This month, our round-up proudly features a new issue brief written by our Source colleagues that discuss what state regulators need to strengthen state antitrust laws and prevent further healthcare provider consolidation. Also highlighted in this month's round-up are studies on the potential impact of the federal No Surprises Act on health care prices, state-level strategies to reduce health care spending, better methods to assess policy-relevant financial information of hospitals, a grassroots push towards the public option, and industry trends and implications in the pharmacy market.
In a new Milbank Memorial Fund issue brief written by the Source team, Alexandra D. Montague, Katherine L. Gudiksen and Jaime S. King round off the second installment of a three-part series looking at antitrust enforcement. The first brief argues that both state and federal antitrust enforcement is critical to address the rising costs that result from consolidation. The second brief, "State Action to Oversee Consolidation of Health Care Providers," examines the importance of well-designed state merger review authority in preventing further consolidation and better oversight of approved transactions. The brief identifies the key elements of a comprehensive merger review framework and analyzes how state regulators and enforcers can use and augment their existing authority to address health care consolidation.

Price Transparency
The federal No Surprises Act, designed to protect consumers from surprise out-of-network medical bills, may be effective at lowering prices for certain services, according to a new report. Published in the JAMA Network, researchers Ambar La Forgia, Amelia Bond, and Robert Tyler Braun discuss the "Association of..."
Surprise-Billing Legislation with Prices Paid to In-Network and Out-of-Network Anesthesiologists in California, Florida, and New York. In comparing prices paid for anesthesiology services in the three states, all of which had passed surprise-billing legislation, the research team analyzed claims from hospital outpatient departments and ambulatory surgery centers for patients in preferred provider organizations and point-of-service plans from 2014 to 2017. The study found that after the three states passed comprehensive surprise-billing legislation, prices paid to anesthesiologists working in hospital outpatient departments and ambulatory surgery centers decreased. These findings illustrate how health care prices could change following the passage of state or federal laws against surprise billing.

Healthcare Market and Costs

Rising health care spending continues to be a concern for state governments and their constituents, who are facing greater out-of-pocket costs and premiums. Researchers Michael E. Chernew, David A. Cutler, and Shivani A. Shah discuss various approaches states can take to control spending growth in "Reducing..."
Health Care Spending: What Tools Can States Leverage?

The Commonwealth Fund report highlights several potential strategies, ranging from efforts to promote competition, reduce prices, or decrease utilization of low-value care to broader strategies that address overall spending. The report also describes how health policy commissions can play a central role in supporting any of these efforts. Given limits to significant federal action, states are better positioned to take the lead on implementing a variety of cost control reforms, all of which can be tailored in ways that work best for each state.

Policymakers need a clear picture of the health care system's financial health to make consequential policy decisions, but where do they get this information? In a report published by the Journal of Healthcare Finance, researchers argue that policymakers often rely on income statement-related metrics that don't paint the full picture of a hospital's financial health. The study, authored by The Source's Advisory Board member Robert Berenson et al., discusses "Why Policymakers Should Use Audited Financial Statements to Assess Health Systems' Financial Health." It identifies a broader range of policy-relevant financial indicators of
Hospital financial health than those reported in an income statement. The study calls for regulators to amass audited financial statements in a national database accessible to the public. According to researchers, a national database of these statements would be an important tool for more informed and socially beneficial policymaking.

Health System Reform

President Biden campaigned on a promise to create a federal public health insurance option, but health policy experts predict a legislative stall on the plan in the near term. Given the close division of power in Washington, Biden’s public option for healthcare is seemingly off the table, but Jacob S. Hacker argues that instead of giving up on it, advocates should recast it through a strategic, self-reinforcing form of advocacy. In his article "Between the Waves: Building Power for a Public Option," published by the Journal of Health Politics, Policy and Law, Hacker describes a path to the public option that involves building power through policy – using the openings that are likely to exist in the near term to reshape the political landscape for the long term. To make this argument, Hacker lays out three interim
steps that could advance the public option’s prospects: 1) pursue immediate improvements in the ACA that are tangible and traceable yet do not work against the eventual creation of a public option, 2) build the necessary foundations for a public option within Medicare while encouraging progressive states to experiment with state public plan models, and 3) seed and strengthen movements to press for more fundamental reform. Rather than coming up with new proposals that cannot be passed in the near term, Hacker’s plan seeks to refine the basic vision of the public option and pursue interim steps that can help build the necessary power to pass it.

