROVIDER REIMBURSEMENT	Increases payments for telephone visits to match payments for similar office and outpatient visits. Increases payments for these services from a range of about $14-$41 to about $46-$110. Payments are retroactive to March 1, 2020.		Medicare Parts A and B Medicaid (also subject to state's recommendations)
PATIENT COST-SHARING		Physicians and other practitioners will not be subject to administrative sanctions for reducing or waiving any cost-sharing obligations.	Medicare Parts A and B Medicaid (also subject to state's recommendations)

PROVIDER ADMINISTRATION	"Patients Over Paperwork" initiative removes paperwork barriers that previously prevented certain practitioners from offering their services virtually. Expands caregivers' ability to administer therapy, improve reporting systems. and reduces psychiatric hospital burdens with a new survey process. Some states have provided additional relief on reporting and audit requirements.		Medicare Medicaid (also subject to state's recommendations)
DELIVERY AND ACCESS	Waives video requirement for certain telephone evaluation and management services. Eased distance and residential requirements are so that more beneficiaries can access telehealth.	Discretion in enforcement of HIPAA regulations. Health care providers may use popular applications that allow for video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, Zoom, or Skype.	Medicare Medicaid (also subject to state's recommendations)

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[1] *Telemedicine*, Medicare.gov, https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html (last visited June 15, 2020).

[2] *Telemedicine Research & Reports – Pre-COVID-19: Utilization/Adoption of Telemedicine*, Alliance for Connected Care, http://connectwithcare.org/studies-reports/#Utilization/Adoption%20of%20Telemedicine (last visited June 15, 2020).

[3] *One in 10 Americans Use Telehealth, But Nearly 75% Lack Awareness or Access, J.D. Power Finds*, J.D. Power (July 31, 2019), https://www.jdpower.com/business/press-releases/telehealth-usage-and-awareness-pulse-survey.

[4] Given the growing number of telehealth apps and providers, patients and beneficiaries are overwhelmed by the choices they have. Moreover, there is a lack of information and resources to help patients determine which platforms and providers are most suitable for their needs. *Id*.

[5] Nearly half (48.7%) of respondents believe the quality of care received in a telehealth session is lower than that of a doctor's office visit." *Id*.

[6] Medicare could traditionally pay for telehealth when the person receiving the service was in a designated rural area and when they leave their home and go to a clinic, hospital, or medical facilities for the service. *Medicare Telemedicine Health Care Provider Fact Sheet*, CMS.gov (Mar. 17, 2020), https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet.

[7] *Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency*, HHS.gov, https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html (last visited June 15, 2020).

[8] Ctr. For Medicare & Medicaid Serv., Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19 1 (2020), https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf.

[9] Dep't of Health & Human Serv., Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program 28, 44-60 (2020), https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf. See also, Dep't of Health & Human Serv., Blanket Waivers of Section 1877(g) of the Social Security Act Due to Declaration of COVID-19 Outbreak in the United States as a National Emergency 1 (2020), https://www.cms.gov/files/document/covid-19-blanket-waivers-section-1877g.pdf.

[10] Office of Inspector General, FAQs – OIG Policy Statement Regarding Physicians and Other Practitioners That Reduce or Waive Amounts Owed by Federal Health Care Program Beneficiaries for Telehealth Services During the 2019 Novel Coronavirus (COVID-19) Outbreak (2020), https://oig.hhs.gov/fraud/docs/alertsandbulletins/2020/telehealth-waiver-faq-2020.pdf.

[11] *Trump Administration Announces Changes to Medicare Advantage and Part D to Provide Better Coverage and Increase Access for Medicare Beneficiaries,* CMS.gov (May 22, 2020), https://www.cms.gov/newsroom/press-releases/trump-administration-announces-changes-medicare-advantage-and-part-d-provide-better-coverage-and.

[12] *List of Telehealth Services,* CMS.gov, https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes (last visited June 15, 2020).

[13] CMS.gov, *supra* note 11.

[14] Ctr. For Medicare & Medicaid Serv., Medicare Telehealth Frequently Asked Questions (FAQs) 4 (2020), https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-f

aqs-31720.pdf.

[15] HHS Office of Inspector General, HHS OIG Policy Statement on Practitioners That Reduce, Waive Amounts Owed by Beneficiaries for Telehealth Services During the COVID-19 Outbreak (2020), https://www.oig.hhs.gov/fraud/docs/alertsandbulletins/2020/factsheet-telehealth-2020.pdf. See also, Office of Inspector General, OIG Policy Statement Regarding Physicians and Other Practitioners That Reduce or Waive Amounts Owed by Federal Health Care Program Beneficiaries for Telehealth Services During the 2019 Novel Coronavirus (COVID-19) Outbreak 1-2 (2020), https://oig.hhs.gov/fraud/docs/alertsandbulletins/2020/policy-telehealth-2020.pdf. See also, *Cost-sharing for Patients in Federal Health Care Programs,* HHS,gov, https://www.hhs.gov/coronavirus/telehealth/index.html#:~:text=The%20HHS%20Office%20of%20Inspector,CHIP)%2C%20during%20the%20public%20health (last visited June 15, 2020).

