State Policies on Provider Market Power

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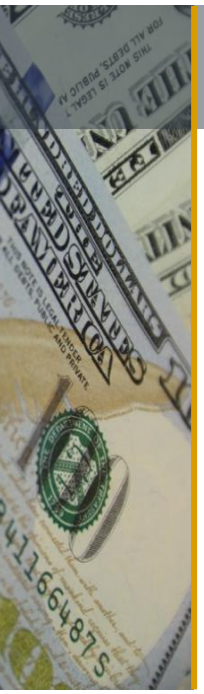

INTRODUCTION

In 2020, the exorbitant cost of health care in the United States remains shocking -- no longer for its novelty -- but for its unchecked inflation, and consequent erosion of affordability across the country. Contrary to popular mythology that Americans use more health care, or that our delivery system is more wasteful than other countries, research shows that the main driver of health expenditures in the U.S. is prices in the commercial insurance sector. Research also shows that consolidated provider market power has eroded commercial health plans' (and other purchasers') negotiating leverage in many markets, suggesting that regulation and public policy solutions may be needed to re-balance the playing field. This report, an update to a similar study from 2014, catalogues state laws and regulations that can serve as a counterweight to provider consolidation and anti-competitive practices within the health care marketplace.

Although Medicare and Medicaid set prices, commercial health care prices remain unregulated, allowing providers to charge as much as the market will tolerate. Studies like the RAND Hospital Price Transparency Study show that prices in some markets have reached extraordinarily high levels -- at the highest end of the spectrum, some health systems can command over 400% of what Medicare pays on average. Nationally, the chasm between Medicare and commercial prices grew significantly over the past two decades: in the 1990s, the average hospital received 110% of Medicare's rates for inpatient care; by 2017 the gap widened to 204% of Medicare's rates for inpatient care, and almost 300% of Medicare for outpatient care.[i]

Some of the price growth in the commercial market can be explained by a consolidation of provider market power – specifically through the ongoing wave of provider mergers and acquisitions. The larger a health system is and the fewer available alternatives in a market, the higher prices a health system can command. The provider consolidation trend started in the 1990s, and over the past two decades, more than 2,000 mergers occurred.[ii]

A merger between two equally sized hospitals is likely to increase hospital prices by about 9%.

Theoretically, provider consolidation could have an upside for patients and health care purchasers: as hospitals align with each other and with the physician community, they have an opportunity for economies of scale, elimination of service redundancy, and tighter care coordination. However, and unfortunately, evidence points to the contrary. One study found, perhaps not surprisingly, that prices in markets with monopoly hospitals are higher than those in markets with several competitors.[iii] Another demonstrated that a merger between two equally sized hospitals is likely to increase hospital prices by about 9%.[iv] Several recent studies have found that consolidation between physician groups is also associated with higher prices for office visits and common procedures.[v,vi] This increase in prices has historically had no demonstrated correlation to improved quality of care, showing mixed results at best, and in one recent study, a measurable decline.[vii,viii,ix,x,xi]

A number of interventions -- market-based, legislative or regulatory -- could promote competition among health care providers, resulting in lower health care prices and costs. In 2014 the National Academy of Social Insurance (The Academy) commissioned Catalyst for Payment Reform (CPR) to research legislative and regulatory approaches across the fifty states -- specifically state efforts to enhance the competitiveness of health care markets and reduce anti-competitive practices within the health care delivery system. Given the continued trend in provider market consolidation and commensurate rising prices, CPR updated the report in 2020.

This report catalogues existing state statutes designed to address market power imbalances that enable anti-competitive practices and escalating health care costs. In doing so, this report provides insight into the current scope of state authority to monitor and regulate health care prices. In addition, because states may pursue policies that exist outside their legislative codes, the report also notes some of the non-legislative efforts that states are taking to address these issues.

METHODOLOGY: SEARCH CATEGORIES

To update the report and identify relevant laws, CPR consulted the Database of State Laws Impacting Healthcare Cost and Quality (the SLIHCQ Database), jointly developed by CPR and The Source on Healthcare Price and Competition at the UC Hastings College of the Law and housed on the website of The Source. The scope of this report is limited to state activity only and does not include a review of federal laws. CPR systematically structured the searches around seven categories, which together capture the likely range of possible state activity. General web searches through Google provided context and supplemental findings in addition to recent research on state activity to promote competition and control prices.[xii] A summary of the search categories with examples, as well as defined search terms, is in Appendix A.

Antitrust related laws

All states have antitrust statutes in place that give them the authority to analyze and either place conditions on or attempt to prevent mergers that may reduce competition in the marketplace. While some of the laws themselves are not specific to health care, it is critical to examine how the state courts have interpreted them and the resources made available for enforcement, to determine how the state has shaped the health care marketplace.

Laws encouraging transparency on quality and/or price

Some states have passed laws to promote quality and price transparency. Such transparency can help to expose variation in the prices for care and the quality of care across physicians and facilities. For this review, we contained our search to statutes that limit suppression of pricing information (e.g., gag clauses) and/or statutes that enable payers to create incentives for consumers to select providers based on price (specifically contracted rates) and quality information.

Laws encouraging competitive behavior in health plan contracting

Regulating health plan contracting practices can mitigate the impact that provider leverage has on prices. For example, implementing limits on providers' ability to demand "all or nothing" contracting and other special privileges can help to minimize the impact of provider consolidation and/or market power.

Laws created to monitor or regulate consolidation and health care costs

Laws intended to monitor or regulate prices can moderate the impact of provider market power. Approaches range from establishing an independent body to monitor health care costs (including provider prices), to setting caps on price increases. Stipulations on how providers can negotiate their prices limit their ability to exert market power.

Laws around the development of accountable care organizations

To form accountable care organizations (ACOs), health care providers may establish new relationships with each other that enhance their power in the marketplace, regardless of whether they intend that outcome. Some laws set standards to maintain competition among providers within the ACO or between the ACO and other ACOs or other provider systems.

Laws around the authority of Departments of Insurance

Expansion of the Department of Insurance's (DOI) jurisdiction over regulating the health care market can curtail providers' ability to raise rates year over year. The Affordable Care Act requires states to review proposed insurance rates and determine the reasonableness of a rate increase above 10%. Increasing the DOI's ability to limit rate increases might be a viable option for many states. While generally tasked with monitoring the financial solvency of health plans, when given the ability to scrutinize provider-insurer contracts actively, the DOI can limit provider rate increases. States can also expand the authority of the DOI to maintain the affordability of health care, broadly, or prohibit an insurance merger.[xii]

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Laws creating or reducing barriers for new entrants to the market

State laws can either create or reduce barriers to competition. Some experts posit that existing certificate of need (CON) laws, for example, create barriers to entry and therefore obstruct new providers from entering a market. Others believe they do more to prevent incumbents from unnecessary expansion.[xii] Scope of practice laws specify the services non-physician medical providers are allowed to perform and the circumstances under which they can operate independently; these laws can limit access to primary care by prohibiting non-physician clinicians (e.g. nurse

practitioners, physician assistants, midwives, etc.) from providing certain primary care services. Telehealth laws may also promote competition, securing additional sources of care for patients. Fostering an environment that promotes competition can have a disruptive impact on markets with historically dominant providers.

TRENDS IN LAWS USED TO ENHANCE MARKET COMPETITION BY STATE

A catalogue of state laws reveals a range of legislative approaches to address provider market power. There is some state activity in each of the categories described in the research methodology above. It is important to note that the success of these activities depends on accompanying regulations and their enforcement. Our research revealed the following trends:

Antitrust related laws

All states have access to antitrust remedies (both federally and through state legislation) allowing state attorneys general (AGs) to respond to anticompetitive provider consolidation. State AGs have a broader mandate to identify and challenge provider mergers than federal antitrust enforcers. Regionally situated, they have a better pulse on state merger and acquisition activity. Some states require the merging entities to provide notice to a state entity, while others require approval prior to merger consummation. Further, state AGs can challenge mergers that violate antitrust, consumer protection and charitable trust doctrines.[xii] The extent to which the law can be applied is most evident through the precedents set in prior cases. A summary of Federal Trade Commission, U.S. Department of Justice and state cases is available on The Source on Healthcare Price and Competition Market Consolidation page.

States also have the ability to regulate the behavior of a merged entity as a condition for allowing the merger to go through. Thirteen states have laws allowing for certificates of public advantage (COPA) or cooperative agreements that create conditions the merged entity must abide by post-merger, including limits on rate increases and investments in the community, for example. Only Tennessee, Virginia and West Virginia are actively using COPAs with a merged entity.[xii]

Laws encouraging transparency on quality and price

Twenty states have passed laws implementing mandatory all-payer claims databases (APCDs), collecting health care claims data from Medicare, state Medicaid agencies, state employee and retiree agencies, and commercial insurance

companies. Some states have translated this information into consumer-facing websites that allow consumers to "shop" for health care services and providers. APCDs also have the benefit of exposing high priced providers for public policy purposes. A few states have begun to implement "Right to Shop" laws, which provide incentives to consumers to seek care from lower cost providers or less expensive services.

Laws encouraging competitive behavior in health plan contracting

Twenty states have attempted to limit providers' influence through banning "most favored nation" contracting clauses. In practice, a "most favored nation" clause prevents a provider from charging a health plan a rate higher than the lowest reimbursement rate the provider agrees to with any other insurer. These clauses can prevent other health plans from entering local markets in the state, stifling competition, raising health care costs and harming consumers.

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The State of Massachusetts is unique in passing legislation to curb another anti-competitive provider practice, known as anti-steering or -tiering clauses. Providers with anti-tiering or steering provisions in their contracts prevent health plans from offering products that steer consumers to lower cost (or higher quality) providers.

Laws created to monitor or regulate consolidation and health care costs

Seven states have established state commissions to promote competition and control health care costs. Their main activities have centered on exposing high and variable prices, implementing cost controls, or overseeing provider merger activity. Massachusetts and Delaware have implemented all-payer, statewide cost growth benchmarks to bring health care spending in line with the growth of their broader economy (per capita gross-state product). Massachusetts' commission is also entrusted to study the effect of health care mergers and make recommendations to the state AG.[xii]

Laws around development of accountable care organizations

While there are an increasing number of ACOs nationwide, only some states have laws governing them. Massachusetts, New York, and Texas have laws that require certificates of authority for ACOs in the state, through which they can offer financial incentives to the ACO in exchange for more stringent antitrust review upon the entity's formation and continued oversight.

Laws around the authority of Departments of Insurance

Although most states have a formal rate review program, Rhode Island has expanded the authority of the DOI to establish affordability standards. The Rhode Island DOI's jurisdiction allows it to include conditions of approval to tie annual price increases for inpatient and outpatient services to the US Consumer Price Index for All Urban Consumers (CPI-Urban) +1%, as well as increase the supply of primary care providers and reduce unnecessary care. The Office of the Health Insurance Commissioner also has the ability to review provider-insurer contracts.[xii]

Laws creating or reducing barriers for new entrants to the market

There are 36 states that have enacted a certificate of need (CON) requirement, but only 26 maintain CON laws for acute care. Opponents of CON claim that, by controlling hospital facility and service expansions, CON effectively prevents market entry. They suggest that repealing these laws would promote competition and result in lower prices; thus, several states have recently repealed their CON laws (e.g., New Hampshire). However, CON laws may serve to prohibit predatory behavior of incumbent health systems seeking to expand capacity; some states have reinstated their CON laws (e.g., Indiana). In short, the research on CON is mixed; it is not clear whether CON laws serve as a barrier to or facilitator of competition.[xii] A growing number of states are expanding market competition with policies to enable telehealth. Setting up a regulatory environment that promotes telehealth as a viable alternative to in-person care can help to spur competition in the market, by introducing a lower-cost option and helping to control utilization of overpriced services.