Pharmaceuticals

Having expanded from traditional hospitals to serve as medication experts in a broad range of other settings, the pharmacy market plays an increasingly prominent role in the health care system. As such, policymakers working towards containing prescription drug costs should understand the market shifts and their implications for the affordability of prescription drugs. Writing for the Commonwealth Fund, Elizabeth Seeley and Surya Singh explore trends in the
pharmacy market and their impact on drugs prices and spending in “Competition, Consolidation, and Evolution in the Pharmacy Market.” Specifically, their brief identifies and reviews four main aspects of the pharmacy industry that affect drug spending: 1) increased pharmacy consolidation and vertical integration, 2) rising challenges facing independent pharmacies, 3) growth of specialty pharmacies, and 4) the evolving role of mail-order pharmacies and e-commerce platforms. How policymakers grapple with containing prescription drug costs may depend on their ability to leverage their understanding of these dynamics in the specific market.

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!

Trends in Price and Quality
Transparency

- All-Payer Claims Database
- Surprise Billing Protections

All Payer Claims Databases (APCD)

For more on APCD’s, check out the report "The Secret of Health Care Prices: Why Transparency Is in the Public Interest".

- Surprise Billing Protections

State Surprise Billing
Protections

For more on state surprise billing statutes, refer to our Issue Brief on The Source Blog.

Recent Action in Price and Quality Transparency

- Recent Legislation
- Recent Litigation
- Recent Legislation
payer claims database; reflecting that Health Care Authority is part of the organizational structure of the Department of Health and Human Resources and is no longer a separate governmental agency; and clarifying and accurately delineating the roles of the entities responsible for the all-payer claims database.

To: (1) Require the Office of Health Strategy to (A) develop, innovate, direct and oversee health care delivery and payment models, (B) develop and adopt health care quality benchmarks, (C) enhance the transparency of health care entities, (D) monitor the development of accountable care organizations and patient-centered medical homes, and (E) monitor the adoption of alternative payment methodologies; (2) require the executive director of the Office of Health Strategy to (A) establish annual health care cost growth benchmarks and primary care targets, (B) submit an annual report to the General Assembly, (C) establish standards governing submission of data, information and documents by certain persons, (D) prepare and disclose an annual report concerning health status adjusted total medical expenses, (E) at least annually, submit a request to the federal Centers for Medicare and Medicaid Services for
the health status adjusted total medical expenses of provider organizations that serve Medicare patients, (F) identify and examine any health care entity or payer that exceeds any annual health care cost growth benchmark and take enforcement action against such entity or payer, and (G) develop and adopt annual health care quality benchmarks for health care entities and payers; (3) require certain providers and provider organizations to annually submit certain data, information and documents to the Office of Health Strategy; (4) authorize the Office of Health Strategy to (A) enter into certain contractual agreements with third parties, and (B) adopt certain regulations; (5) subject to approval by the federal government, require the Commissioner of Consumer Protection to establish a Canadian legend drug importation program and authorize the commissioner, in consultation with the Commissioner of Public Health, to adopt regulations to implement such program; (6) adopt the Insurance Commissioner’s recommendations concerning stop-loss insurance; (7) subject to approval by the federal government, require the Office of Health Strategy, in conjunction with the Office of Policy and Management, Insurance Department and Health Reinsurance Association, to establish a reinsurance program; (8) require the
Auditors of Public Accounts to annually conduct an audit of certain health care plans administered or offered by this state and disclose the results of such audit to the General Assembly; (9) establish term limits for members of the board of directors of the Connecticut Health Insurance Exchange and require that members appointed or reappointed to the board have insurance expertise; (10) require the Connecticut Health Insurance Exchange to (A) conduct a public meeting before charging an assessment or user fee to certain health carriers, increasing the amount of any such assessment or fee or implementing or changing any process used to calculate any such assessment or fee, and (B) receive the approval of the joint standing committee of the General Assembly having co-

AN ACT CONCERNING HOSPITAL BILLING AND COLLECTION EFFORTS BY HOSPITALS AND COLLECTION AGENTS. To: (1) Restrict (A) the amount that a hospital or collection agent may recover from an uninsured or underinsured patient for the unpaid cost of health care, and (B) the manner in which a hospital or collection agent may secure or recover payment for the unpaid cost of health care; and (2) modify provisions concerning hospital billing.
practices to protect patients who receive health care at outpatient clinics that are owned by, or affiliated with, hospitals.

AN ACT CONCERNING OUT-OF-NETWORK HEALTH CARE PROVIDERS. To require an out-of-network health care provider to inform an insured that the provider is out-of-network, and provide the insured with an opportunity to decline to receive health care services from the provider, before the provider provides health care services to the insured.

AN ACT REQUIRING AN ANNUAL AUDIT AND REPORT CONCERNING CERTAIN HEALTH CARE PLANS ADMINISTERED BY THIS STATE. To provide for greater transparency in, and legislative oversight of, health care plans administered by this state and offered to persons other than state employees.

AN ACT CONCERNING HEALTH CARE AND HEALTH INSURANCE IN CONNECTICUT. To reduce the cost of, and provide for additional transparency regarding, the cost of health care and health insurance in this state.