[16] *Anti-kickback Statute and Physician Self-Referral Laws (Stark Laws),* American Society of Anesthesiologists, https://www.asahq.org/quality-and-practice-management/managing-your-practice/timely-topics-in-payment-and-practice-management/anti-kickback-statute-and-physician-self-referral-laws-stark-laws#:~:text=The%20federal%20Anti%2DKickback%20Statute,by%20federal%20health%20care%20programs (last visited June 15, 2020).

[17] HHS.gov, *supra* note 6.

[18]*When does the Notification of Enforcement Discretion regarding COVID-19 and remote telehealth communications expire?*, HHS.gov (March 26, 2020),

https://www.hhs.gov/hipaa/for-professionals/faq/3020/when-does-the-notification-of-enforcement-discretion-regarding-covid-19-and-remote-telehealth-communications-expire/index.html.

[19] CMS.gov, *supra* note 10.

[20] Ctr. For Medicare & Medicaid Serv., Patients Over Paperwork Fact Sheet

(2019), https://www.cms.gov/About-CMS/Story-Page/Patients-Over-Paperwork-fact-sheet.pdf.

[21] Ctr. For Medicare & Medicaid Serv., Status Update: Reducing Home Health Burden with Human Centered Design 1-3 (2020), https://www.cms.gov/files/document/february-2020-update.pdf.

[22] *AllyHealth's Telemedicine Demand Surges vs. Pre COVID-19 Levels*, AllyHealth (Apr. 7, 2020), https://www.allyhealth.net/allyhealths-telemedicine-demand-surges-vs-pre-covid-19-levels/.

[23] Robert King, *HHS official: 'Cat out of the bag' on telehealth but unclear what changes will stick,* Fierce Healthcare (June 5, 2020), https://www.fiercehealthcare.com/payer/hhs-official-cat-out-bag-telehealth-but-unclear-what-changes-will-stick?mkt_tok=eyJpIjoiTWpoaU1qQmtZamxoTldVdyIsInQiOiJFbXJzdjBpckd1dlhRV2VrZHNTakxhS2hTWStPeXlSc3hoMENNSTJBREl1Vnh0TGxVQnQ1VWwxMDdPN0xJZzlSVmdUbHRUa0VKcHFnbHplQk5ob1ZsY2VZZFZmNEtDSkJYV2JJOHFrNThtMTE2RkNEMm50ZjZSdGNSSGF4YUNQUVk3d0V2bU9CUHNjUU5ETlZhblpZUnc9PSJ9&mrkid=57343265.

[24] Heather Landi, *Providers to Congress Patients will lose access to care without permanent expansion of telehealth,* Fierce Healthcare (June 18, 2020), https://www.fiercehealthcare.com/tech/providers-to-congress-permanent-expansion-telehealth-will-help-address-health-disparities?mkt_tok=eyJpIjoiTnpBMU9UVXlOalkzWm1SbCIsInQiOiJaXC90XC85QUR1cHRDMkNqUUNNbTlKamRUODREcGRvMFVxdU5MUUFrR3R0WUlyM2REYW8wNm9wU2NMYXg1SjA3OGhsT0U2VXNXR1hoWkkrUlgzTkZ2cG1TdE5pbERSMWJibXY5alp5NXdBeFpndlUzOUphdko0OUtLZ0M1RkI2bHlLZGZTdlZrZjdxem9Mc1ozZFdDaHNDQT09In0%3D&mrkid=57343265. See also, Joyce Frieden, *COVID-19 Changes to Telehealth Rules Should Stick, Senator Says*, MedPage Today (June 17, 2020), https://www.medpagetoday.com/practicemanagement/reimbursement/87140.

[In the Press] Source Executive Editor Quoted in California Healthline Regarding Sutter Settlement

Executive Editor Jaime King was quoted in the 6/17/2020 California Healthline article Citing COVID, Sutter Pushes To Revisit Landmark Antitrust Settlement:
In its filing, Sutter does not specifically object to the $575 million settlement amount. But Jaime King, an associate dean at UC Hastings College of the Law who has followed the case, said the request for a delay could be a tactical strategy to support such a move.

“The longer they can delay, the more they can show they have significant losses from COVID-19, which allows them to plead for a lower settlement,” King said.

Podcast from Harvard Professor Anna Sinaiko Provides Insights on

Healthcare Consumerism

Tune in to the latest podcast with Anna Sinaiko, PhD, Assistant Professor at the Harvard T. H. Chan School of Public Health, who discusses with Catalyst for Payment Reform (CPR) Executive Director Suzanne Delbanco past price and quality transparency efforts and benefit design programs.

CPR, in partnership with The Source, recently released a Report Card on State Transparency Laws that assesses state efforts to help consumers access health care price information to facilitate consumer shopping (see Suzanne Delbanco's op-ed in Governing).

This latest podcast from CPR provides insights on patient preferences in healthcare choices and efforts that have steered patients toward higher-value providers. Sinaiko hopes to inform future policies aimed at helping patients be better consumers in today's complex healthcare market. Listen here.

Just Published: Research Report on Preventing Anticompetitive Healthcare Consolidation

Recent evidence demonstrates that provider and insurer markets in the United States have been highly concentrated for years and have led to increased healthcare prices and insurance premiums without a commensurate increase in quality. The coronavirus pandemic is placing additional financial strain on many physician practices and small, rural hospitals, elevating the risk of unchecked consolidation. State governments can play a critical role in improving oversight of anticompetitive

mergers and other affiliations, especially in this time.