Scope of practices laws can create barriers to competition as they restrict lower cost providers (e.g., nurse practitioners, physicians' assistants) from performing services that traditionally only licensed physicians can legally provide. Some states have begun to expand practice authority to allow non-physician clinicians to offer a broader range of services without physician oversight. While this report does not directly address the broad swath of scope of practice laws present in all 50 states (as their relationship to market power is somewhat tangential), we felt it was important to highlight its potential role in expanding competition and lowering costs.

Additional Resources

For additional information and detail on state laws governing provider market power, the following resources are available:

- A complete catalogue of state laws designed to enhance market competition or limit provider market power can be found in Appendix B.
- Interactive maps and continuously updated information on laws and regulations like those listed in Appendix B can be found in the Database of State Laws Impacting Health Care Costs and Quality.

STATE ACTIVITY BEYOND LEGISLATION

Through our review of state laws, CPR found a short list of states – California, Massachusetts, Montana, New Hampshire, North Carolina, Oregon, and Rhode Island – that are particularly active in their policy efforts regarding health care provider consolidation and market power.

Across these seven states, general trends include:

- The most common strategy to maintain a competitive health care market is to block potential mergers under states' existing antitrust jurisdiction.
- Active states have resources devoted to maintaining and/or creating a competitive health care market. Regardless of the authority of a state's regulatory bodies, without the necessary resources, states are unable to devote adequate attention to the issue. One marker for this, as an example, is whether the state attorney general's office has an antitrust bureau.
- A few states are attempting to regulate competition by allowing mergers to occur through conditional settlements. These consent decrees, similar to COPAs and cooperative agreements, are designed to enhance competition

and limit the ability of the newly consolidated entity to leverage higher rates through their increased market share.

- Some states are actively working to bring public awareness to the issue of provider market power. State governments are giving agencies the authority to collect, monitor, and analyze provider pricing data. None of these actions specifically addresses the consequences of provider market power. The data have, however, proved instrumental to litigation against potentially harmful mergers.
- Three states have attempted to implement rate limits for state employee and retiree plans to eliminate excessive payments to outlier physician groups, hospitals or health systems.

California

In 2019, the California AG filed a lawsuit challenging Sutter Health's anti-competitive practices, including its use of all-or-nothing contracting, as well as anti-steering and gag clauses. The AG alleged that Sutter used its market power to thwart competition and charge exorbitant prices. A study found that the average cost for a heart attack was $10,000 more in San Francisco than in Los Angeles.[xiii] Just before trial, Sutter and the AG reached a settlement, requiring Sutter to pay $575 million in compensation to affected parties, limit out-of-network charges, increase transparency, and end the anti-competitive practices identified by the AG. Further, a compliance monitor will ensure that Sutter is complying with the terms of the settlement over a 10-year period.[xiv]

The AG's Antitrust Law Section also works closely with the charitable trusts section to maintain a competitive health care market.[xii] California law requires the AG's consent for any sale or transfer of a health care facility owned or operated by a nonprofit corporation whose assets are held in public trust. The charitable trusts section is tasked with protecting the public's interest in the property and assets committed to charitable purposes through registration, education, and enforcement. In cases where a potential material change in ownership occurs within a nonprofit facility, the change must be reviewed by the AG's office at the provider's expense. By collaborating with the charitable trusts section, the Antitrust Law Section can advise on the impact of the sale or transfer on provider market power. In these scenarios, blocking the merger through the charitable trusts section can save the AG's office significant resources by avoiding a formal antitrust trial.

Massachusetts

Massachusetts' Health Policy Commission (HPC) is an independent commission, created through statute, that has the authority to implement and oversee a statewide benchmark for the growth of total health care expenditures (3.1% in 2018), credential ACOs and patient-centered medical homes, and conduct cost and market impact reviews (CMIR), among other activities. Transactions anticipated to have a significant impact on the market are subject to a comprehensive review and cannot be finalized until the HPC releases the CMIR. While the HPC cannot stop a merger, its reports supply critical information for regulatory bodies, including the Office of the Attorney General, to determine if further action related to the transaction is needed.

In 2018, the Massachusetts AG approved a merger between Beth Israel Deaconess Medical Center and Lahey Health with conditions for the new entity's conduct. Consent decrees regulate the merged entities' behavior to ensure that they do not use their new market share and power in a way that harms patients, such as by increasing rates. The consent decree requires that Beth Israel-Lahey limit annual price growth and make investments to improve population health and support vulnerable populations.[xv,xvi,xvii,xviii]

Similarly, the Department of Public Health issued new regulations in 2017 for Massachusetts' determination of need (DON) laws to incorporate public and community health principles. To receive approval for facility or service expansion, hospital projects must demonstrate that they "will add measurable public health value in terms of improved health outcomes and quality of life… while providing reasonable assurances of health equity." This approach may prevent incumbent providers from expanding unless they can demonstrate that any new service line or facility benefits the community.

Montana

The State Administrator found that the state paid as much as three times the Medicare rates for inpatient services and as much as six times the Medicare rates for outpatient services.[xix] Therefore, in 2016, the State Health Plan set an annual limit on rates at an average of 234% of Medicare for both inpatient and outpatient services. Most of the state's hospitals agreed to participate, leading to savings of approximately $1.5 million in the first year.[xx]

New Hampshire

New Hampshire's Insurance Department (NHID) is responsible for bringing more transparent price information to consumers. The NHID oversees the state's APCD, which collects claims data from all payers in the state. A publicly accessible website, NH HealthCost, makes provider- and procedure-specific prices available to consumers. An analysis in 2018 found that NH HealthCost led to a large reduction in the price of medical imaging procedures, as higher priced providers lowered their prices to compete for patients. The study found that NH HealthCost saved consumers $7.9 million and health plans $36 million over five years on medical imaging alone.[xxi]

North Carolina

In 2016, the U.S. Department of Justice and the North Carolina AG filed a civil antitrust lawsuit against Atrium Health System for its anti-competitive practices, including anti-steering language in contracts with health insurance plans and gag clauses preventing disclosure of price information to consumers. The case ended in a settlement, prohibiting Atrium from using steering restrictions and gag clauses.[xxii]

In 2018, the State Treasurer proposed a resolution to implement rate limits for the State Health Plan. The Treasurer originally set average inpatient and outpatient rates to 177% of Medicare but received significant push back from the provider community and raised the limit to 196% of Medicare. The Treasurer was unable to secure commitments from many large hospitals and health systems in the state, and thus, the plan did not succeed.[xxiii]

Oregon

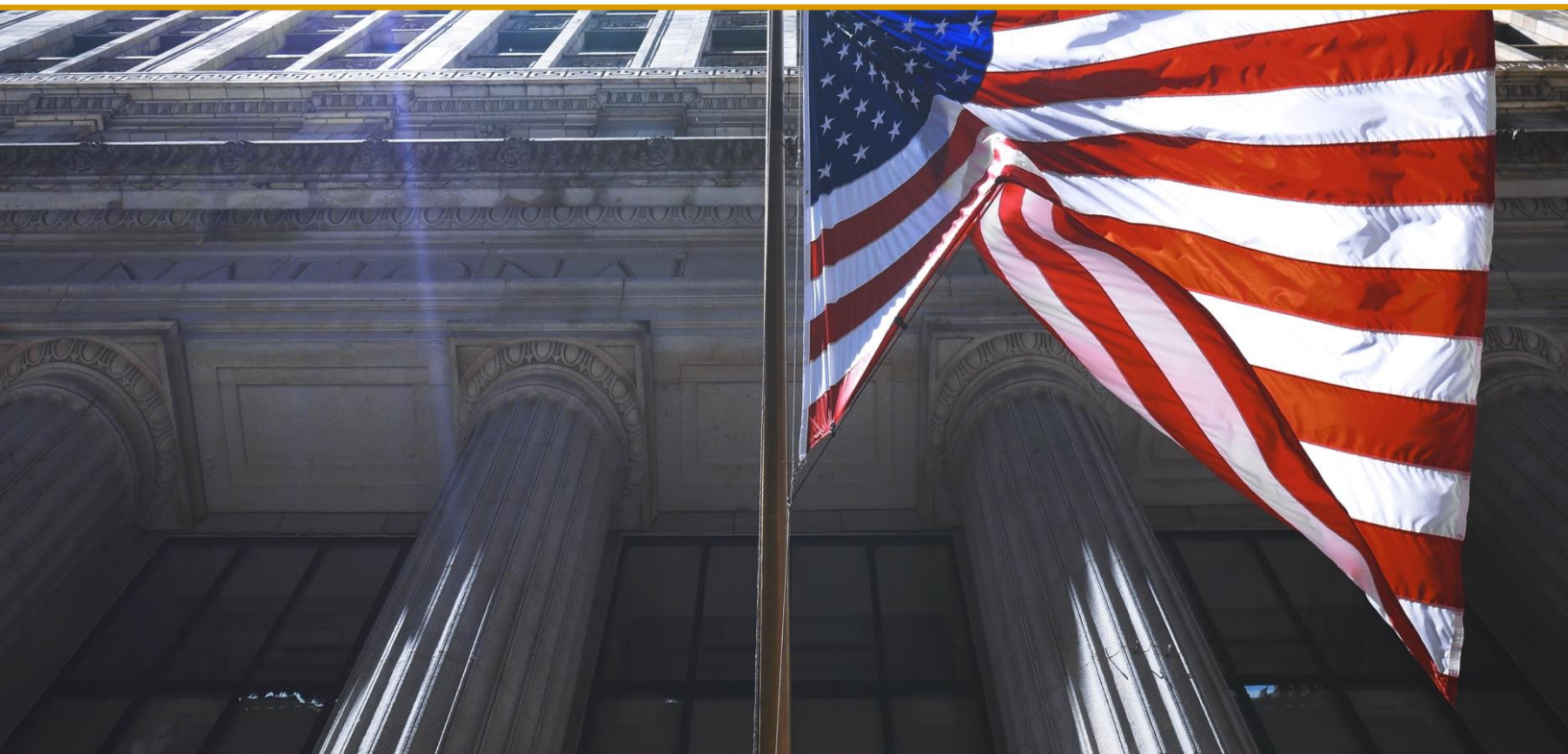
Oregon spearheaded a plan to control costs for the Public Employees Benefit Board (PEBB) and the Oregon Educators Benefit Board (OEBB). The state also implemented rate limits through the legislature in 2017. The legislation specifies that inpatient or outpatient claims submitted by in-network hospitals shall not exceed 200% of Medicare and claims submitted by out-of-network hospitals shall not exceed 185% of Medicare for the PEBB and OEBB. Analyses performed by the PEBB and OEBB suggest that the program will save at least $158.7 million in the next two years.[xxiv,xxv]

