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 Carolina page.

North Carolina is a state that is active in antitrust enforcement in the healthcare market. In addition to prohibiting most-favored nation clauses in provider contracts, the state is also the site of a major enforcement case that alleged anticompetitive contract practice in a lawsuit against Atrium Health (formerly Carolinas Healthcare System). Joining the Department of Justice, the North Carolina state attorney general sued the
provider for using illegal anti-steering and anti-tiering clauses in its contracts with insurers, which prohibited commercial health insurers in the Charlotte area from offering patients financial benefits to use less-expensive healthcare services offered by Atrium's competitors. The case settled when Defendants agreed to end their anticompetitive practices. Additionally, while noncompete agreements for physicians in North Carolina are not per se unenforceable, the Court of Appeals of North Carolina has recognized in several cases its potential for harm to the public health and found noncompetes unenforceable (see Aesthetic Facial & Ocular Plastic Surgery Ctr., P.A. v. Zaldivar and Calhoun v. WHA Med. Clinic, PLLC).

The North Carolina AG has also been active in enforcing merger oversight of healthcare providers in the state. State law requires prior notice to the state AG for healthcare transactions involving certain charitable or religious corporations and the written consent or court approval of the merger after review based on a criteria of public interest. In response to a wave of healthcare consolidation in North Carolina, the state repealed its certificate of public advantage law in 2015, which some
argued have contributed to increased consolidation and market power in the provider market. Additionally, Attorney General Josh Stein released a statement in 2021 criticizing and expressing concerns over the potential impact of consolidation and warned of increased scrutiny of proposed mergers by the AG's office. For example, in HCA's acquisition of Mission Health System, the AG imposed conditions that would permit the office to take legal action under North Carolina law should HCA fail to comply with its commitments under the consent order.

North Carolina is also a national leader in value-based payment reforms. The state implemented various alternative payment initiatives in both the public and private sectors, including Medicaid managed care alternative payment models, Medicare ACOs, BCBS North Carolina ACOs, and state employee health plan reference pricing strategy. North Carolina is on track to see alternative payment models account for 70% of healthcare payments in the state. In health care transparency, the state legislature enacted law that requires the NC Department of Health and Human Services to publish charge information relating to the most frequently reported admissions. However, the state still lacks
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Medi-Cal: County of Sacramento.

Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which health care services are provided to qualified low-income persons under various health care delivery systems, including fee-for-service and managed care. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law authorizes the department to enter into various types of contracts for the provision of services to beneficiaries, including contracts with Medi-Cal managed care plans.

Existing law provides that in counties selected by the Director of Health Care Services with the concurrence of the county, a special county health authority may be established, and in any county, by ordinance, a special commission may be established, in order to meet the problems of delivery of publicly assisted medical care in each county, and to demonstrate ways of promoting quality care and cost efficiency. Existing law authorizes several counties, including the County of Alameda, to establish, by ordinance, a health authority, and specified counties, such as the Counties of San Joaquin and Tulare, to establish,
by ordinance, a special county health commission.

This bill would authorize the Board of Supervisors of the County of Sacramento to establish a health authority to perform specified duties, including negotiating and entering into contracts with health plans, as prescribed. The bill would require the health authority to meet with any health plans intending to contract with the department, and, subsequent to meeting with all interested health plans, to designate to the department at least 2 licensed health plans for the department's approval based on specified criteria.

(2) This bill would make legislative findings and declarations as to the necessity of a special statute for the County of Sacramento.

Communications: California Advanced Services Fund: deaf and disabled telecommunications program: surcharges.

(1) Under existing law, the Public Utilities Commission has regulatory authority over public utilities, including telephone corporations. Existing law requires the commission to develop, implement, and administer the California Advanced Services Fund (CASF) to encourage deployment of high-quality advanced communications services to all
Californians that will promote economic
growth, job creation, and the substantial
social benefits of advanced information
and communications technologies.

Existing law authorizes the commission
to impose a surcharge to collect
$330,000,000 for deposit into the CASF
beginning January 1, 2018, and
continuing through the 2022 calendar
year. Existing law specifies the amount of
surcharge revenues to be deposited into
each account within the CASF, subject to
appropriation by the Legislature.

This bill would authorize the commission
to impose the surcharge to fund the
CASF until December 31, 2032, as
specified.

Existing law requires the commission,
until April 1, 2023, to annually report
specified information to the Legislature,
including the remaining unserved areas
in the state, the status of the CASF
balance, and the projected amount to be
collected in each year.

This bill would require the commission to
report that information in perpetuity.

This bill would authorize the commission
to require each internet service provider,
as defined, to report specified
information regarding each free, low-
cost, income-qualified, or affordable
internet service plan advertised by the
provider.
to require interconnected Voice over Internet Protocol service providers to collect and remit surcharges on their California intrastate revenues in support of specified public purpose program funds. Existing law authorizes those providers to use certain methodologies to identify their intrastate revenues subject to the surcharge. This bill would repeal that authorization to use those methodologies.

