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 along with Nancy Kane 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
Financial statements from hospitals are an important tool for informed policymaking. Researchers have called for regulators to amass audited financial statements in a national database accessible to the public.

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 but 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
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!
System Reform

State Public Option Proposals

Recent Action in Healthcare System Reform

- Recent Legislation
- Recent Litigation
- Recent Legislation
payment models, (B) develop and adopt healthcare quality benchmarks, (C) enhance the transparency of healthcare 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 healthcare 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 healthcare 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
AN ACT ESTABLISHING A SINGLE PAYER HEALTH CARE PROGRAM IN CONNECTICUT.

To: (1) Establish (A) a self-insured single payer health care program for this state, and (B) various agencies and entities to oversee this state's single payer health care program; and (2) request a waiver from the federal government pursuant to the Patient Protection and Affordable Care Act.

AN ACT ESTABLISHING A COMMISSION TO STUDY A HUSKY FOR ALL SINGLE PAYER, UNIVERSAL HEALTH CARE PROGRAM.

To establish a commission to conduct an economic analysis of establishing a single payer, universal health care program.

AN ACT CONCERNING A STUDY OF MEDICAID-FUNDED PROGRAMS. To study the efficacy of Medicaid-funded programs.
INSURANCE AND HEALTH CARE IN CONNECTICUT. To: (1) Authorize the Comptroller to offer health coverage to plan participants and beneficiaries in this state under a multiemployer plan, nonprofit employers and their employees; (2) assess an annual fee against certain insurers, health care centers and exempt insurers; (3) require the Connecticut Health Insurance Exchange to (A) administer the “Connecticut Health Insurance Exchange account”, (B) consult with the Office of Health Strategy to develop and, if approved, implement a plan to (i) establish a subsidiary, (ii) seek a state innovation waiver, and (iii) use the moneys deposited in said account for the purposes set forth in the plan, (C) consult with the Commissioner of Social Services to develop and, if approved, implement a methodology to determine eligibility for the working persons with disabilities program, and (D) determine whether certain individuals referred to the exchange by the Labor Commissioner are eligible for free or subsidized health coverage or other assistance or benefits and, if such individuals are eligible for such coverage, assistance or benefits, enroll such individuals in such coverage, assistance or benefits; (4) establish the “Connecticut Health Insurance Exchange account”; (5) require certain
qualified health plans offered through the exchange to (A) provide coverage for certain benefits, (B) have a minimum actuarial value of at least seventy percent, and (C) provide enrollees with access to the broadest provider network available under the qualified health plans offered by the health carrier through the exchange; (6) require the Office of Health Strategy to (A) annually determine, and disclose to the Office of Policy and Management, the amount of an annual assessment against certain insurers, health care centers and exempt insurers, and (B) develop, and submit to the joint standing committee of the General Assembly having cognizance of matters relating to insurance for approval, a plan for the exchange to (i) establish a subsidiary to create a marketplace for health carriers to offer affordable health insurance coverage to persons who are ineligible for coverage under the qualified health plans offered through the exchange, (ii) seek a state innovation waiver to (I) reduce the cost of health insurance in this state, (II) make health insurance coverage available to persons in this state who are ineligible for coverage under a qualified health plan offered through the exchange, and (III) allow persons to receive coverage under the working persons with disabilities...
program through the exchange, and (iii) use the moneys deposited in the "Connecticut Health Insurance Exchange account" to (I) reduce the cost of qualified health plans offered through the exchange, (II) make coverage affordable for persons who are ineligible for coverage under a qualified health plan offered through the exchange, and (III) implement the state innovation waiver if the federal government issues such waiver; (7) (A) require the Commissioner of Social Services to amend the Medicaid state plan to develop a methodology to determine eligibility for the working persons with disabilities program and delegate authority to the exchange to determine eligibility for said program, and (B) expand eligibility for said program; (8) expand eligibility for medical assistance under the state's Medicaid program; and (9) require the Labor Commissioner to (A) notify applicants for unemployment compensation benefits that such applicants may be eligible for free or subsidized health coverage or other assistance or benefits, and (B) refer such applicants to the Connecticut Health Insurance Exchange.

AN ACT ESTABLISHING A TASK FORCE TO STUDY HEALTH INSURANCE AND HEALTH CARE INEQUITY IN THIS
To establish a task force to: (1) Study inequity in the provision of health insurance coverage and health care services in this state; and (2) identify any means available to promote equity in the provision of health insurance coverage and health care services in this state.

Recent Litigation

[Consolidated with California et al. v. Texas et al. for Supreme Court review]

This case arises out of the Supreme Court's decision in NFIB v. Sebelius and the Tax Cuts and Jobs Act of 2017. In NFIB v. Sebelius, the National Federation of Independent Business and 26 state attorneys general challenged Congress' ability to require Americans to purchase health insurance, as doing so would regulate inaction, as opposed to action, in commerce. Finding justifications grounded in interstate commerce or the Necessary and Proper clause lacking, Chief Justice Roberts rested the constitutionality of the individual mandate on the fact that it functioned as a tax – citizens had to prove that they had qualifying health insurance or pay the shared responsibility payment, which was collected by the I.R.S. when people filed
their tax returns. Robert’s opinion did not save the individual mandate from controversy for long, however. Following the 2016 election of Donald Trump, the Republican attack on 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
claiming that under the Supreme Court's ruling in *NFIB*, the elimination of the tax penalty voids the constitutionality 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.](#)