Oregon also implemented a 3.4% per capita growth rate limit for its public programs.[xxvi] In June 2019, Oregon passed a bill to create a statewide benchmark, which will be established by a newly appointed Committee that is overseen by the Oregon Health Policy Board.[xxvii]

Rhode Island

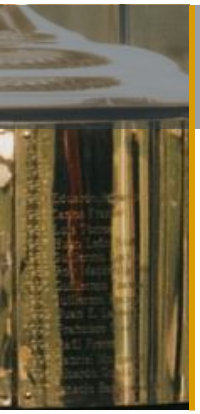
State legislation in 2004 established the Office of the Health Insurance Commissioner (OHIC) and tasked it with protecting consumers, encouraging fair treatment of medical service providers, ensuring solvency of health insurers, and improving the health care system's quality, accessibility and affordability. The health insurance commissioner in Rhode Island has the unique ability to limit rate increases below the US Consumer Price Index for All Urban Consumers (CPI-Urban). If the rate increase is above CPI-Urban and the health insurance commissioner deems that it is not in the interest of the public, the commissioner may deny the negotiated rate. [xii] A study in 2019 determined that these standards reduced quarterly fee-for-services spending by $76 per enrollee, with little to no change in quality and utilization.[xxviii]

In 2019, Rhode Island established a health care cost growth benchmark, setting it equal to the state's per capita gross state product (3.2%). The state authority reports performance according to the benchmark at the state, insurance market, individual payer and ACO levels, by collecting data through various sources, including from private insurers, the state Medicaid program and CMS.[xxix]



CONCLUSION

Looking ahead, states will continue to innovate in the face of growing consolidation and rising prices. State AGs are active in challenging mergers and litigating against anti-competitive behavior. But some markets are so consolidated, with one dominant provider system, that it may be impossible to "unscramble the eggs" or facilitate the entry of new competitors. In the face of highly consolidated markets, some states may turn to regulation to control health care prices or monitor anti-competitive behavior. More states may attempt to implement rate caps to eliminate outlier payments and generate savings. Others may choose to regulate annual rate updates to mediate current price differentials between dominant provider systems and safety net hospitals. As states implement a variety of approaches to promote competition and control prices, researchers should continue to evaluate them.



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APPENDIX A: SEARCH CATEGORIES WITH EXAMPLES

Antitrust

Transparency

Competitive behavior

Prices

Accountable care organizations

Departments of insurance

New entrants

Antitrust Related Laws

Examples

- Certificates of public advantage (COPA)
- State AG authority
- Antitrust enforcement
- Health care consolidation
- Price manipulation
- Competitive bidding
- Trade secret

Laws and Regulations Encouraging Transparency on Quality and Price

Examples

- State comparison shopping tool
- Prohibiting information as "trade secret"
- Requiring disclosure on rate approvals
- All-payer claims database
- Right to shop laws
- Surprise or balance billing

Laws and Regulations Encouraging Competitive Behavior in Health Plan Contracting

Examples

- Limiting most favored nation (MFN) agreements

- Removing restrictions on plan's ability to offer steered or tiered products (e.g. no "anti-steering or tiering" legislation)
- Limiting "all or none" contracting for hospital systems
- Limitations on gag clauses

Laws and Regulations Implementing the Monitoring or Regulating of Prices

Examples

- Governing body over price increases (e.g. Mass) or rate-setting (e.g. Maryland)
- Limits on emergency care pricing
- State regulation on how payments are set
- Rate limits (e.g., Oregon)
- Global budgets (e.g., Vermont, Pennsylvania and Maryland)

Laws and Regulations Around Development of ACOs

Examples

- Limits on exclusivity contracts
- Certificates of authority (COA)

Laws and Regulations Expanding the Authority of Departments of Insurance

Examples

- Rate regulation (e.g., Rhode Island)
- Disclosure requirements
- Increased contract scrutiny

Laws and Regulations Facilitating or Reducing Barriers for New Entrants to the Market

Examples

- Certificate of need (CON)
- Network adequacy
- Provider network (narrow or tiered)
- Public option
- Telehealth
- Scope of practice expansions

Appendix A

APPENDIX B: CATALOGUE OF LAWS USED TO ENHANCE MARKET COMPETITION BY STATE

ALABAMA

Antitrust

AL Code §§ 8-10-1 through 8-10-3 — Restraint of Trade or Production:
Any person or corporation who engages or agrees with other persons or corporations or enters, directly or indirectly, into any combination, pool, trust, or confederation to regulate or fix the price of any article or commodity to be sold or produced within this state or any person or corporation who enters into, becomes a member of or party to any pool agreement, combination, or confederation to fix or limit the quantity of any article or commodity to be produced, manufactured, mined, or sold in this state must be fined, on conviction, not less than $500 nor more than $2,000.
AL Code §§ 41-16-20 through 41-16-32 — Competitive Bidding on Public Contracts Generally:
Specifies for which contracts competitive bidding is required and for which it is not. Any agreement or collusion among bidders or prospective bidders in restraint of freedom of competition by agreement to bid at a fixed price or to refrain from bidding or otherwise shall render the bids of such bidders void. Each bidder shall accompany his bid with a sworn statement that he has not been a party to such an agreement.

Competitive Behavior in Health Plan Contracting

AL Code § 27-1-19 — Reimbursement of health care providers: General Provisions:
The agreement providing coverage to an insured may not exclude assignment of benefits to any provider at the same benefit paid to a contract provider.

Regulation Around Development of ACOs

AL Code §§ 22-6-150 through 22-6-164 — Delivery of Medical Services:
Establishes probationary and full certification standards for regional care organizations to enter into risk-based contracts with Alabama's Medicaid program to provide a comprehensive package of benefits to enrollees in a coordinated and cost-effective manner.

Expansion of DOI Authority

AL Code § 27-2-17 — Insurance:
Vests the insurance commissioner with prior approval authority.
AL Code § 27-14-8 — Forms - Filing and approval or disapproval: The Insurance Contract:
Requires rate filing and prior approval for HMOs and Blue Cross Blue Shield. Requires filing rate for commercial not carriers (approval required).

Creating or Reducing Barriers to New Entrants

AL Admin Code R 410-2-4-.01 through 410-2-4-.15 (Regulation) — Alabama State Health Plan:
Describes the methodology for a range of health care facilities, including acute care hospitals, nursing homes, and adult day care programs. Some of these requirements are applicable to the facilities that require a certificate of need.
AL Code §§ 22-4-30 through 22-4-32 — Alabama Health Planning Facilitation Act:
Alabama has adopted a system of health planning and development administered by the State Health Planning and Development Agency (SHPDA). In addition, the Statewide Health Coordinating Council (SHCC) is charged with reviewing Alabama's health planning needs and writing the State Health Plan to assist the Certificate of Need Review Board. The Certificate of Need Review Board is responsible for reviewing and approving certificate of need applications in Alabama.
AL Code §§ 22-21-260 through 22-21-278 — Control and Regulation of Development of Certain Health Care Facilities:
Implements the state Certificate of Need program, which creates a system of mandatory regulatory reviews before a healthcare facility offers new or expanded services.
AL Code § 34-22-82 — Telemedicine — Protocols; privacy practices: License to Practice Across State Lines:
A provider who uses telemedicine in his or her practice shall adopt protocols to prevent fraud and abuse through the use of telemedicine.
AL Code § 34-22-83 — Telemedicine — Services; provider-patient relationship; standards of practice; confidentiality: License to Practice Across State Lines:
Allowing telemedicine to be used for all patient visits, requiring proper provider-patient relationship for patients that are not present at a treatment site.
AL Code § 27-46-1 — Reimbursement or payment for services: Certified Registered Nurse Anesthetist Coverage:
Notwithstanding any other provision of law, when any contract or plan of health insurance, or any plan or agreement for health care services provides for the reimbursement or payment for services which are within the scope of practice of registered nurses who have passed or who are qualified to take the national certification examination for the specialty practice of nurse anesthetist as recognized by the Alabama Board of Nursing, then the insured, or any other person covered by the policy, plan, contract, or certificate shall be entitled to reimbursement or payment for such services performed by the certified registered nurse anesthetist, and said certified registered nurse anesthetist shall be entitled to direct reimbursement by the insurer,

unless the certified registered nurse anesthetist is employed by contract with a group practice of anesthesiologist or a hospital, then such services shall be reimbursed through the employer.
AL Code § 27-1-18 — Contract providing for mental health services to entitle insured to reimbursement for outpatient and inpatient services by qualified psychiatrist or psychologist: Alabama Insurance Code:
Whenever any group, or blanket hospital or medical expense insurance policy or hospital or medical service contract issued for delivery in this state provides for the reimbursement of health or health related services which includes mental health services, and such services are within the lawful scope of practice of a duly qualified psychiatrist or psychologist, the insured or other person entitled to benefits under such policy or contract shall be entitled to reimbursement for outpatient services, and inpatient services if requested by the attending physician, performed by a duly qualified psychiatrist or psychologist notwithstanding any provisions of the policy or contract to the contrary.

Appendix

ALASKA

Antitrust

Alaska Stat § 23.50.020 — Collective action by competing physicians: Collective Negotiation by Physicians:
States that competing physicians may meet and communicate in order to collectively negotiate with a health benefit plan concerning any of the contract terms and conditions described in this subsection, but may not negotiate the exclusion of providers who are non-physicians from direct reimbursement by a health benefit plan, and may not negotiate the setting in which providers who are non-physicians deliver services. An authorized third party that intends to negotiate with a health benefit plan the items identified under (a) of this section shall provide the attorney general with written notice of the intended negotiations before the negotiations begin.
Alaska Stat § 45.50.577 — Enforcement by attorney general: Alaska Restraint of Trade Act:
The attorney general may bring a civil action in superior court to secure monetary relief as provided in this section on behalf of the state and its agencies injured either directly or indirectly by reason of any violation of AS 45.50.562 — 45.50.570.
Alaska Stat § 45.50.590 — Powers of the attorney general: Alaska Restraint of Trade Act:
States that if the attorney general determines, upon complaint or otherwise, that a person has engaged in, or engages in, or is about to engage in an act or practice prohibited or declared unlawful by AS 45.50.562 — 45.50.596, or that a person has assisted or participated in a plan, scheme, agreement, or combination of the nature described in AS 45.50.562 — 45.50.596, or when the attorney general believes it to be in the public interest, the attorney general may commence an investigation. The attorney general may compel production of documentary material and take testimony, under oath, before the institution of an action under AS 45.50.562 — 45.50.596.
Alaska Stat § 45.50.580 — Injunction by attorney general: Alaska Restraint of Trade Act:
States that in addition to any other relief provided by AS 45.50.562 — 45.50.596, the attorney general may bring an action to enjoin a violation of AS 45.50.562 — 45.50.596. This action may be brought as a sole action or in conjunction with another action that the attorney general is authorized to bring.