With support from Arnold Ventures and in collaboration with the Nicholas C. Petris Center on Health Care Markets and Consumer Welfare in the School of Public Health, UC Berkeley, The Source conducted a research of statutes, regulations, and antitrust enforcement actions in all fifty states. In the newly released research report "Preventing Anticompetitive Healthcare Consolidation: Lessons from Five States", we identify best practices that state policymakers should consider to enhance oversight of healthcare consolidation in their own state.

This research report is the latest installment in a collaborative research series that leverages the latest and most comprehensive data on state laws, healthcare markets, and healthcare prices in provider and insurer markets in the United States in the last ten years and presents evidence-based information and analyses on the most effective strategies for states to address rapidly consolidating healthcare markets. Additional research findings and analyses are published on the "Market Consolidation" key issue page.

Download the report here.

The Landmark Sutter Health Antitrust Case was Settled. Will COVID-19 Uproot it Like it Did Everything Else?

When Sutter Health reached a preliminary settlement agreement with California Attorney General Xavier Becerra restricting its anticompetitive practices, antitrust experts breathed a collective sigh of relief on clinching a favorable outcome. Then

came COVID-19. As with all other aspects of business and life, the pandemic has turned existing order upside down. Will it throw a wrench in the all but finalized case that would've served as strong guidance to other health systems in the country?

The terms of the settlement in the high-profile antitrust case were released last December in a preliminary settlement agreement filed with the Superior Court of San Francisco. Sutter agreed to both monetary compensation for the private plaintiffs in the amount of half a billion dollars, as well as injunctions against its anticompetitive conduct, including bundling of services, all-or-nothing contracting, and gag clause provisions (see The Source Blog for details). The terms promise to improve competition and promote transparency in the provider market, and more importantly, serve as a model for similar antitrust enforcement cases in other states.

To finalize the settlement, the case was set for a preliminary approval hearing in front of Superior Court Judge Anne-Christine Massullo on February 25, at which Judge Massullo requested supplemental filings to address issues including: 1) potential substantial change in the regulatory framework regarding how medical services are provided; 2) authority for the AG's request to share in attorney fees; 3) steps to ensure diversity selection of the monitor; and 4) appropriate process to educate the court about specific provisions of the injunction.[1] Specifically, the court requested supplemental filings from Plaintiffs that would provide, among other things, a term-by-term summary of the proposed injunction, explaining as to each term, what the term does and does not prohibit Sutter from doing, how the restriction serves the purpose of unfettering the market from anticompetitive conduct, and justification for any limitations in the restriction imposed.[2]

The court ordered supplemental filings by March 18 and a further preliminary approval hearing on April 6. But when the coronavirus pandemic hit, courthouses around the country temporarily shuttered, and the court issued an order on April 3 staying the case for 60 days, with the preliminary approval hearing set to resume on June 22. Then Sutter saw an opportunity, and communications between the parties began to break down. While COVID-19 might be interrupting all aspects of life as we know it, for Sutter it could be seen as a lifeline in all the chaos to reverse losses from the settlement. According to recent reports, Sutter Health posted an operating loss of $236 million for the first quarter of 2020, and a net loss of $1.1 billion,[3] largely

attributed to declines in non-COVID-19 related hospital services due to the pandemic.

In a letter to the court on May 28, Sutter cited adverse financial and operational impact from COVID-19 and asserted that the circumstances have changed substantially since the parties entered the settlement. As a result, Sutter maintains that it may be forced to make operational changes "that could render impracticable and otherwise materially impact key injunctive relief provisions,"[4] because compliance with such would "interfere with Sutter's ability to provide coordinated and integrated care to patients in California."[5] Sutter suggests that the proposed settlement should be modified or at least reevaluated to take into account the disruption in the healthcare industry caused by COVID-19, preferably when the healthcare landscape stabilizes.

In addition, Sutter claims that SB 977, a bill co-sponsored by the AG that arose out of the Sutter litigation, may change existing antitrust law that formed the basis of the settlement. Sutter reasons that SB 977, should it be passed at the end of the legislative session in September, could materially impact the injunction or even render it necessary. SB 977 was sent to suspense file after the Senate Appropriations Committee hearing on June 9, with opposition from provider organizations including California Hospital Association, Adventist, and Stanford Healthcare. While a vote-only suspense hearing will be held after the committee has a better sense of the state budget, a suspense bill can often times fail to proceed without further discussion. Regardless of the fate of SB 977, antitrust experts believe it has no bearing on the Sutter settlement, as the injunctions should be imposed on Sutter regardless of what SB 977 may do.

Taken together, Sutter is requesting continued stay of the preliminary approval process, either in hopes of walking back on specific provisions of the settlement, or at the very least, delay the final settlement amidst the indefinite uncertainty of the COVID-19 crisis. At the court status conference held on May 29, Judge Massullo indicated that in order to formally consider Sutter's request, Sutter needs to file a noticed motion by June 12 to either stay the case and/or to continue the motion for preliminary approval. In the meantime, the court ordered that the 60-day stay entered on April 3 will be allowed to expire as previously ordered and the original

June 22 hearing date will proceed as either a status conference or further hearing on preliminary approval of the settlement.

