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.

North Dakota is one of the few states that bans most-favored nation clauses in provider contracts. It is also one of the even fewer states that prohibits most noncompete agreements, by making them generally unenforceable. Specifically, state law provides that a contract by which anyone is restrained from exercising a lawful profession, trade, or business of any kind is void, except in the sale of a business or in dissolution of a
partnership. The Supreme Court of North Dakota ruled in a 1992 case that a noncompete agreement between physicians and a group supplying emergency room physicians was void. In provider merger review authority, North Dakota law requires notice to the attorney general for all transactions involving non-profit hospitals. However, the statute provides limited review and approval authority. In a notable antitrust enforcement challenge, the FTC and North Dakota AG sued to block the merger of Sanford Health of South Dakota and Mid Dakota of North Dakota, challenging the merger of the two hospital systems on the grounds that it would reduce competition for healthcare services in the region, resulting in higher prices and lower quality of services. The district court granted a preliminary injunction and the Eighth Circuit affirmed for the FTC and the hospitals abandoned the merger in 2019. North Dakota law also provides coverage and reimbursement parity in telehealth services, with additional COVID-19 emergency cost-sharing requirements and coverage expansion. The state applied for and received Section 1332 waiver approval for federal pass through funding to partially finance the Reinsurance Association of North Dakota.
Trends in Healthcare System Reform

State Public Option Proposals

Recent Action in Healthcare System Reform

- Recent Legislation
- Recent Litigation
Recent Legislation

- Reimburses health care providers at the same rate for telephonic and telehealth visits as in-person visits.
- Reimburses health care providers at the same rate for telehealth visits as in-person visits.

Global Hospital Budgets Task Force. Relating to health; establishing the global hospital budgets task force to study global hospital budgets, create a demonstration project, determine federal funding impacts and provide a recommendation to the secretary of health and the secretary of human services to apply for funding from the federal centers for medicare and medicaid services; authorizing the secretary of human services and secretary of health to apply for funding from the federal centers for medicare and medicaid services pursuant to section 1115(a) of the federal social security act to test the demonstration project upon the task force's recommendation. The task force shall study global hospital budgets to determine prospective changes in health care quality outcomes and spending within rural hospitals that elect to participate in the demonstration project.
Health care coverage outreach.

Existing federal law, the Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. Existing state law creates the California Health Benefit Exchange (Exchange), also known as Covered California, governed by an executive board, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA.

Existing law requires the Exchange board to market and publicize the availability of health care coverage through the Exchange and to undertake outreach and enrollment activities.

Under existing law, the information obtained in the administration of the Unemployment Insurance Code is for the exclusive use and information of the Director of Employment Development in the discharge of the director's duties and is not open to the public. Existing law permits the use of the information for specified purposes, including to enable the Exchange and the State Department of Health Care Services to obtain information regarding employee wages, California employer names and account numbers, employer reports of wages and...
number of employees, and disability insurance and unemployment insurance claim information. Existing law makes it a crime for a person to knowingly access, use, or disclose this confidential information without authorization. This bill would require the Exchange, at least monthly beginning July 1, 2022, to request from the Employment Development Department (EDD) contact information of each applicant for unemployment compensation or any other program administered by EDD. The bill would require EDD to provide specified information to the Exchange or the State Department of Health Care Services upon request to assist in determining eligibility for the state and federal health subsidy programs administered by those state agencies. The bill would require the Exchange to market and publicize the availability of health care coverage through the Exchange, and engage in outreach activities, to the individuals whose contact information the Exchange receives from EDD. By expanding the scope of distribution of confidential information, thereby expanding the number of persons subject to the access, use, and confidentiality restrictions, the bill would expand the scope of related crimes and 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.