Encouraging Price Transparency

Alaska Stat § 18.23.400 — Disclosure and reporting of health care services, price, and fee information: Electronic Health Information Exchange System:
A health care provider and facility shall annually compile a list, including a brief description in plain language that an individual with no medical training can understand, of the 10 health care services most commonly performed by the health care provider in the state in the previous calendar year from each of the six sections of Category I, Current Procedural Terminology, adopted by the American Medical Association and, for each of those services, state (1) the procedure code; (2) the undiscounted price; and (3) any facility fees. The department shall annually compile the lists provided under (a) and (b) of this section by health care service and, where relevant, health care provider and health care facility name and location, post the information on the department's Internet website, and enter the information in the database maintained under AS 18.15.360.

Expansion of DOI Authority

Alaska Stat § 21.51.405 — Rate requirements; filings; regulations: Health Insurance Policies:
Requires insurers to file individual health plan premium rates with the director before implementing them. The premium rate or rate change must be filed at least 45 days prior to the effective date. General standard of review is that rates may not be excessive, inadequate or unfairly discriminatory. Vests the insurance commissioner with prior approval authority.
Alaska Stat § 21.87.180 — Filing and approval of agreements and contracts: Hospital and Medical Service Corporations:
Requires hospital and medical service corporations to file with the director any agreements and contracts. The director reviews them and has the authority to disapprove them under specified conditions, including violations of Law or deception. After the filing is effective, it is open for public inspection.

Competitive Behavior in Health Plan Contracting

Alaska Stat § 21.07.010 (b)(3) — Insurance:
Banning most favored nation clauses, a promise obtained by an insurer that the provider will not give a better price to another insurer.

Creating or Reducing Barriers to New Entrants

Alaska Stat §§ 18.07.02 through 18.07.111 — Certificate of Need Program:
Certificate of Need guidelines and principles.

Appendix

ARIZONA

Antitrust

AZ Rev Stat § 20-1057.13 — Public hearing; notice; requirements; summary report: Hospital and Community Health Center Mergers and Other Transactions – General Provisions:

No later than ninety days before the anticipated closing of the intended transaction, any nonprofit health care entity that intends to engage in any of the transactions described in section 10-11252, subsection A shall give written notice to the director of the department of health services and the attorney general.

AZ Rev Stat §§ 44-1401 through 44-1416 — Uniform State Antitrust Act:
A contract, combination or conspiracy between two or more persons in restraint of, or to monopolize, trade or commerce, any part of which is within this state, is unlawful. The establishment, maintenance or use of a monopoly or an attempt to establish a monopoly of trade or commerce, any part of which is within this state, by any person for the purpose of excluding competition or controlling, fixing or maintaining prices is unlawful. If the attorney general has reasonable cause to believe that a person has information or is in possession, custody or control of any document or other tangible object relevant to an investigation for a violation of this article, the attorney general may serve upon the person, before bringing any action in the superior court, a written demand to appear and be examined under oath, to answer written interrogatories under oath and to produce the document or object for inspection and copying.

Encouraging Price Transparency

AZ Rev Stat §§ 20-3111 through 20-3118 — Timely Payment of Claims – Out-of-Network Claim Dispute Resolution:
A bill for a health care service, a laboratory service or durable medical equipment that was provided in a network facility by a health care provider that is not a contracted provider is considered a surprise out-of-network bill if it was provided in the case of an emergency or was not provided in the case of an emergency and the health care provider or the provider's representative did not provide to the enrollee, or did not provide to the enrollee within a reasonable amount of time before the enrollee received the services, a written disclosure that he or she is not a contracted provider, the amount of the bill or that the patient has waived his or her rights to dispute resolution.

AZ Rev Stat §§ 36-436 through 36-437 — Review of Rates, Rules and Regulations:
Requires new hospitals or nursing care institutions to file a schedule of its rates to the director as well as those seeking to increase their rates. Requires a home health agency, supervisory care home, and a hospice to provide a copy of the institution's rates and charges to the public on request.

AZ Rev Stat § 36-437 — Health care facilities; charges; public availability; direct payment; notice; definitions: Review of Rates, Rules and Regulations:
Requires facilities with more than 50 inpatient beds to make available upon request or online the direct pay price for at least the 50 most used DRG codes, and if applicable, for the 50 most used outpatient service codes. For facilities with less than 50 inpatient beds, the requirement is to provide information for the 35 most used DRG and outpatient service codes.

AZ Rev Stat § 36-125.05 through 36-125.06 — Uniform Reporting: Public Health and Safety:
Requires the state to publish a semiannual comparative report of patient charges that contains a simple and concise comparison of average charges per confinement for the most common diagnoses and procedures at hospitals and emergency departments.

AZ Admin Code R9-10-209 — Patient Rights: Hospitals:
Requires hospitals to inform a patient how to obtain a schedule of hospital rates and charges required in A.R.S. § 36-436.01(B).

AZ Rev Stat § 32-3216 — Health care providers; charges; public availability; direct payment; notice; definitions: Health Professionals — General Provisions:
A health care provider must make available on request or online the direct pay price for at least the twenty-five most commonly provided services, if applicable, for the health care provider.

Expansion of DOI Authority

AZ Admin Code R20-6-607 — Reasonableness of Benefits in Relation to Premium Charged: Types of Insurance Contracts:
Provides the Arizona DOI the authority to review any individual PPO or indemnity rate revision including revisions that do not result in a rate increase.
AZ Admin Code R20-6-2301 through R20-6-2305 — Threshold Rate Review – Individual Health Insurance:
Provides the Arizona DOI the authority to review any health care service organization (HMO) rate increase where the average increase for all enrollees weighted by premium volume is 10% or more.
AZ Rev Stat § 20-1342.02 — Insurance:
Insurance companies must file their proposed rates with the department of insurance, but the rates may go into effect without department approval. The department may have the ability to go back and disapprove a rate increase that was later deemed unreasonable, usually triggered by a consumer complaint process.

Creating or Reducing Barriers to New Entrants

AZ Rev Stat § 20-1057 — Telemedicine; coverage of health care services; definitions: Health Care Services Organizations:
An evidence of coverage issued, delivered or renewed by a health care services organization on or after January 1, 2015 must provide coverage for health care services that are provided through telemedicine if the health care service would be covered were it provided through in-person consultation between the enrollee and a health care provider and provided to an enrollee receiving the service in a rural region of this state. The evidence of coverage may limit the coverage to those health care providers who are members of the health care services organization's provider network.

Appendix

ARKANSAS

Antitrust

AR Code § 4-75-315 — Civil actions and settlements by the Attorney General: Monopolies Generally:
States that whenever the Attorney General has reason to believe that any person is engaging, has engaged, or is about to engage in any act or practice declared unlawful by this subchapter, the Attorney General may bring an action in the name of the state against that person.
AR Code §§ 4-75-201 through 4-75-217 — Unfair Practices Act:
States that the General Assembly declares that the purpose of this subchapter is to safeguard the public against the creation or perpetuation of monopolies and to foster and encourage competition by prohibiting unfair and discriminatory practices by which fair and honest competition is destroyed or prevented.
AR Code § 4-88-113 — Civil enforcement and remedies – Suspension or forfeiture of charter:
States that the court may take certain approaches to prohibit unlawful practices, brought by the Attorney General, as defined in this chapter.

Encouraging Price Transparency

AR Code §§ 20-7-301 through 20-7-306 — State Health Data Clearinghouse Act:
To better understand patterns and trends in the availability, use, and costs of health care services, the Division of Health within the Department of Health and Human Services (DHHS) will compile and disseminate health data for its price transparency and consumer driven health care project. All hospital and outpatient surgery centers will submit health data and price information to the department.

AR Code §§ 20-8-401 through 20-8-404 — Health Data Initiative:
The purpose is to serve as a repository of state and federal health information to support policy officials. The Arkansas Center for Health Improvement will work with state agencies to access the following data: (1) Public health data- bases; (2) Health care utilization data; (3) Financial data related to the procurement of health or health care-related services; (4) Data supplied as part of mandated reporting requirements to state agencies by entities, including, but not limited to, other state agencies and departments, nonstate entities, external vendors, and other entities as identified by the initiative; (5) Data collected and maintained under the State Health Data Clearinghouse Act, § 20-7-301 et seq.; and (6) Other data sources supported and maintained with state funds.

AR Code § 23-99-407 — "Gag clause" prohibition: Arkansas Health Care Consumer Act:
No participating provider may be prohibited, restricted, or penalized in any way from disclosing to any covered person any healthcare information that the participating provider deems appropriate regarding the nature of treatment, risks, or alternatives thereto, the availability of alternate therapies, consultations, or tests, the decision of utilization reviewers or similar persons to authorize or deny services, the process that is used to authorize or deny healthcare services or benefits, or information on financial incentives and structures used by the insurer.

AR Code §§ 23-61-901 through 23-61-910 — Arkansas Healthcare Transparency Initiative Act of 2015:
It is the intent of the General Assembly to create and maintain an informative source of healthcare information to support consumers, researchers, and policymakers in healthcare decisions within the state.

AR Code § 20-8-110. Collection and dissemination of health data: Health Services Permit Agency
The Health Services Permit Agency shall act as a statewide health data clearinghouse for the acquisition and dissemination of data from healthcare providers, the Arkansas Medicaid Program, third-party payors, state agencies, and other appropriate sources.

Competitive Behavior in Health Plan Contracting

AR Code § 23-99-1204 — Prohibition–Most favored nation clause: Healthcare Contracting Simplification Act:
Prohibits the use of most favored nation clauses, a promise obtained by an insurer that the provider will not give a better price to another insurer.

AR Code §§ 23-99-201 through 23-99-209 — Patient Protection Act of 1995:
Benefit differentials are prohibited. Insurers must give qualified health care providers the opportunity to participate if providers are willing to accept the plan's terms and conditions.

Expansion of DOI Authority

AR Code § 23-67-207 — Noncompetitive market: Regulation of Insurance Rates:
If the Insurance Commissioner has cause to believe that a reasonable degree of competition does not exist in a market, the commissioner shall hold a hearing. The commissioner shall

consider relevant tests of competition pertaining to market structure, market performance, and market conduct, and the practical opportunities available to consumers in the market to acquire pricing and other consumer information and to compare and obtain insurance from competing insurers.

Creating or Reducing Barriers to New Entrants

AR Code §§ 20-9-201 through 20-9-223 — Health Facilities Services:
Certificate of Need guidelines and principles.
AR Code § 23-76-130 — Insurance Commissioner's authority to contract: Health Maintenance:
The Insurance Commissioner may contract with qualified persons to make recommendations concerning the adequacy, network adequacy, or accessibility of healthcare services under a healthcare plan furnished or proposed to be furnished by a health maintenance organization.
AR Code § 23-79-1602 — Coverage for telemedicine: Coverage for Services Provided Through Telemedicine:
A health benefit plan shall not impose on coverage for healthcare services provided through telemedicine
AR Code §§ 17-80-401 through 17-80-407 — Telemedicine Act:
Outlines how a professional should utilize telemedicine.
AR Code § 23-79-154 — Reimbursement for physician assistant services: Insurance Policies Generally — General Provisions:
A health plan shall not refuse to reimburse a physician at the full rate for healthcare services provided by a physician assistant if the practice complies with the laws of this state.
AR Code § 23-79-157 — Payment for services rendered by physical therapists, Occupational therapists, and speech-language pathologists: Insurance Policies Generally — General Provisions:
An insurer shall not impose a copayment, coinsurance, or an office visit deductible amount or a combination of a copayment, coinsurance, or an office visit deductible amount charged to the insured for services rendered for a date of service by a licensed physical therapist, Occupational therapist, or speech-language pathologist that is greater than the copayment, coinsurance, or office visit deductible amount charged to the insured for an office visit for the service of a licensed primary care physician or osteopath.