Will Sutter continue to create more obstacles to the settlement in the COVID-19 chaos? Attorneys for Sutter seemed to indicate so. Whether they will succeed, however, is a much bigger question. At the May 29 status conference, Emilio Varanini from the AG office pointed to the financial support that Sutter is getting from federal relief grants.[6] As of May 12, Sutter has received $200 million in COVID-19 grants from the Coronavirus Aid, Relief, and Economic Security (CARES) Act's Provider Relief Fund, $1 billion in accelerated Medicare payments from the Centers for Medicaid and Medicare, and other benefits from the CARES Act's assistance programs.[7] Varanini also noted that federal antitrust authorities including the Federal Trade Commission and Department of Justice have said that COVID-19 is not an excuse to disregard antitrust law.[8] At the same time, the federal case against Sutter is also heating up (look for The Source's updated coverage on that case forthcoming). As uncertainty from the COVID-19 crisis rages on, one thing is for certain, like the pandemic, the Sutter Health drama is far from over.

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[1] Order re (1) Plaintiffs' Motion for Preliminary Approval of Settlement; and (2) Plaintiffs' Motion to Appoint a Monitor, UFCW & Employers Benefit Trust, et al. v. Sutter Health, et al., No. CGC 14-538451 (Cal. Super. Ct. S.F. City and Cnty. 2020).

[2] *Id*. at 2.

[3] Ron Shinkman, *COVID-19 shreds Sutter Health's finances in matter of weeks*, Healthcare Dive (May 15, 2020), https://www.healthcaredive.com/news/covid-19-shreds-sutter-healths-finances-in-matter-of-weeks/578021/.

[4] Letter to Judge Anne-Christine Massullo Re: UFCW v. Sutter Health, CGC-14-538451, from Jones Day and Bartko, Zankel, Bunzel & Miller, Attorneys for

Defendant Sutter Health (May 28, 2020).

[5] Transcript of Status Conference at 17, UFCW & Employers Benefit Trust, et al. v. Sutter Health, et al., No. CGC 14-538451 (Cal. Super. Ct. S.F. City and Cnty. 2020) (May 29, 2020), https://sourceonhealthcare.org/wp-content/uploads/2020/06/2020-05-29-Hearing-Transcript.pdf.

[6] *Id.* at 22.

[7] Tara Bannow, *Sutter Health's operating loss margin nears 20% in April*, Modern Healthcare (May 27, 2020), https://www.modernhealthcare.com/finance/sutter-healths-operating-loss-margin-nears-20-april.

[8] Joint Antitrust Statement Regarding COVID-19 (March 24, 2020),

https://www.ftc.gov/system/files/documents/public_statements/1569593/statement_on_coronavirus_ftc-doj-3-24-20.pdf.

[In the Press] Source Executive Editor Interview Quoted in Los Angeles Times Regarding SB 977

Los Angeles Times

The Source Executive Editor Jaime King was recently quoted in the Los Angeles Times article "California seeks more power to fight healthcare mergers," regarding

SB 977, a bill that would grant significantly more merger review power to the Attorney General in California:

“The best way to prevent problems from occurring in a merger is just to prevent the merger altogether,” said Jaime King, associate dean at UC Hastings College of the Law in San Francisco. “It’s really hard to unwind a merger after you’ve already done it.”

SB 977 incorporated many of the recommendations from a policy brief written by The Source team, published by the California Health Care Foundation (CHCF) in April. The report examines the California Attorney General’s merger review authority and suggests expansion of the AG’s oversight of health care mergers to address the escalating scope and impact of health care industry consolidation. Download it here.

The Source Roundup: June 2020 Edition

The Source continues to extend wishes of safety and good health to you and your loved ones during this uniquely challenging time. Despite the reality that much of the healthcare industry suffers financial catastrophe due to the pandemic, experts note improvements in some areas. Authors this month expect some advancements to last and suggest how the U.S. should use them to diminish costs.

Changes in Telehealth Will Likely Outlast the Pandemic

In JAMA’s Implications for Telehealth in a Postpandemic Future, Carmel Shachar and co-authors affirm positive outcomes that the pandemic-induced increase in telehealth services caused in some areas of healthcare. They expect some state cost

regulations on telehealth services during the COVID-19 crisis will remain after the pandemic because payment and reimbursement parity are essential in making telehealth economical for small and rural practices. In addition, before the pandemic, regulations on privacy and licensing usually constrain telehealth expansion. As states relax these restrictions during COVID-19, they help health care markets and state lawmakers learn which privacy regulations and inter-state licensure requirements states would need to relax to maintain broad, long-term telehealth use. The authors believe that the U.S. healthcare system and federal lawmakers could learn from states' pandemic-related emergency HIPAA waivers, price protections, and licensing shifts to develop lasting telehealth deregulation.

In Removing regulatory barriers to telehealth before and after COVID-19, published by the Brookings Institution, Nicol Turner Lee and colleagues argue that federal and state lawmakers should continue to relax limits on telehealth as it proves to be successful during the coronavirus crisis. They highlight disparities in telehealth laws between states, including reimbursement policies, licensing constraints, and access disparities between communities. The authors argue these dissimilarities prevented universal use of telehealth before the pandemic because they restricted healthcare providers' abilities to relocate or administer care across state lines. They recommend several policy actions: lawmakers should analyze COVID-19 telehealth data, implement consistent federal telehealth regulations, allow telehealth for all primary care purposes, and make telehealth services cheaper than in-person visits to reduce costs for patients and providers.