Existing law establishes the deaf and disabled telecommunications program and requires the commission to establish a rate recovery mechanism through a surcharge not to exceed 1/2 of 1% uniformly applied to a subscriber’s intrastate telephone service, other than one-way radio paging service and universal telephone service, until January 1, 2025, to allow providers of equipment and service pursuant to that program to recover their costs as they are incurred. This bill would revise those requirements to instead require the commission to administer a surcharge to collect revenues of up to $100,000,000 per year until January 1, 2025, subject to annual appropriation of moneys by the Legislature, to allow providers of equipment and service pursuant to the deaf and disabled telecommunications program to recover their costs as they are incurred.
Under existing law, a violation of the Public Utilities Act or any order, decision, rule, direction, demand, or requirement of the commission is a crime. Because certain of the above provisions would be part of the act and a violation of a commission action implementing this bill's requirements would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.

This bill would become effective only if SB 4 of the 2021–22 Regular Session is enacted and takes effect on or before January 1, 2022.

This bill would declare that it is to take effect immediately as an urgency statute.

Health care coverage: employer associations.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, requires the Department of Managed Health Care to license and regulate health care service plans and makes a willful
violation of the act a crime. Existing law also requires the Department of Insurance to regulate health insurers. Existing law regulates individual, small employer, and large employer health care service plan contracts and health insurance policies, as defined. Existing federal law, the federal Employee Retirement Income Security Act of 1974 (ERISA), authorizes multiple employer welfare arrangements (MEWAs) in which two or more employers join together to provide health care coverage for employees or to their beneficiaries. Under existing state law, the status of each distinct member of an association determines whether that member’s association coverage is individual, small group, or large group health coverage.

This bill would authorize an association of employers to offer a large group health care service plan contract or large group health insurance policy consistent with ERISA if certain requirements are met, including that the association is headquartered in this state, is a MEWA as defined under ERISA, and was established as a MEWA prior to March 23, 2010, and has been in continuous existence since that date. The bill would also require the large group health care service plan contract or health insurance policy to have provided a specified level...
of coverage as of January 1, 2019, and to include coverage for employees, and their dependents, who are employed in designated job categories on a project-by-project basis for one or more participating employers, with no single project exceeding 6 months in duration, and who, in the course of that employment, are not covered by another group health care service plan contract or group health insurance policy in which the employer participates. The bill would also require the MEWA and participating employers to have a genuine organizational relationship unrelated to the provision of health care benefits and would require the participating employers to have a commonality of interest from being in the same line of business, as specified.

This bill would require the MEWA, on or before June 1, 2022, to file an application for registration with the Department of Managed Health Care or the Department of Insurance, as applicable, and to annually file evidence of ongoing compliance with the bill's requirements with the applicable department. The bill would prohibit a health care service plan or health insurer, on or after June 1, 2022, from marketing, issuing, amending, renewing, or delivering large employer health care coverage or large employer health insurance coverage to a MEWA.
that provides benefits to a resident in this state unless the MEWA is registered and is in compliance with the bill or unless the MEWA filed an application for registration and the application is pending before the applicable department.

Because a violation of the bill by a health care service plan would be a crime, the bill would impose a state-mandated local program.

(2) This bill would incorporate additional changes to Section 1357.503 of the Health and Safety Code and Section 10753.05 of the Insurance Code proposed by SB 326 and SB 718 to be operative only if this bill and SB 326, SB 718, or both are enacted and this bill is enacted last.

(3) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.


(1) Existing law provides for the licensure and regulation of various healing arts professions and vocations by boards
within the Department of Consumer Affairs. Under existing law, it is unlawful for healing arts licensees, except as specified, to offer, deliver, receive, or accept any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, in the form of money or otherwise, as compensation or inducement for referring patients, clients, or customers to any person, subject to certain exceptions. This bill would provide that the payment or receipt of consideration for internet-based advertising, appointment booking, or any service that provides information and resources to prospective patients of licensees does not constitute a referral of a patient if the internet-based service provider does not recommend or endorse a specific licensee to a prospective patient.