Appendix

CALIFORNIA

Antitrust

CA Corp. Code §§ 5913 through 5930 — Sales of Assets – Health Facilities:
States that a corporation shall give written notice to the Attorney General 20 days before it sells, leases, conveys, exchanges, transfers or otherwise disposes of all or substantially all of its assets unless the transaction is in the usual and regular course of its activities or unless the Attorney General has given the corporation a written waiver of this section as to the proposed transaction. The Attorney General shall have discretion to consent to, give conditional consent to, or not consent to any agreement or transaction described in subdivision (a) of Section 5914.
CA Corp. Code §§ 6010 through 6019 — Merger:
A public benefit corporation may merge with any domestic corporation, foreign corporation (Section 171), or other business entity (Section 5063.5). However, without the prior written consent

of the Attorney General, a public benefit corporation may only merge with another public benefit corporation or a religious corporation or a foreign nonprofit corporation or an unincorporated association the governing documents of which provide that its assets are irrevocably dedicated to charitable, religious, or public purposes. In addition, a public benefit corporation that is exempt from the supervisory authority of the Attorney General pursuant to Sections 12581 and 12583 of the Government Code by virtue of being a committee, as defined in Section 82013 of the Government Code, that is required to and does file any statement pursuant to the provisions of Article 2 (commencing with Section 84200) of Chapter 4 of Title 9 of the Government Code, may merge with another public benefit corporation similarly exempt without having to obtain the Attorney General's consent.

CA Bus Code §§ 16600 through 17365 — Preservation and Regulation of Competition:
Every contract by which anyone is restrained from engaging in a lawful profession, trade, or business of any kind is to that extent void.

CA Bus Code § 16770 — General Provisions:
Effect of antitrust prohibitions on health care services.

CA Health & Safety Code §§ 1340 through 1345 — Knox-Keene Health Care Service Plan Act of 1975 – General:
States that there is in state government, in the California Health and Human Services Agency, a Department of Managed Health Care that has charge of the execution of the laws of this state relating to health care service plans and the health care service plan business including, but not limited to, those laws directing the department to ensure that health care service plans provide enrollees with access to quality health care services and protect and promote the interests of enrollees.

CA Bus & Prof Code §§ 17000 through 17101 — Unfair Trade Practices:
The Legislature declares that the purpose of this chapter is to safeguard the public against the creation or perpetuation of monopolies and to foster and encourage competition, by prohibiting unfair, dishonest, deceptive, destructive, fraudulent and discriminatory practices by which fair and honest competition is destroyed or prevented.

CA Bus Code §§ 17200 through 17210 — Preservation and Regulation of Competition:
Defines general unfair trade practices for the market generally; limits monopoly power.

Encouraging Price Transparency

CA Health & Safety Code § 1367.49, 1367.50 & **1367.52**— Standards:
No contract between a health care service plan and a provider or a supplier shall prohibit, condition, or in any way restrict the disclosure of claims data related to health care services provided to an enrollee or subscriber of the health care service plan or beneficiaries of any self-funded health coverage arrangement administered by the health care service plan, to a qualified entity. Requires claims disclosure

CA Ins Code § 10117.52 — General Provisions:
No health insurance contract between a health insurer and a provider or a supplier shall prohibit, condition, or in any way restrict the disclosure of claims data related to health care services provided to a policyholder or insured of the insurer or beneficiaries of any self-insured health coverage arrangement administered by the insurer, to a qualified entity.

CA Health & Safety Code §§ 1339.50 through 1339.59 — Payers' Bill of Rights:
Requires hospitals to make a written or electronic copy of their charge description master available online or onsite, as well as submit a copy to the Office of Statewide Health Planning and Development (OSHPD).

CA Health & Safety Code § 128735 — Health Facility Data:

Requires health care facilities to submit a statement detailing patient revenue by payer and hospital discharge data to OSHPD.
CA Health & Safety Code §§ 127670 through 127674 — Health Care Cost Transparency Database:
It is the intent of the Legislature in enacting this chapter to establish a system to collect information regarding the cost of health care. Health care data is reported and collected through many disparate systems. Creating a process to aggregate this data will provide greater transparency regarding health care costs, and the information may be used to inform policy decisions regarding the provision of quality health care, reduce disparities, and reduce health care costs.

Expansion of DOI Authority

10 CA ADC §§ 2222.10 through 2222.19— Standards for Determining Whether Benefits of an Individual Hospital, Medical or Surgical Policy are Unreasonable in Relation to the Premium Charged Pursuant to Subdivision C:
Standards for Determining Whether Benefits of an Individual Hospital, Medical or Surgical Policy Are Unreasonable in Relation to the Premium Charged Pursuant to Subdivision (C) of Section 10293.
CA Ins Code § 10293 — Approval of Commissioner:
Authority for commissioner to consider reasonableness of premiums (but **CA** does not have prior approval).
CA Health & Safety Code §§ 1385.01 through 1385.13 — Knox-Keene Health Care Service Plan Act of **1975** – Review of Rate Increases:
All health care service plans shall file with the department all required rate information for grandfathered individual and grandfathered and non-grandfathered small group health care service plan contracts at least 120 days prior to implementing any rate change. If the department determines that a plan's rate increase for individual or small group health care service plan contracts is unreasonable or not justified consistent with this article, the health care service plan shall provide notice of that determination to any individual or small group applicant. The notice provided to an individual applicant shall be consistent with the notice described in subdivision (c) of Section 1389.25. The notice provided to a small group applicant shall be consistent with the notice described in subdivision (c) of Section 1374.21.
CA Health & Safety Code § 1342.4 — Knox-Keene Health Care Service Plan Act of 1975 – General:
Discusses the Department of Insurance's role in ensuring consumer protections.

Creating or Reducing Barriers to New Entrants

10 CA ADC §§ 2240 through 2240.5 — Provider Network Access Standards for Disability Policies and Agreements:
Outlines provisions for provider network access standards; defines that providers cannot make any additional charges for rendering network services except as provided for in the contract between the insurer and the insured.
CA Health & Safety Code §§ 129475 through 129535 — Health Planning:
Indefinitely suspended the requirement that health facilities and specialty clinics apply for, and obtain, certificates of need or certificates of exemption.
CA Health & Safety Code §§ 1250 through 1264 — Health Facilities:
Indefinitely suspended the requirement that health facilities and specialty clinics apply for, and obtain, certificates of need or certificates of exemption.
Telehealth

CA Health & Safety Code § 1374 — Telehealth; medical services without in-person contact; type of setting where services are provided; health care service plan and Medi-Cal managed care plan contracts with the department; use of telehealth not to be required if inappropriate: Knox-Keene Health Care Service Plan Act of 1975:
No health care service plan shall require that in-person contact occur between a health care provider and a patient before payment is made for the covered services appropriately provided through telehealth, subject to the terms and conditions of the contract entered into between the enrollee or subscriber and the health care service plan, and between the health care service plan and its participating providers or provider groups.
CA Bus & Prof Code § 3535 — Employment qualifications; scope of practice; supervision; application; fees; violations: Osteopathic Physician Assistants:
Notwithstanding any other provision of law, physicians and surgeons licensed by the Osteopathic Medical Board of California may use or employ physician assistants provided (1) each physician assistant so used or employed is a graduate of an approved program and is licensed by the board, and (2) the scope of practice of the physician assistant is the same as that which is approved by the Division of Licensing of the Medical Board of California for physicians and surgeons supervising physician assistants in the same or similar specialty.
CA Bus & Prof Code §§ 2725, 2725.5, & 2728.5 — Nursing — Scope of Regulation:
"The practice of nursing within the meaning of this chapter means those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require a substantial amount of scientific knowledge or technical skill, including all of the following:
(1) Direct and indirect patient care services that ensure the safety, comfort, personal hygiene, and protection of patients; and the performance of disease prevention and restorative measures.
(2)Direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a physician, dentist, podiatrist, or clinical psychologist, as defined by Section 1316.5 of the Health and Safety Code.
(3) The performance of skin tests, immunization techniques, and the withdrawal of human blood from veins and arteries.
(4)Observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and (A) determination of whether the signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics, and (B) implementation, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures."
CA Bus & Prof Code §§ 3500 through 3503 — Physician Assistants — General Provisions:
Notwithstanding any other provision of law, a physician assistant may perform those medical services as set forth by the regulations of the board when the services are rendered under the supervision of a licensed physician and surgeon who is not subject to a disciplinary condition imposed by the board prohibiting that supervision or prohibiting the employment of a physician assistant.
CA Bus & Prof Code §§ 2834 through 2837 — Nurse Practitioners:
Furnishing or ordering of drugs or devices by nurse practitioners is defined to mean the act of making a pharmaceutical agent or agents available to the patient in strict accordance with a standardized procedure.
CA Bus & Prof Code § 2069 — Medical assistants; authorized tasks under direction of certain medical professionals; delegation of supervision; authorization of activities which medical assistant is not authorized to perform prohibited; inpatient care in general acute care hospitals prohibited: License Required and Exemptions:

Notwithstanding any other law, a medical assistant may administer medication only by intradermal, subcutaneous, or intramuscular injections and perform skin tests and additional technical supportive services upon the specific authorization and supervision of a licensed physician and surgeon or a licensed podiatrist. A medical assistant may also perform all these tasks and services upon the specific authorization of a physician assistant, a nurse practitioner, or a certified nurse-midwife.

Appendix

COLORADO

Antitrust

CO Rev Stat §§ 10-4-401 through 10-4-421 — Rate Regulation:
The purpose of this part 4 is to promote the public welfare by regulating insurance rates to the end that they not be excessive, inadequate, or unfairly discriminatory, to prohibit price-fixing agreements and other anticompetitive behavior by insurers, to promote price competition among insurers, to provide rates that are responsive to competitive market conditions, and to improve the availability and reliability of insurance. For such purposes, the division of insurance of the department of regulatory agencies and the head of the division, the commissioner of insurance, shall be charged with the execution of this part 4.
CO Rev Stat §§ 6-4-101 through 6-4-122 — Colorado Antitrust Act of 1992:
The general assembly hereby finds and determines that competition is fundamental to the free market system and that the unrestrained interaction of competitive forces will yield the best allocation of our economic resources, the lowest prices, the highest quality commodities and services, and the greatest material progress, while at the same time providing an environment conducive to the preservation of our democratic, political, and social institutions.
CO Rev Stat §§ 6-1-101 through 6-1-115 — Consumer Protection - General:
The attorney general and the district attorneys of the several judicial districts of this state are concurrently responsible for the enforcement of this article. Until the Colorado supreme court adopts a venue provision relating to this article, actions instituted pursuant to this article may be brought in the county where an alleged deceptive trade practice Occurred or where any portion of a transaction involving an alleged deceptive trade practice Occurred, or in the county where the principal place of business of any defendant is located, or in the county in which any defendant resides.