Antitrust Issues Persist in Healthcare Markets

In Antitrust & COVID-19 in the U.S.: Four Key Issues for Healthcare Providers, published in the May edition of the *CPI Antitrust Chronicle*, John Carroll and Alexis Gilman find healthcare providers face several antitrust issues during the current pandemic. They emphasize the Federal Trade Commission (FTC) will not relax its legal standards for antitrust enforcement, even if processes may change. Although temporary collaboration efforts between organizations to provide personal protective equipment may not raise antitrust concerns due to their limited duration

and scope, any merger and acquisition will be scrutinized as strictly as they would have pre-pandemic. In addition, during the pandemic, the FTC will use its power against "unfair or deceptive acts or practices" that constitute price gouging, which lacks any federal prohibition. Carroll and Gilman caution that the FTC and Department of Justice could struggle in evaluating the validity of "failing firm" defenses since many healthcare organizations suffer financial declines with unclear outlook and duration as a result of the coronavirus crisis. However, because of the pandemic, healthcare markets will want to avoid losing any hospital to consolidation now more than ever. As such, the authors caution healthcare providers during this worldwide challenge to beware of antitrust considerations.

Also in *CPI Antitrust Chronicle* this month, Drs. Paul Wong and colleagues offer a unique view of non-compete agreements in healthcare contracts in Non-Compete Agreements: Might They Be Procompetitive in Healthcare*?*. They consider non-compete agreements valuable solutions to investment hold-ups. Sometimes, an investor will withhold an investment if they are unable to rely on an employee's cooperation with a non-compete agreement. The authors worry that state bans on physician non-compete agreements focus too narrowly on wages and employment turnover and fail to account for important investments that could otherwise improve access and quality of healthcare. They propose a balanced approach to enforcement of non-compete agreements that will promote healthcare worker mobility and capital investment interests.

Healthcare Prices Continue to Increase and Vary Between States

In a new *Health Affairs* article, Wide State-Level Variation In Commercial Health Care Prices Suggests Uneven Impact Of Price Regulation, Michael E. Chernew and scholars researched the potential to match commercial insurance rates to Medicare rates to curb health care service cost increase. They found that lifting Medicaid rates to match Medicare prices could mitigate the loss in revenue hospitals will endure. In general, however, implementing regulation of rates too quickly could disrupt market structures. Additionally, as commercial insurance and market rates vary widely by state, states would experience the effects of the potential change

disparately. This poses another challenge and provides a catalyst that incentivizes the need to narrow the gap between Medicare and commercial payments.

Also in *Health Affairs* this month, Mark A. Unruh et al. analyzed the relationship between Physician Prices and the Cost and Quality of Care for Commercially Insured Patients. Unruh et al. found physician payment varied over two hundred percent between the highest and lowest price general internal medicine physicians. At the same time, patient costs varied by about twenty percent between the highest and lowest price physicians. Interestingly, however, these variations in prices did not impact quality or outcome. There was no correlation between prices and patients' hospital readmittance rates nor ambulatory care rates. As a result, the authors suggest that policy makers should determine root causes for such puzzling price disparities that are not explained by differences in care quality and outcome.

Progress and Considerations of Price Transparency Efforts

This month, The Source on Healthcare Price and Competition and Catalyst for Payment Reform jointly released the 2020 Report Card on State Price Transparency Laws, which assesses how each state has advanced healthcare price transparency to help consumers access health care price information since the previous Report Card released in 2017. Using the Database of State Laws Impacting Healthcare Cost and Quality (SLIHCQ) available on The Source, Roslyn Murray et al. gave sixteen states passing grades. The transparency grading was determined by factors including the depth of healthcare price data, such as the scope of prices, services, and providers covered by the data, and its accessibility to the public. The highest-scoring states, including Maine and New Hampshire, maintained powerful transparency laws and favorable consumer resources, such as free, user-friendly websites on healthcare price information. The authors also note that twenty-one states implement All-Payer Claims Databases (APCDs) and urge the thirty-eight failing states to establish accessible and affordable APCD data to expose the variation in health care prices and costs.

In the May *CPI Antitrust Chronicle*'s Price Transparency: Friend or Foe? How Price Transparency May Impact Competition in the Healthcare Industry, Dionne Lomax

and Sophia Sun argue that price transparency alone cannot repress health care cost escalation. While consumers increasingly demand transparency, this article exposes its potential adverse impacts, particularly related to recent rules issued by the Centers for Medicare and Medicaid Services (CMS). The CMS rules require all U.S. hospitals publicly avail standard charges, which the authors suggest would place burdens on hospitals that would better fall on insurers. In addition, Lomax and Sun remind readers that standard charges often reveal little about consumers' out-of-pocket costs. They fear that full disclosure of prices will harm competition in health care markets by allowing providers to see their competitors' prices. Instead, they recommend future rules and disclosures tailor information to maximize wise consumer decision-making while limiting data to respect antitrust boundaries.

If you find additional articles that you would like to see included in the monthly roundup, please send them our way! The Source team hopes you stay safe and healthy in the upcoming month.