(2) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a contract issued, amended, or renewed on or after January 1, 2021, between a health care service plan or health insurer and a health care provider to require the
plan or insurer to reimburse the provider for the diagnosis, consultation, or treatment of an enrollee, subscriber, insured, or policyholder appropriately delivered through telehealth services on the same basis and to the same extent as the same service through in-person diagnosis, consultation, or treatment. This bill would delete that date restriction, thereby extending the telehealth reimbursement parity requirement for all contracts between a health care service plan or a health insurer and a health care provider. The bill would provide that these provisions are severable. The bill would also enact the Protection of Patient Choice in Telehealth Provider Act, and would require a health care service plan and a health insurer to comply with specified notice and consent requirements if the plan or insurer offers a service via telehealth to an enrollee or an insured through a third-party corporate telehealth provider, as defined. For an enrollee or insured that receives specialty telehealth services for a mental or behavioral health condition, the bill would require that the enrollee or insured be given the option of continuing to receive that service with the contracting individual health professional, a contracting clinic, or a contracting health facility. The bill would
exempt specified health care service plan contracts and Medi-Cal managed care plan contracts from those provisions. The bill would require the State Department of Health Care Services to consider the appropriateness of applying those requirements to the Medi-Cal program, as specified. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

(3) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.

Health care coverage: federal health care reforms.

(1) Existing federal law, the Patient Protection and Affordable Care Act (PPACA), enacts various health care market reforms. Among other things, PPACA requires applicable individuals to maintain minimum essential coverage, and imposes a shared responsibility penalty on an applicable individual who does not maintain minimum essential coverage. This provision is referred to as
the individual mandate. PPACA prohibits a nongrandfathered health benefit plan from imposing a preexisting condition provision on an individual and requires a nongrandfathered health benefit plan to include coverage for essential health benefits, as defined. PPACA also includes a coverage guarantee that requires each health insurance issuer that offers health insurance coverage in the individual or group market in a state to accept every employer and individual in the state that applies for coverage, and prohibits discriminatory premium rates, as specified.

Existing state law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires the above-described federal health care coverage market reforms to apply to a health care service plan or health insurer, but conditions the operation of certain of these market reforms on the continued operation of PPACA or certain of its requirements. This bill would delete the conditional operation of the above-described provisions based on the continued
operation of PPACA, the federal individual mandate, the federal coverage guarantee, and federal essential health benefits coverage requirements. By indefinitely extending the operation of these provisions, and thus indefinitely extending the applicability of a crime for a willful violation by a health care service plan, the bill would impose a state-mandated local program.

(2) This bill would incorporate additional changes to Section 1357.503 of the Health and Safety Code and Section 107530.5 of the Insurance Code proposed by SB 255 and SB 718 to be operative only if this bill and SB 255 and SB 718, or both, are enacted and this bill is enacted last.

(3) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.

Nurses: implicit bias courses. Existing law, the Nursing Practice Act, requires the Board of Registered Nursing to prepare and maintain a list of approved schools of nursing in this state whose graduates are eligible to apply for
a license to practice nursing. Existing law specifies that an approved school of nursing, or an approved nursing program, is one that has been approved by the board, gives the course of instruction approved by the board, covering not less than 2 academic years, is affiliated or conducted in connection with one or more hospitals, and is an institution of higher education.

This bill would require an approved school of nursing or an approved nursing program to include direct participation in one hour of implicit bias training, as specified, as a requirement for graduation. The bill would prohibit that provision from being construed to require a curriculum revision or to affect the requirements for licensure or endorsement under the Nursing Practice Act.

Existing law requires a person holding a regular renewable license under the act, whether in an active or inactive status, to renew their license and pay the biennial renewal fee, as specified. Existing law requires a person renewing their license to submit proof satisfactory to the board that, during the preceding 2-year period, they completed specified continuing education requirements, unless the licensee is still within the first 2 years of holding their license immediately following their initial licensure.
This bill would, starting January 1, 2023, require a licensee still within the first 2 years of holding their license immediately following their initial licensure to complete one hour of direct participation in an implicit bias course, as specified, offered by a continuing education provider that has been approved by the board.

Existing law requires a hospital that provides perinatal care, and an alternative birth center or a primary clinic that provides services as an alternative birth center, to implement an evidence-based implicit bias program, as specified, for all health care providers involved in perinatal care of patients within those facilities.

This bill would require a hospital, as defined, to implement an evidence-based implicit bias program, as specified, as part of its new graduate training program that hires and trains new nursing program graduates. Under the bill, a hospital that hires and trains new nursing program graduates involved in the perinatal care of patients, as specified, that complies with existing implicit bias program requirements on hospitals that provide perinatal care, would meet the implicit bias program requirements with respect to those new nursing program graduates involved in the perinatal care of patients.
Health care coverage: timely access to care.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires each department to develop and adopt regulations to ensure that enrollees and insureds have access to needed health care services in a timely manner. Under existing law, a Medi-Cal managed care plan is required to comply with timely access standards developed by the department.

Existing regulations require a health care service plan or an insurer to ensure that their contracted provider networks have adequate capacity and availability of licensed health care providers to offer enrollees and insureds appointments that meet specified timeframes. Existing regulations require a health care service plan or an insurer to ensure that for an enrollee requesting a nonurgent appointment with a nonphysician mental health care provider, or an insured requesting a nonurgent appointment with a nonphysician mental health care or substance use disorder provider, appointments are offered within 10 business days of the request for an
appointment. Existing regulations also authorize appointments for preventive care services and periodic followup care, including periodic office visits to monitor and treat mental health or substance use disorder conditions, as specified, to be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the provider's scope of practice. These regulations of the Department of Managed Health Care are limited in application to mental health care providers, while those regulations of the Department of Insurance are applicable to both mental health care and substance use disorder providers.