Encouraging Price Transparency

CO Rev Stat § 10-16-104 — Mandatory coverage provisions–definitions–rules: Health Care Coverage:
Reporting of health care and quality data to enable transparency. Also contains mandatory coverage provisions.
CO Rev Stat § 10-16-133 — Health carrier information disclosure -website-insurance producer fees and disclosure requirements-legislative declaration-rules: Colorado Health Care Coverage Act:
The commissioner shall implement and maintain a consumer guide on the division of insurance website that is easily accessible and available to consumers regarding each carrier authorized to do business in this state.

CO Rev Stat § 10-16-134 — Health care transparency-information required-website-definition: Colorado Health Care Coverage Act:
A health care facility shall make available to the public, in a single document, either electronically or by posting conspicuously on its website if one exists, the health care prices for certain services.
CO Rev Stat § 10-16-221 — Statewide health care review committee - creation - membership - duties: Sickness and Accident Insurance:
Creates the statewide health care review committee created to study health care issues that affect Coloradans.
CO Rev Stat § 10-16-704 —Network adequacy - rules - legislative declaration:
Provides some protections for consumers when care is received, unknowingly, from providers that are out-of-network.
CO Rev Stat § 10-16-709 — Evaluation-nonparticipating health care providers-legislative declaration-rules: Health Care Coverage Act:
Declares that it is in the interest of consumers to inform health plans, providers and others of health insurance coverage in order to avoid balance billing.
CO Rev Stat §§ 25-3-601 through 25-3-603 — Hospital Acquired Infections Disclosure:
The hospital report card act provides that the executive director shall approve a comprehensive hospital information system to provide for the collection, compilation, coordination, analysis, indexing, and utilization data.
CO Rev Stat §§ 25-3-701 through 25-3-705 — Colorado Hospital Report Card Act:
Each hospital licensed pursuant to part **1** of this article shall report annually to the association of hospitals the information necessary to allow the association to determine the charges for the twenty-five most common inpatient diagnostic related groups for which there are at least ten cases rendered by the hospital during the calendar year immediately preceding the release of the hospital charge report. The commissioner of insurance shall work with the association of hospitals to incorporate the information reported pursuant to this section on the website.
CO Rev Stat §§ 25-49-101 through 25-49-105 — Transparency in Health Care Prices Act:
A health care provider shall make available to the public, in a single document, either electronically or by posting conspicuously on the provider's website if one exists, the health care prices for at least the fifteen most common health care services the health care provider provides.
CO Rev Stat §§ 25.5-1-204 through 25.5-1-204.5 — Health Care Policy and Financing Act:
Creates an advisory committee for the all payer health claims database that would support the database in its established mission of facilitating the reporting of health care and health quality data that results in transparent and public reporting of safety, quality, cost, and efficiency information; and analysis of health care spending and utilization patterns for purposes that improve the population's health, improve the care experience, and control costs.

Competitive Behavior in Health Plan Contracting

CO Rev Stat §§ 25-37-101 through 25-37-116 — Contracts with Health Care Providers:
Creates a standard managed care contract for insurers-physicians—the contract does not include a most favored nation clause, which effectively prohibits such clauses in insurer-physician contracts. While not an explicit ban on most favored nation clauses, it does create a standard managed care contract which does not include a most favored nation clause.

Monitoring/Regulating Prices

CO Rev Stat § 25-3-105 — License–fee–rules–penalty: Hospitals:
Authorizes state board of health to establish a fee schedule.

Regulation Around Development of ACOs

CO Rev Stat § 12- 36.5-104 — Establishment of professional review committees - function - rules: Professional Review Proceedings - Physicians:
Contains a provision which allows an ACO created under the Affordable Care Act to qualify as a professional review committee.
CO Rev Stat § 25.5-5-419 — Accountable care collaborative-reporting-rules: Statewide Managed Care System:
Outlines a plan for the state department's development of accountable care organizations.

Expansion of DOI Authority

CO Rev Stat § 10-1-304 — Authority and scope of market conduct surveillance - rules: Market Conduct:
The commissioner may conduct market conduct surveillance of any company as often as the commissioner, in the commissioner's sole discretion, deems appropriate. When initiating market conduct surveillance and in determining its nature, scope, and frequency, the commissioner may consider any market analysis performed pursuant to section 10-1-303 and any other criteria as set forth in the most recent available edition of the Market Regulation Handbook.
CO Rev Stat § 10-1-108 — Duties of Commissioner-report-publications-fees-disposition of funds adoption of rules -examinations and investigations: Insurance-General Provisions:
Outlines the Commissioner's duties, including examining requests for and granting certificates of authority, disseminating insurance information to the public, adopting rules around adequate provider networks, and reviewing and determining if rates are reasonable, among other things.
CO Rev Stat § 10-16-107 — Rate filing regulation - benefits ratio - rules:
Vests the insurance commissioner with prior approval authority.

Creating or Reducing Barriers to New Entrants

CO Rev Stat § 10-16-704 — *Network Adequacy*-rules-legislative declaration: Consumer Protection
Standards Act for the Operation of Managed Care Plans:
A carrier providing a managed care plan shall maintain a network that is sufficient in numbers and types of providers to assure that all covered benefits to covered persons will be accessible without unreasonable delay. In the case of emergency services, covered persons shall have access to health care services twenty-four hours per day, seven days per week.
CO Rev Stat § 25.5-5-406.1 — Required features of statewide managed care system: Colorado Medical Assistance Act:
The MCE shall meet the network adequacy standards, as established by the state department, describing the maximum time and distance an enrolled member is expected to travel in order to access the provider types covered under the state contract;
CO Rev Stat § 10-16-123 — Telehealth-Definitions: Colorado Health Care Coverage Act:
Recognizes that the practice of telehealth is a legitimate mode of providing health care, no longer requiring in-person contact as part of the health benefit plan.
CO Rev Stat § 25.5-5-414 — Telemedicine Legislative Intent: Colorado Medical Assistance Act:

Establishes the legislative intent to recognize the practice of telemedicine as a legitimate means by which an individual can receive medical services. It also authorizes the state to expend resources to promote telemedicine.
CO Rev Stat § 6-18-303 — Effect on scope of practice – limited exception to prohibitions on corporate practice of licensed health care providers: Provider Networks:
The fact that an entity or provider is a member of a provider network shall not exempt such entity from any licensure or scope of practice statute. This includes other employment and joint venture relationships.
CO Rev Stat § 25.5-4-409 — Authorization of services-nurse anesthetists-advanced practice nurses: Colorado Medical Assistance Act:
Describes reimbursement of services by certified registered nurse anesthetists.
CO Rev Stat §10-16-125 — Reimbursement to nurses: Colorado Health Care Coverage Act:
A health plan or carrier shall not discriminate between a physician and an advanced nurse when establishing payment rates for covered services that could be performed by either party.

Appendix

CONNECTICUT

Antitrust
CT Gen Stat §§ 35-24 through 35-49 — Connecticut Antitrust Act:
Connecticut Antitrust Act
CT Gen Stat §§ 42-110a through 42-110q — Unfair Trade Practices:
States that no person shall engage in unfair methods of competition and unfair or deceptive acts or practices in the conduct of any trade or commerce. The commissioner may, in accordance with chapter 54, establish by regulation acts, practices or methods which shall be deemed to be unfair or deceptive in violation of subsection (a) of this section.
CT Gen Stat §§ 19a-486 through 19a-487b — Health Care Institutions:
States that no nonprofit hospital shall enter into an agreement to transfer a material amount of its assets or operations or a change in control of operations to a person that is organized or operated for profit without first having received approval of the agreement by the executive director and the Attorney General pursuant to sections 19a-486 to 19a-486h, inclusive, and pursuant to the Attorney General's authority under section 3-125. Prior to any transaction described in subsection (a) of this section, the nonprofit hospital and the purchaser shall concurrently submit a certificate of need determination letter as described in subsection (c) of section 19a-638 to the executive director and the Attorney General by serving it on them by certified mail, return receipt requested, or delivering it by hand to each office.

Encouraging Price Transparency
CT Gen Stat § 19a-508c — Hospital and health system facility fees charged for outpatient services at hospital-based facilities. Notice re establishment of hospital-based facility at which facility fees billed: Health Care Institutions:
If a hospital or health system charges a facility fee utilizing a current procedural terminology evaluation and management (CPT E/M) code for outpatient services provided at a hospital-based facility where a professional fee is also expected to be charged, the hospital or health system shall provide the patient with a written notice.

CT Gen Stat §§ 19a-612 through 19a-613 — Office of Health Care Access:
Establishes the Office of Health Care which is tasked to collect patient-level outpatient data from health care facilities or institutions.
CT Gen Stat §§ 19a-644 through 19a-654 — Office of Health Care Access:
Establishes requirements for submitting data.
CT Gen Stat § 19a-634 — State-wide health care facility utilization study:
State-wide health care facilities and services plan. Inventory of health care facilities, equipment and services.
CT Gen Stat §§ 19a-755a through 19a-755b — Health Information Technology: Describes expectations for the consumer health information Internet web site including, information comparing quality, price and cost of health care services, be designed to assist consumers and institutional purchasers in making informed decisions.
CT Gen Stat § 19a-724b — *All-Payer Claims Database* program: Office of Health Reform and Innovation:
Authorizes Access Health CT to (A) Oversee the planning, implementation and administration of the all-payer claims database program for the purpose of collecting, assessing and reporting health care information relating to safety, quality, cost-effectiveness, access and efficiency for all levels of health care; (B) ensure that data received from reporting entities is securely collected, compiled and stored in accordance with state and federal law; and (C) conduct audits of data submitted by reporting entities in order to verify its accuracy.
CT Gen Stat § 38a-1091 — *All-Payer Claims Database* program:
There is established an all-payer claims database program. The exchange shall: (A) Oversee the planning, implementation and administration of the all-payer claims database program for the purpose of collecting, assessing and reporting health care information relating to safety, quality, cost-effectiveness, access and efficiency for all levels of health care; (B) ensure that data received from reporting entities is securely collected, compiled and stored in accordance with state and federal law; and (C) conduct audits of data submitted by reporting entities in order to verify its accuracy.
CT Gen Stat § 38a-478k — Gag clauses prohibited: Health Insurance: Managed Care:
No contract delivered, issued for delivery, renewed, amended or continued in this state between a managed care organization and a participating provider shall prohibit the provider from discussing with an enrollee any treatment options and services available in or out of network, including experimental treatments. No contract delivered, issued for delivery, renewed, amended or continued in this state between a managed care organization and a participating provider shall prohibit the provider from disclosing, to an enrollee who inquires, the method the managed care organization uses to compensate the provider.
CT Gen Stat § 38a-477aa — Cost-sharing and health care provider reimbursement for emergency services and surprise bills: Health Insurance: In General:
No health carrier shall impose, for emergency services rendered to an insured by an out-of-network health care provider, a coinsurance, copayment, deductible or other out-of-pocket expense that is greater than the coinsurance, copayment, deductible or other out-of-pocket expense that would be imposed if such emergency services were rendered by an in-network health care provider. A health carrier shall reimburse the out-of-network health care provider or insured, as applicable, for health care services rendered at the in-network rate under the insured's health care plan as payment in full, unless such health carrier and health care provider agree otherwise.
CT Gen Stat § 38a-477h — Participating provider directories: Health Insurance: In General:
Requires health plans to post on its web site a current and accurate participating provider directory, updated at least monthly, for each of its network plans and provide such information upon request from a covered person.