AN ACT REQUIRING DISCLOSURE AND PRIOR LEGISLATIVE APPROVAL OF SEVERANCE AND NONDISCLOSURE AGREEMENTS WITH THE
• Recent Litigation
may contain more than one subject, which must be clearly stated in its title. Here, the original bill was intended to regulate and fund the Bureau of Worker's Compensation, and the transparency provision was an "unnatural," unrelated addition to the bill intended to cover another subject. Additionally, the court held the transparency provision also violated the Ohio Constitution's three-reading rule, which requires every bill to be considered by each house on three different days. The court said the entire legislative history of that bill had been about workers compensation, and when it passed both the House and Senate, it contained no reference to health care price transparency. Then on June 25, 2015, with no hearings or prior introduction, the amendment was added with the price transparency act. Attorney General David Yost's office filed an appeal March 14, 2020.

The 2019 Oklahoma law, Patient's Right to Pharmacy Choice Act, targets PBM conflict of interest by prohibiting higher reimbursement rates for PBM-owned pharmacies and bans PBMs from preventing pharmacies to disclose cost information to consumers. PCMA filed suit in Oklahoma district court just before the new law takes effect on November 1, 2019, arguing that the law "operates
primarily to weaken competition among pharmacies by limiting the ability of PBMs to offer their cost-saving and quality assurance initiatives within the State of Oklahoma. The parties agreed to a stay in the lawsuit as the Supreme Court had granted review of the lawsuit challenging a similar Arkansas law, PCMA v. Rutledge.

In September 2017, just three months after Nevada passed its insulin transparency law (SB 539) in June 2017 to increase transparency over the price of diabetes drugs, two drug lobbying groups, the Pharmaceutical Research and Manufacturers of America (PhRMA) and the Biotechnology Innovation Organization (BIO), filed a lawsuit asking the U.S. District Court to declare that federal law preempts several provisions of the transparency law. SB 359 requires drug manufacturers to report a range of pricing information for a list of essential diabetes drugs compiled by the state, including pricing history and costs, price hikes above inflation, and rebates paid to pharmacy benefit managers (PBMs). Plaintiffs sued the state claiming the law is unconstitutional and deprives drug makers of their right to protect trade secrets under the Fifth Amendment. The case was voluntarily dismissed after Nevada's Department of Health and
Human Services adopted a trade secret option that would allow pharmaceutical companies to keep certain drug pricing data confidential when they begin complying with the new transparency law, provided they explain why the information shouldn't be disclosed to the public. Documents related to the case can be found here.

Act 900 (SB 688), enacted in 2015, required disclosure of generic drug pricing and sets a floor on prices that PBMs can pay to pharmacies for generic drugs. Pharmaceutical Care Management Association (PCMA), a trade association representing PBMs, brought the suit against the state in 2015.

Closely following the 8th Circuit decision in PCMA v. Gerhart handed down just two months earlier which struck down a similar Iowa law, the District Court of Arkansas was compelled to strike down the Arkansas law in March 2017. The district court found that ERISA preempted the law but Medicare Part D did not.

The 8th Circuit affirmed on appeal and held that both ERISA and Medicare Part D preempted Arkansas' drug pricing law Act 900. Arkansas filed a petition for certiorari, requesting the Supreme Court
to review the case, citing split circuit court decisions in the matter of ERISA preemption of PBM laws among the 1st Circuit, 8th Circuit, and D.C. Circuit, which created ‘‘confusion and uncertainty’’ about state power to regulate drug prices.” Multiple states including California and New York signed on the amicus brief to the Supreme Court, urging review of the case.

In January 2020, the Supreme Court granted certiorari of the case. Oral arguments originally set for April 2020 has been postponed due to the coronavirus outbreak.

PhRMA is challenging California’s drug price transparency law SB 17 alleging that the law is unconstitutional because it violates the Commerce Clause, the First Amendment, and the Due Process Clause. SB 17, which Gov. Jerry Brown signed 10/9/17, requires pharmaceutical companies to notify insurers and government health plans 60 days in advance of a price increase above a certain threshold and provide a rationale for it. After California federal court’s dismissed the original suit (PhRMA v. Brown) on procedural grounds, on September 28, 2018, PhRMA amended and refiled its complaint as PhRMA v. David.
In a significant victory for the pharmaceutical industry, the 4th U.S. Circuit Court of Appeals found Maryland’s landmark 2017 law (HB 631), which punishes generic drug manufacturers for price gouging, unconstitutional because it violates the dormant commerce clause. The April 2018 ruling reversed the lower court’s decision in a lawsuit originally brought by the generic pharmaceutical industry led by the Association for Accessible Medicines (AAM).

In February 2019, the Supreme Court denied certiorari to review the 4th Circuit decision, effectively putting the nail on the coffin on the law.
If you would like to report a possible data discrepancy, please email info@sourceonhealthcare.org or contact The Source here.