Health care coverage: contraceptives. 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 establishes health care coverage requirements for contraceptives, including, but not limited to, requiring a health care service plan, including a Medi-Cal managed care plan, or a health insurance policy issued, amended, renewed, or delivered on or after January 1, 2017, to cover up to a 12-month supply of federal Food and Drug Administration approved, self-administered hormonal contraceptives when dispensed at one time for an enrollee or insured by a provider or pharmacist, or at a location licensed or authorized to dispense drugs or supplies.
This bill, the Contraceptive Equity Act of 2021, would make various changes to expand coverage of contraceptives by a health care service plan contract or health insurance policy issued, amended, renewed, or delivered on and after January 1, 2022, including requiring a health care service plan or health insurer to provide point-of-sale coverage for over-the-counter FDA-approved contraceptive drugs, devices, and products at in-network pharmacies without cost-sharing or medical management restrictions and to reimburse enrollees and insureds for out-of-pocket costs for over-the-counter birth control methods purchased at any out-of-network pharmacy in California, without medical management restrictions. The bill would also require coverage for clinical services related to the provision or use of contraception, as specified. The bill would revise provisions applicable when a covered, therapeutic equivalent of a drug, device, or product is deemed medically inadvisable by deferring to the attending provider, as specified.

With respect to religious employers, this bill would authorize an enrollee or insured to submit a request to the health care service plan or health insurer if the employer elects not to purchase coverage for contraceptive methods, as required by existing law. The bill would require the...
applicable to reimburse a religious employer for the contraceptive care and related products provided to the employee, as specified. The bill would prohibit the employer from discriminating or retaliating against the employee for independently obtaining contraceptives outside of the employer's plan under this authorization.

This bill would prohibit the Board of Public Relations of the Public Employees' Retirement System and the University of California from approving or renewing a health benefit plan that does not comply with the contraceptive coverage requirements of the bill and existing law described above, on and after January 1, 2022.

Because a willful violation of the bill's requirements by a health care service plan 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.

Health care coverage: pervasive developmental disorders or autism.
Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), 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 also provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or a health insurance policy to provide coverage for behavioral health treatment for pervasive developmental disorder or autism. Existing law defines “behavioral health treatment” for these purposes to mean professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs that meet specified criteria.

This bill would modify that definition to mean professional services and treatment programs based on behavioral, developmental, relationship-based, or other evidence-based models, including applied behavior analysis and other evidence-based behavior intervention programs that meet the specified criteria. Because a willful violation of the bill’s provisions by a health care service plan would be a crime, it 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.

Medi-Cal: eligibility. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. The federal Medicaid program provisions prohibit payment to a state for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.

Existing law requires individuals under 19 years of age enrolled in restricted-scope Medi-Cal at the time the Director of Health Care Services makes a determination that systems have been programmed for implementation of these provisions to be enrolled in the full scope of Medi-Cal benefits, if otherwise eligible, and extends eligibility for full-scope Medi-Cal benefits to individuals under 25 years of age, and who are otherwise
eligible for those benefits but for their immigration status. Existing law makes the effective date of enrollment for those individuals the same day that systems are operational to begin processing new applications pursuant to the director's determination, and requires the department to maximize federal financial participation for purposes of implementing the requirements. Existing law provides that Medi-Cal benefits for individuals who are 65 years of age or older, and who do not have satisfactory immigration statuses or are unable to establish satisfactory immigration statuses, will be prioritized in the Budget Act for the upcoming fiscal year if the Department of Finance projects a positive ending balance in the Special Fund for Economic Uncertainties for the upcoming fiscal year and each of the ensuing 3 fiscal years that exceeds the cost of providing those individuals full scope Medi-Cal benefits.

This bill would, subject to an appropriation by the Legislature, and effective July 1, 2022, extend eligibility for full-scope Medi-Cal benefits to individuals who are 65 years of age or older, and who are otherwise eligible for those benefits but for their immigration status. The bill would delete provisions delaying implementation until the director makes the determination.
described above. The bill would require the department to seek federal approvals to obtain federal financial participation to implement these requirements. Because counties are required to make Medi-Cal eligibility determinations and this bill would expand Medi-Cal eligibility, 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, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

- Recent Litigation
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 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.

[1] 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.