CT Gen Stat § 38a-477f — Contract provision prohibiting certain disclosures prohibited: Health Insurance -- In General:
Prohibits contracts entered into after Jan 2016 from containing provisions that prohibit the disclosure of billed or allowed amounts, reimbursement rates or out of pocket costs and any data to the all-payer claims database program.
CT Gen Stat § 38a-478d — Provider directory. Notification to enrollee of termination or withdrawal of enrollee's primary care provider: Health Insurance: Managed Care:
Requires managed care organizations to provide a provider directory to each enrollee annually, allow an enrollee to designate a participating, in network provider as its primary care provider, and notify the enrollee upon the termination or withdrawal of his or her primary care provider.

Expansion of DOI Authority

CT Gen Stat § 38a-676a — Review of classifications, rules, rates and form of commercial risk insurance contracts. Waiting period for workers' compensation and employers' liability insurance. Prior rate approval and hearing re medical malpractice insurance:
Each admitted insurer shall submit to the Insurance Commissioner for the commissioner's information, except as to inland marine risks which by general custom of the business are not written according to manual rates or rating plans, each manual of classifications, rules and rates, and each minimum, class rate, rating plan, rating schedule and rating system and any modification of the foregoing which it uses.
CT Gen Stat § 38a-9 — Divisions of Consumer Affairs and Rate Review. Duties. Annual reports by commissioner. Arbitration procedure: Insurance Commissioner. Powers and Duties:
Subject to the provisions of sections 38a-663 to 38a-696, inclusive, the division shall assist the commissioner in reviewing rates and supplementary rate information filed with the department for compliance with statutory requirements and standards.
CT Gen Stat § 19a-638 — Certificate of Need:
Certificate of Need guidelines and principles.

Competitive Behavior in Health Plan Contracting

CT Gen Stat § 38a-479b(d) — Material changes to fee schedules:
Banning most favored nation clauses, a promise obtained by an insurer that the provider will not give a better price to another insurer.

Creating or Reducing Barriers to New Entrants

CT Gen Stat § 38a-472f — Access plan duties and responsibilities. Access plan filing: Health Insurance:
The Insurance Commissioner shall determine the sufficiency of a health carrier's network in accordance with the provisions of this subsection and may establish sufficiency by reference to any reasonable criteria.
CT Gen Stat §§ 19a-638 through 639f — Office of Health Care Access — Certificate of Need:
Requires health care facilities, proposing to relocate a facility, to submit a letter to the office demonstrating that the population served and payer mix will not substantially change.
CT Gen Stat § 19a-486a — Sale of nonprofit hospitals: *Certificate of Need* determination letter. Hearing. Application for approval: Health Care Institutions:
Requires Certificate of Need determination for sale of non-profit hospitals.
CT Gen Stat § 19a-906 — Telehealth services: Public Health and Well-Being — Miscellaneous Provisions:

Describes when it is appropriate for telehealth providers to provide telehealth services to the patient, such as when the telehealth provider is communicating real-time, has access to the patient's medical history, among other things.
CT Gen Stat § 38a-526a — Coverage for telehealth services: Group Health Insurance:
States that each group health insurance policy shall provide coverage for medical advice, diagnosis, care or treatment through telehealth to the extent coverage is provided in-person.
CT Gen Stat § 38a-499a — Coverage for telehealth services: Individual Health Insurance:
States that each group health insurance policy shall provide coverage for medical advice, diagnosis, care or treatment through telehealth to the extent coverage is provided in-person.
CT Gen Stat § 20-87a — Definitions. *Scope of Practice*: Nursing:
States that an advanced practice registered nurse with a license shall collaborate with a physician licensed to practice medicine in Connecticut, providing them responsibility to prescribe, dispense, and administer medical therapeutics and corrective measures and…
CT Gen Stat § 20-9 — Who may practice medicine or surgery: Medicine and Surgery:
Nurses cannot practice medicine except in accordance with their licenses and under supervision of physician.
CT Gen Stat § 20-12d — Prescriptive authority: Medicine and by physician assistants. Prescriptive authority: Medicine and Surgery:
A physician assistant who has complied with the provisions of sections 20-12b and 20-12c may perform medical functions delegated by a supervising physician when: (1) The supervising physician is satisfied as to the ability and demonstrated competency of the physician assistant; (2) such delegation is consistent with the health and welfare of the patient and in keeping with sound medical practice; and (3) such functions are performed under the oversight, control and direction of the supervising physician.
CT Gen Stat § 38a-499 — Coverage of services of physician assistants and certain nurses: Individual Health Insurance:
Insurance policies shall provide coverage for the services of physician assistants, certified nurse practitioners, certified psychiatric-mental health clinical nurse specialists and certified nurse-midwives if such services are within the individual's area of professional competence as established by education and licensure or certification and are currently reimbursed when rendered by any other licensed health care provider.
CT Gen Stat § 38a-526 — Coverage of services of physician assistants and certain nurses: Group Health Insurance:
Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for the services of physician assistants, certified nurse practitioners, certified psychiatric-mental health clinical nurse specialists and certified nurse-midwives if such services are within the individual's area of professional competence as established by education and licensure or certification and are currently reimbursed when rendered by any other licensed health care provider.
CT Gen Stat § 20-94b — Nurse anesthetists. Prescriptive authority: Nursing:
An advanced practice registered nurse licensed pursuant to section 20-94a and maintaining current certification from the American Association of Nurse Anesthetists may prescribe, dispense and administer drugs, including controlled substances in schedule II, III, IV,
CT Gen Stat §§ 20-12a through 20-12l — Medicine and Surgery:
Defines terms and scope of Physicians Assistants.

Appendix

DELAWARE

Antitrust

6 DE Code §§ 2101 through 2114 — Delaware Antitrust Act:
States that the purpose of this chapter shall be to promote the public benefits of a competitive economic environment based upon free enterprise. It is the intent of the General Assembly to promote efficiency in business operations, an equitable return on capital investments, an efficient allocation of goods and services and freedom of economic opportunity.
18 DE Code §§ 2301 through 2318 — Unfair Trade Practices Act:States that the purpose of this chapter is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945, 15 U.S.C. § 1011 et seq., by defining or providing for the determination of all such practices in this State which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

Encouraging Price Transparency

16 DE Code §§ 2001 through 2009 — Uniform Health Data:
It is the purpose of this chapter to establish a health information data base that will assist the health care system to advance the general well-being of the population by better directing and improving the availability of health-care services.
18 DE Code § 3348 — Referrals: Uniform Health Policy Provisions Law:
This section applies to every policy or contract of health insurance which is delivered or issued for delivery in this State, including each policy or contract issued by a health service corporation, and which designates network physicians or providers or preferred physicians or providers (hereinafter referred to collectively as "network providers"). In such circumstances, the non-network provider may not balance bill the insured.
16 DE Code §§ 10301 through 10315 — The Delaware Health Care Claims Database:
Creates a centralized health care claims database to enable the State to more effectively understand utilization across the continuum of health care in Delaware and achieve the Triple Aim.
24 DE Code § 1769 — Disclosure of laboratory costs: Medical Practice Act -- Miscellaneous Provisions:
Statute requires that a person who bills patients or third-party payors for individual tests or test series administered by a clinical laboratory shall disclose on the bill the name of the laboratory, the amount or amounts charged by the laboratory for individual tests or test series and the amount of any procurement or processing charge made by the person certified to practice medicine.
18 DE Code § 3303 — Scope, format of policy: Uniform Health Policy Provisions Law:
Statutes lay out the requirements of a health insurance policy and state that the policy shall contain no provision or nondisclosure clause prohibiting physicians or other healthcare providers from giving patients information regarding diagnoses, prognoses and treatment options.
18 DE Code § 6414 — Nondisclosure clause: Delaware Managed Care Organization Act:
A managed care organization contract shall contain no provision or nondisclosure clause prohibiting physicians or other health-care providers from giving patients information regarding diagnoses, prognoses and treatment options.

Monitoring/Regulating Prices

16 DE Code § 9902-9903 — Delaware Health Care Commission:
Establishes a Delaware Health Care Commission and defines its duties and responsibilities, one of which includes: monitoring cost trends in order to recommend methods to reduce and control health-care costs for public programs and in conjunction with the private sector.

Expansion of DOI Authority

16 DE Code §§ 9902 through 9903 — Delaware Health Care Commission:
Vest the insurance commissioner with prior approval authority
16 DE Code §§ 2503 through 2507 — Health-Care Decisions:
All hospitals and all nursing homes must submit all hospital and nursing home inpatient discharges to the agency. All compilations prepared and authorized by the state agency for release and dissemination shall be public records.

Creating or Reducing Barriers to New Entrants

16 DE Code §§ 9301 through 9312 — Health Planning and Resources Management:
Requires a health care facility must obtain a "Certificate of Public Review" (analogous to a Certificate of Need) prior the acquisition of major medical equipment or the construction or expansion of a facility.
24 DE Code §§ 1702 & 1769D — Medical Practice Act — Miscellaneous Provisions:
Physicians may practice telemedicine and telehealth. Provided that telemedicine shall not be utilized by a physician with respect to any patient in the absence of a physician-patient relationship, except for the instances in subsection (k) of this section.
24 DE Code §§ 1770 through 1772 — Physician Assistants:
Delegated medical acts provided by physician assistants to include, but not be limited to:
a. The performance of complete patient histories and physical examinations;
b. The recording of patient progress notes in an outpatient setting;
c. The relaying, transcribing, or executing of specific diagnostic or therapeutic orders;
d. Medical acts of diagnosis and prescription of therapeutic drugs and treatments which have been delegated by the supervising physician;
e. Prescriptive authority for therapeutic drugs and treatments within the scope of physician assistant practice, as delegated by the supervising physician. The physician assistant's prescriptive authority and authority to practice as a physician assistant are subject to biennial renewal upon application to the Physician Assistant Regulatory Council; and
f. The use of telemedicine as defined in this chapter and, as further described in regulation, the use of and participation in telehealth.

Appendix

FLORIDA

Antitrust

FL Stat §§ 626.951 through 626.99 — Unfair Insurance Trade Practices:
Defines unfair insurance trade practices and provides the state the authority to regulate.

FL Stat § 641.3903 — Unfair methods of competition and unfair or deceptive acts or practices defined:
Defines unfair methods of competition and unfair or deceptive acts or practices.
FL Stat § 542.27 — Enforcement authority: Combinations Restricting Trade or Commerce:
States that the Attorney General, or a state attorney with written permission from the Attorney General, acting jointly or independently, may commence and try all criminal prosecutions under this chapter. The Attorney General is authorized to institute or intervene in civil proceedings seeking the full range of relief afforded by this chapter or by federal laws pertaining to antitrust or restraints of trade on behalf of the state, its departments, agencies, and units of government.
FL Stat §§ 408.18 through 408.185 — Health Facility and Service Planning:
The health care community (licensed providers, insurers, networks, purchasers, and other participants) may ask the AG's office to review their proposed business activity and essentially receive pre-clearance through an "antitrust no-action letter."