Affordable Care Act Litigation – May 2020 Updates

The coronavirus pandemic has highlighted the urgent need for healthcare coverage for all Americans, once again putting the Affordable Care Act (ACA) in the national spotlight. The law, however, has long been immersed in various types of litigation, involving both state governments and private insurers, a few of which have reached the Supreme Court after many years in the making. This month, we take a look at the latest Supreme Court action in two recent lawsuits involving the ever-controversial law and its legacy.

Insurers Win $12 Billion Lawsuit for ACA Risk-Corridor Payments

In April, the Supreme Court issued an 8-1 ruling[1] that would require the federal government to honor its obligation and pay $12 billion in funds owed to insurers under the ACA risk corridor program. The ACA's temporary risk corridor program, implemented from 2014 to 2016, was created to encourage insurers to participate in the health insurance marketplaces in the early years. To incentivize insurance companies to offer affordable premiums to people with preexisting conditions and those who otherwise would have been denied coverage, the government promised to provide subsidies and reimburse participating insurers that had excessive costs and losses. Specifically, using a formula under Section 1342 of the ACA mandates, the Department of Health and Human Services (HHS) would claim excess savings from the profitable health plans and redistribute these funds in payments to the nonprofitable plans.

In practice, HHS collected savings from the profitable insurers as intended under the program. However, the funds collected were far less than the subsidies needed to reimburse the unprofitable insurers, creating a deficit that the government failed to pay. Claiming more than $12 billion in unpaid funds, health insurers filed suit in the Court of Federal Claims to recover the payments owed under the program. The government argued that Congress intended to repeal or suspend the risk corridor payments when it passed appropriation riders in 2015 and 2016 which limited the funds from which HHS could pay insurers. They reasoned that because Congress did not appropriate alternative funds to pay the risk corridor payments beyond what was collected in the savings fund, it effectively released the government from the payment obligation.

The Court of Appeals for the Federal Circuit ruled for the government in June 2018, holding that the risk corridor was an incentive program that did not impose an obligation, because the government did not provide budgetary authority to HHS to administer the payments. The question presented before the Supreme Court, in three consolidated cases brought by four insurers,[2] was whether Congress can use its appropriation power to amend or repeal a statutory obligation and apply such changes retroactively.

The Supreme Court answered in the negative and reversed the lower courts. In an 8-1 decision, the justices held that the language "shall pay" in the ACA provision created a legal duty for the federal government to pay regardless of appropriations. Additionally, any appropriation riders passed by Congress did not repeal that obligation, because the mere omission of an appropriation does not sufficiently imply intent to cancel the obligation. In the majority opinion, Justice Sonia Sotomayor said the decision reflects "a principle as old as the nation itself: The government should honor its obligations." Justice Stephen Breyer concurred that the government should pay its contracts, just like anybody else.

While this a big win for insurers, health policy experts indicate these retroactive payments will not matter much because the failure to collect government payments back then had forced many of the insurers to go out of business. Not only will they be unable to collect these retroactive payments, their exit from the marketplace had reduced competition and in turn contributed to premium increases in the ensuing years. Such damage cannot be remedied after the years of litigation it took to reach the Supreme Court. Nonetheless, the decision upholds the integrity of the ACA and affirmatively honors an ACA obligation despite the heavy price tag. This ruling may indicate the high court's willingness to rule similarly in other cases that seek to weaken the ACA.

Democratic States and Lawmakers Argue ACA Indispensable During COVID-19 in Opening Briefs to Supreme Court

In a separate case involving the ACA that will be a far bigger test of the law with far greater implications, the Supreme Court is set to review the validity of the law itself.

In March, the high court granted certiorari of the 5th Circuit's decision in Texas v. United States, in which Republican states led by Texas sought to overturn the entire law. In response, California led several Democratic states to defend the law in California v. Texas. The questions presented before the court, in the two consolidated cases, are whether the elimination of the tax penalty renders the individual mandate provision unconstitutional, and if so, whether the entire law should be struck down or is severable and stands alone on its own.

This month, California Attorney General Xavier Becerra, along with 20 Democratic attorneys generals, filed an opening brief stating that the ACA's mandates "have proven indispensable in the context of the current pandemic." According to a new Kaiser Family Foundation (KFF) report, nearly 27 million Americans have lost employer-sponsored insurance as a result of losing their jobs in the COVID-19 crisis. The brief pointed out, as confirmed by the KFF study, that the ACA helped many people maintain affordable health coverage through subsidies and other mandates under the law.[3] The House of Representatives echoed the argument in its own opening brief, writing that the pandemic makes it "impossible to deny that broad access to affordable health care is not just a life-or-death matter for millions of Americans, but an indispensable precondition to the social intercourse on which our security, welfare and liberty ultimately depend." Following the Petitioner's opening brief, several more state attorneys general, including Maryland, Pennsylvania, and Maine, members of the Senate, and a slew of provider and payer groups filed amicus briefs in support of the seminal law. They further emphasized that invalidating the law, which had significantly expanded access and coverage, would strain the healthcare system, particularly in the middle of a devastating pandemic. Respondents led by Texas have a deadline of June 25 to file their opening briefs, and amicus briefs in support of Respondents are due for filing by July 2.