This bill would codify the regulations adopted by the Department of Managed Health Care and the Department of Insurance to provide timely access standards for health care service plans and insurers for nonemergency health care services. The bill would require both a health care service plan and a health insurer, including a Medi-Cal Managed Care Plan, to ensure that appointments with nonphysician mental health and substance use disorder providers are subject to the timely access requirements, as specified. The bill would additionally require, commencing July 1, 2022, a health care service plan and a
health insurer, including a Medi-Cal Managed Care Plan, to ensure that an enrollee or insured that is undergoing a course of treatment for an ongoing mental health or substance use disorder condition is able to get a followup appointment with a nonphysician mental health care or substance use disorder provider within 10 business days of the prior appointment. The bill would require that a referral to a specialist by another provider meet the timely access standards. If a health care service plan is operating in a service area that has a shortage of providers and the plan is not able to meet the geographic and timely access standards for providing mental health or substance use disorder services with an in-network provider, the bill would require the plan, including a Medi-Cal Managed Care Plan, to arrange coverage outside the plan's contracted network. By imposing new requirements on health care service plans, the willful violation of which would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no
- **Recent Litigation**
Obamacare continued with new fervor. After numerous failed attempts to repeal the law directly, Congress modified the ACA as part of its tax reform package, the Tax Cuts and Jobs Act of 2017, in December 2017. The tax bill changed the penalty for failing to have health insurance from $695 for an adult to $0, eliminating the tax. Republicans did so for three reasons. First, the Congressional Budget Office predicted that eliminating the penalty would reduce the federal deficits by $338 million between 2018 and 2027, which Republicans needed to successfully pass their planned tax cuts. Second, it allowed them to claim that they had delivered on their campaign promises of repealing at least some portion of the ACA. Third, it would allow them to once again challenge the constitutionality of the individual mandate, as it no longer functioned as a tax, and as a result, challenge the entirety of the ACA.

In February 2018, 20 state attorneys general filed suit in the Northern District of Texas against the Department of Health and Human Services and the Internal Revenue Service (Texas v. U.S.) claiming that under the Supreme Court’s ruling in NFIB, the elimination of the tax penalty voids the constitutionality of the individual mandate and the entirety of
the Patient Protection and Affordable Care Act ("ACA"). They argue that because the Supreme Court's validation of the ACA's constitutionality in 2012 "rested solely on the flimsy support of Congress' authority to tax," now that the tax penalty is eliminated, the entire law is unconstitutional and invalid. On April 9, 2018, another group of state attorneys general filed a motion to intervene in the case to protect the benefits promised to their citizens and more than $650 billion in federal money scheduled to come to the states under the ACA to provide health care.

U.S. District Judge Reed O'Connor heard oral arguments in a three-hour hearing on September 5, 2018. On December 14, 2018, he issued an opinion that struck down the entire ACA as unconstitutional. The judge ruled in favor of the plaintiffs by determining that the "individual mandate" is no longer a tax and is therefore an unconstitutional exercise of congressional authority. The judge also found that the individual mandate was inseverable from the rest of the ACA, which makes the entire ACA unconstitutional. The intervening states appealed the case to the 5th Circuit Court of Appeals and the U.S. House of Representatives joined the appeal.
On December 18, 2020, the three-judge panel of the 5th Circuit ruled two to one that the individual mandate was unconstitutional in the absence of a tax penalty, and remanded the case back to Judge O'Connor in the Texas District Court to determine whether the individual mandate can be severed from the rest of the ACA or the entire law must fall with the individual mandate.

Twenty democratic states and the House of Representatives immediately appealed the 5th Circuit decision to remand the case on severability (California et al. v. Texas et al.) to the Supreme Court for an expedited review in the 2019-2020 term, but the court declined the motion on January 21, 2020. The States and the House of Representatives also asked the 5th Circuit to review the decision en banc, meaning in front of the entire 5th Circuit, and the fourteen judge court decided along party lines (8-6) to decline the request to review the decision on January 29, 2020.

However, in March 2020, the Supreme Court granted review of the 5th Circuit’s decision for the 2020-2021 term and consolidated the two cases Texas v. United States and California v. Texas. The Supreme Court review would...
considerably fast-track the case by bypassing the lower court remand. The case is expected to be heard in Fall 2020 (oral arguments) and decided by June 2021.

CBO predicted that the savings would result from the nearly 13 million people that would lose health insurance coverage by 2027 from repeal of the penalty.

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