No stranger to attempts to bring down the law, all eyes are on the Supreme Court, especially as the COVID-19 pandemic significantly changes not just the healthcare but also economic landscape. This further raises the stakes of the lawsuit for all Americans, which could potentially change the trajectory of the litigation. Oral arguments in the case may take place as soon as October, when the Supreme Court's fall term begins, while a decision may not be handed down until end of the spring term in June 2021. Stay tuned for more developments and latest actions.

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[1] Maine Community Health Options v. United States, U.S., No. 18-1023, 4/27/20.

[2] The lead case for Supreme Court review is Maine Community Health Options v. United States, U.S., No. 18-1023, 4/27/20. The four insurers in the consolidated

cases are Maine Community Health Options, Blue Cross and Blue Shield of North Carolina, Land of Lincoln Health, and Moda Health Plan.

[3] Kaiser Family Foundation estimates that more than 20 million people losing job-based health coverage will become eligible for ACA coverage through Medicaid or marketplace tax credits. See https://www.kff.org/coronavirus-covid-19/issue-brief/eligibility-for-aca-health-coverage-following-job-loss/.

AB 2036 Seeks to Rectify a Loophole in California AG Merger Oversight But Can Go Further

As California continues to shelter in place and limit the spread of COVID-19, the California Legislature is forced to cut the number of bills it can consider this session. However, as hospitals struggle financially and possibly seek mergers to survive, merger oversight over nonprofit hospitals is more critical than ever to maintain health access. Under California law, the state Attorney General ("AG") can impose conditional approval for mergers or acquisitions involving non-profit health facilities. Two recent bankruptcy court cases have threatened the viability of these conditional approvals by limiting the AG's enforcement in certain cases. AB 2036 seeks, in response, to strengthen the AG's conditional approval authority by allowing continued enforcement of any previously imposed condition to ensure health care access for the communities the hospital serves.

Brief Primer on AG's Merger Oversight and Conditional Approval

The AG's scope of merger review is specified in California Corporations Code

sections 5914 and 5920, which require the AG to be notified and to approve a sale, transfer, or other forms of disposition of a nonprofit corporation's health facilities' assets. Specifically, section 5914 allows review of a transaction for assets transferred, sold, or otherwise disposed to a for-profit or mutual benefit corporation or entity, while section 5920 provides review authority for the same type of transaction with another nonprofit corporation or entity.

Furthermore, under California Corporations Code sections 5917 and 5923, the AG has the ability to conditionally consent to the transaction, which means the AG can impose conditions in exchange for its approval. These consent decrees have been used to impose conditions that ensure healthcare access after a transaction, including a requirement for continued operation of emergency rooms and reproductive health services.

Recent Federal Bankruptcy Cases Limit AG Oversight Authority

Two recent cases, *In re Gardens Regional Hospital* (Mar. 15, 2017) and *In re Verity Heath System* (Dec 26, 2018), have revealed limits of the AG's merger oversight. While the sales in both cases arise from bankruptcies, the limits set by these cases could also apply to non-bankruptcy sales.

In Re Gardens Regional Hospital and Medical Center, Inc. Exempts Sale of Closed, Nonprofit Hospitals from AG Oversight

In this case, Gardens Regional Hospital and Medical Center ("Gardens") closed and suspended its general acute care hospital license. Gardens sought approval in bankruptcy court for the sale of its closed hospital to American Specialty Management Group, which would reopen the hospital. While the Attorney General sought to place conditions on the sale, Gardens argued that because the hospital was "closed" and no longer qualified as a "health facility" per definition, the AG no longer had jurisdiction.[1] The federal bankruptcy court agreed.

The court's opinion rested upon the statutory interpretation of whether a closed hospital is within the definition of a "health facility" for the purposes of AG

oversight.[2] Prior to 2018, a health facility was defined either as "a facility that provides similar health care" or by Section 1250 of the Health and Safety Code. Under Health and Safety Code section 1250, a "health facility" means, in part, "a facility, place, or building that *is* organized, maintained, and operated for the diagnosis, care, prevention, and treatment of human illness, physical or mental, including convalescence and rehabilitation and including care during and after pregnancy." (emphasis added.) Without any case precedent, the court interpreted the definition of a "health facility" under Health and Safety Code section 1250 in two consequential parts: a health facility must be (1) operating and receiving patients (2) in the present time. The court noted that the use of "is" in Health and Safety Code section 1250 rather than "is or previously was" made it clear that the health facility must be operating in the present.[3] In this case, the court held that the since the closed hospital was no longer operating or receiving patients at the present time,[4] it would not qualify as a health facility that is under the jurisdiction of the AG's nonprofit merger oversight.

The AG argued that such an interpretation would lead to "other health facilities [] temporarily ceas[ing] operations in order to circumvent the Attorney General's review of a sale of those facilities' assets."[5] The court disagreed for two reasons: (1) as the hospital was not operating at the time of the sale, the "Legislature's objective of preserving charitable health facilities for the benefit of the uninsured is not implicated by the sale," and (2) such a strategy "defies credulity," as hospital closures result in significant value destruction as seen in the case at hand, where the sale value went from $19.5 million to $6.6 million, and as the court observed, are "time-consuming, costly, and requires fastidious planning."[6]

In re Verity Heath System of California, Inc. Exempts Sale of Nonprofit Hospitals to Public Entities from AG Oversight

About a year and a half later, the same federal bankruptcy court (and judge) furthered limited AG merger oversight by reasoning in *In re Verity* that the AG's oversight authority and previously imposed conditions do not apply when nonprofit hospitals are sold to public entities. In this case, Verity Health Systems, a nonprofit healthcare system, filed for bankruptcy and sought to sell two of its hospitals to the County of Santa Clara, which was already managing the Santa Clara Valley Medical

Center. While the main reason the court allowed the sale without conditions is because the AG initially did not contest or impose conditions, the court also stated the AG's merger oversight is limited to sales to for-profit or mutual benefit corporations.[7] The court held that (1) the sale of nonprofit health facilities to a public entity like County of Santa Clara is not subject to AG review and (2) conditions previously imposed on the hospitals for sale would no longer be applicable.[8]

In explaining its reasoning for the first holding, the court stated that "because public entities are required by law to furnish healthcare services to those in need," nonprofit health facilities sold to public entities will continue operations that are consistent with the "charitable mission and … public interest."[9] Therefore, there is no further need for the AG to review whether a sale to a public entity would be in line with the charitable mission or the public interest.

Furthermore, in describing its reasoning for the second holding, the court stated that the AG did not provide any "statutory provision permitting his continued enforcement of the Conditions."[10] Most importantly, the court wrote that the AG's "reliance upon provisions purporting to make the Conditions binding upon all successors, regardless of the circumstances under which such successors acquire the Hospitals, is an impermissible attempt to expand his regulatory authority over the Hospital."[11]

AB 2036 and Additional Amendments Can Resolve Loopholes in *In re Gardens* and *In Re Verity*

AB 2036, as introduced in the 2020 legislative session, seeks to rectify the loophole in *In Re Verity* by requiring that any previously imposed "condition shall remain in effect for the entire period of time specified by the Attorney General." (emphasis added) It specifically requires that "an additional or subsequent sale, transfer [. . .], or other disposition of assets" would not affect continued enforcement of the conditions. In doing so, AB 2036 would directly answer the court's reasoning in *In Re Verity*, which stated that there was no statute that allowed the AG to continually enforce previously imposed conditions.

However, AB 2036 still does not ensure AG review of the sale of closed, nonprofit hospitals (as in *In re Gardens*) or sales to public entities (as in *In re Verity*). It could be argued that the loophole in *In re Gardens*, namely preventing continued enforcement of conditions on previously closed hospitals that were sold and then reopened, was addressed by a pair of bills enacted in 2017 (AB 651 and SB 687) that allow the AG to review transactions "regardless of whether it is currently operating or providing health care services or has a suspended license." As both bills were amended to include this language post-*In re Gardens*, it may be possible that its inclusion was in response to the court decision.[12] Nonetheless, this amendment applied only to "a facility that provides similar health care" and did not specifically amend the definition of a "health facility", as defined in Section 1250 of the Health and Safety Code. As such, it's unclear if the court in *In re Gardens* would have differed in its analysis, which hinged on the definition of "health facilities" rather than "a facility that provides similar health care."

As such, to cover both exceptions entirely, legislators could amend AB 2036 with appropriate language to allow the AG to review any sale involving assets of a nonprofit health facility, regardless of whether it is continuously operating or to whom the facility is being sold. Furthermore, legislators should cite both bankruptcy cases discussed above as legislative intent to ensure proper AG oversight despite the court's reasoning in *In re Gardens* and *In Re Verity*.

If passed, AB 2036 would be applicable to federal bankruptcy proceedings, as amendments to the federal Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 (BAPCPA) provides that federal bankruptcy law would coexist with state, non-bankruptcy laws. This is important as the California Attorney General could continue to enforce conditions even if a hospital tries to release itself from the conditions via bankruptcy proceedings.

Conclusion

The AG review of a sale, transfer, or other forms of disposition of a nonprofit corporation's health facilities assets ensures that these hospitals provide sufficient healthcare access to the community despite budgetary concerns or profit motives. It

is important, therefore, that the AG continue to exercise such enforcement authority without limitations.

AB 2036 corrects, in part, the loophole identified in the federal bankruptcy case, *In re Verity Heath System of California, Inc.*, to ensure that the AG may continuously enforce previously imposed conditions on nonprofit hospitals when they are sold to a public entity. Such enforcement would help ensure continued healthcare access. However, the bill stops short and could do more to correct additional loopholes in *In Re Gardens* and *In Re Verity*, which prevent AG review for certain type of sales, such as the sale of closed hospitals and the sale of nonprofit hospitals to public entities. Nonetheless, AB 2036 is an important step to ensuring healthcare accessibility in the midst of increased healthcare consolidation.

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[1] In re Gardens Regional Hospital and Medical Center, No. 2:16-bk-17463-ER at *3 (Bankr. C.D. Cal. May 15, 2017).

[2] *Id.* at *5.

[3] *Id.* at *5-6.

[4] *Id.*

[5] *Id.* at *6.

[6] *Id.* at *7.

[7] In re Verity Health System of California, Inc., No. 2:18-bk-20151-ERat *9, *10 (Bankr. C.D. Cal. Dec. 26, 2018).

[8] *Id.* at *10-11.

[9] *Id.* at *10.

[10] *Id.* at *11.

[11] *Id.* at *11.

[12] The bill analyses for either bill did not indicate the *Gardens* court case as a reason for the amendment.