Encouraging Price Transparency

FL Stat § 408.05 — Florida Center for Health Information and Transparency: Health Care Administration:
Establishes a Florida Center for Health Information and Policy Analysis.
FL Stat §§ 408.061 through 408.063 — Health Facility and Service Planning:
Requires health care facilities, health care providers, and health insurers to submit data to the Agency for Health Care Administration.
FL Stat § 408.09 — Assistance on cost containment strategies: Health Facility and Service Planning:
The Agency for Health Care Administration can assist purchasers and employers requiring technical assistance on cost effective purchasing strategies as well as developing cost containment strategies.
FL Stat § 382.026 — Florida Patient's Bill of Rights and Responsibilities: Public Health: General Provisions:
A primary care provider may publish a schedule of charges for the medical services that the provider offers to patients. A health care provider or a health care facility shall, upon request, furnish a person, before the provision of medical services, a reasonable estimate of charges for such services. The health care provider or the health care facility shall provide an uninsured person, before the provision of a planned nonemergency medical service, a reasonable estimate of charges for such service and information regarding the provider's or facility's discount or charity policies for which the uninsured person may be eligible.
FL Stat § 110.12303 — State group insurance program; additional benefits; price transparency program; reporting: General State Employment Provisions:
Provides state employees information on the cost and quality of health care services and allows state employee plan members to shop for health care services and providers using price and quality information.
FL Stat § 400.9935 — Clinic Responsibilities: Health Care Clinic Act:
Ensure that the clinic publishes a schedule of charges for the medical services offered to patients. The schedule must include the prices charged to an uninsured person paying for such services by cash, check, credit card, or debit card.
FL Stat § 395.301 — Price transparency; itemized patient statement or bill; patient admission status notification: Hospitals and Other Licensed Facilities:
A facility licensed under this chapter shall provide timely and accurate financial information and quality of service measures to patients and prospective patients of the facility, or to patients' survivors or legal guardians, as appropriate. Each licensed facility shall make available to the

public on its website information on payments made to that facility for defined bundles of services and procedures. The payment data must be presented and searchable in accordance with, and through a hyperlink to, the system established by the agency and its vendor using the descriptive service bundles developed under s. 408.05(3)(c).
FL Stat § 627.6385 — Disclosures to policyholders; calculations of cost sharing: Health Insurance Policies:
Each health insurer shall make available on its website: (a) A method for policyholders to estimate their copayments, deductibles, and other cost-sharing responsibilities for health care services and procedures. Such method of making an estimate shall be based on service bundles established pursuant to s. 408.05(3)(c). Estimates do not preclude the actual copayment, coinsurance percentage, or deductible, whichever is applicable, from exceeding the estimate. (b) A method for policyholders to estimate their copayments, deductibles, and other cost-sharing responsibilities based on a personalized estimate of charges received from a facility pursuant to s. 395.301 or a practitioner pursuant to s. 456.0575.
FL Stat § 627.6499 — Reporting by insurers and third-party administrators: Insurance Rates and Contracts:
Each health insurance issuer shall make available on its Internet website a link to the performance outcome and financial data that is published by the Agency for Health Care Administration.
FL Stat § 627.0621 — Transparency in rate regulation: Rates and Rating Organizations:
Defines rate filing and describes the website for public access to rate filing information.
FL Stat § 641.54 — Information disclosure: Health Care Services:
Every health maintenance organization shall maintain a current list, by geographic area, of all hospitals which are routinely and regularly used by the organization, indicating to which hospitals the organization may refer particular subscribers for nonemergency services. The list shall also include all physicians under the organization's direct employ or who are under contract or other arrangement with the organization to provide health care services to subscribers. Subscribers may also access plan details.
FL Admin Code R 59B-9.030 — Purpose of Ambulatory and Emergency Department Patient Data Reporting:
Reporting of ambulatory and emergency department patient data will provide a statewide integrated database that includes hospital based and free standing ambulatory surgery centers, and hospital emergency department services for the assessment of variations in utilization, disease surveillance, access to care and cost trends.

Competitive Behavior in Health Plan Contracting

FL Stat § 456.053 — Financial arrangements between referring Health care providers and providers of Health care services: Health Professions and Occupations: General Provisions:
Discusses the issue of providers referring patients to facilities they have an ownership stake in. Acknowledges that it may be appropriate to refer to provider owned facilities as long as there are adequate safeguards.

Expansion of DOI Authority

FL Stat § 627.410 — Filing, approval of forms: Insurance Rates and Contracts:
Requires all insurance policies or annuity contract forms to be reviewed by the state.
FL Stat § 627.640 — Filing of classifications and rates: Insurance Rates and Contracts:
Insurers must file classification of risks and premium rates with the Commissioner's office before delivering or issuing policies.

FL Stat § 627.062 — Rate standards: Rates and Rating Organizations:
Insurers or rating organizations shall establish and use rates, rating schedules, or rating manuals that allow the insurer a reasonable rate of return on the classes of insurance written in this state.

Creating or Reducing Barriers to New Entrants

FL Stat §§ 408.031 through 408.7071 — Health Facility and Services Planning:
Certificate of Need requirement. Note: currently has a moratorium on certificate of need for additional nursing home beds until Medicaid managed care is implemented or until October 2016, whichever is earlier.

Appendix

GEORGIA

Antitrust

GA Code §§ 31-7-400 through 31-7-412 — Hospital Acquisition:
No acquiring entity shall engage in an acquisition without first notifying the Attorney General pursuant to this article. No nonprofit corporation which owns, controls, or operates, directly or indirectly, a hospital having a permit under this chapter shall engage in a disposition without first notifying the Attorney General pursuant to this article. The parties to the transaction shall provide the Attorney General with at least 90 days' notice of the proposed transaction prior to its consummation.

Encouraging Price Transparency

GA Code §§ 33-20C-1 through 33-20C-6 — Accurate Provider Directories:
Requirements for accurate and accessible provider directories.
GA Code §§ 31-7-280 through 31-7-285 — Health Care Data Collection:
There shall be required from each health care provider in this state an annual report of certain health care information to be submitted to the department. The report shall be due on the last day of January and shall cover the 12-month period preceding each such calendar year. "Health care provider" means any hospital or ambulatory surgical or obstetrical facility having a license or permit issued by the department under Article 1 of this chapter.

Competitive Behavior in Health Plan Contracting

GA Code § 33-20-29 — Unlawful actions by unauthorized persons: Health Care Plans:
Makes it unlawful for any person except a health care corporation established in accordance with state Law and operating in accordance with authority from the Insurance Commissioner to establish, maintain, or operate a health care plan.
GA Code § 33-20A-62 — Payment: Managed Health Care Plans:
Contains various prohibitions for managed health care plans, e.g. no post payment audit or retroactive denial of payment.
GA Code § 33-30-25 — Reasonable limits on number or classes of preferred providers: Preferred Provider Arrangements:

Insurers may impose "reasonable limits" on the number/classes of preferred providers that meet the insurers' standards. Insurers must give all licensed and qualified providers within a defined service the opportunity to become a preferred provider.
GA Comp R & Regs 120-2-20-03 — Unlawful Agreements between Insurers and Providers:
Banning most favored nation clauses, a promise obtained by an insurer that the provider will not give a better price to another insurer.

Expansion of DOI Authority

GA Code § 33-29A-5 — Georgia Health Benefits Assignment System: Availability and Assignment System:
Provides that the Insurance Commissioner shall develop the Georgia Health Benefits Assignment System and shall assign eligible individuals to one of two plans chosen by the Commissioner.

GA Code § 33-21-13 — Evidence of coverage; filing and approval of basic rates and method of computation of coverage:
Vests prior approval authority in the insurance commissioner only for subsets of the insurance market.

Creating or Reducing Barriers to New Entrants

GA Code § 31-6-40 to **31-6-50** — Certification of Need Program:
Certificate of Need guidelines and principles.
GA Code § 33-24-56.4 — Payment for telemedicine services: Georgia Telemedicine Act:
Every health benefit policy shall include payment for services that are covered under such health benefit policy and are appropriately provided through telemedicine.

Appendix

HAWAII

Antitrust

HI Rev Stat §§ 323D-71 through 323D-83 — Hospital Acquisition:
"States that no person shall engage in the acquisition of a hospital without first: applying for and receiving the approval of the agency; and notifying the attorney general and, if applicable, receiving approval from the attorney general pursuant to
this part."
HI Rev Stat §§ 480-1 through 480-24 — Antitrust Provisions:
Unfair competition and practices are declared unlawful. Includes limit on tying agreements -- No person shall sell or buy any commodity, or fix a price or discount from, or rebate upon, such price, on the condition, agreement, or understanding that the other person or persons shall not deal in the commodity of a competitor of the seller, or shall not deal with the competitor of the purchaser, as the case may be, when the effect of the sale or purchase or the condition, agreement, or understanding, may be to substantially lessen competition or tend to create a monopoly in any line of commerce in any section of the State.

HI Rev Stat § 431:13-103 — Unfair methods of competition and unfair or deceptive acts or practices defined: Insurance Code:
Defined as unfair methods of competition and unfair or deceptive acts or practices.

Encouraging Price Transparency

HI Rev Stat § 323D-18.5 — Access to Health and dental insurance data; mandatory reporting for certain insurers; uses; confidentiality: State Health Planning and Development Program:
Providers of health insurance doing business in the State and who are not subject to subsection (b) may submit to the state agency or its designee, upon request of the state agency, administrative data that the state agency deems necessary to perform its functions. The state agency shall submit data collected pursuant to this section to the college of social sciences, social sciences research institute, pacific health informatics and data center at the University of Hawaii for processing, assignment of encrypted identifiers, and any other task deemed necessary by the state agency.

HI Rev Stat § 346-421 — Health analytics program; appointments: Health Analytics:
The health analytics program shall develop, design, or implement databases, primarily an all-claims, all-payer database, and an encompassing data center to collect and analyze healthcare data.
HI Rev Stat § 431:26-105 — Provider directories: Health Benefit Plan Network Access and Adequacy
For the information required by subsections (a)(3), (a)(4), and (b)(1) in a provider directory pertaining to a health care professional, hospital, or facility other than a hospital, the health carrier shall make information available.

Expansion of DOI Authority

HI Rev Stat §§ 431:14G-101 through 431:14G-112 — Health Insurance Rate Regulation:
No person, business, or entity may change or rerate any rate approved by the commissioner in any subsequent transfer, sale, resale, or pass through of health insurance issued by a managed care plan. Rates shall not be excessive, inadequate, or unfairly discriminatory and shall be reasonable in relation to the costs of the benefits provided. Vests the insurance commissioner with prior approval authority.

Creating or Reducing Barriers to New Entrants

HI Rev Stat §§ 323D-42 through 323D-54 — Certificate of Need:
Certificate of Need guidelines and principles.
HI Rev Stat §§ 431:26-101 through 431:26-110 — Health Benefit Plan Network Access and Adequacy:
Outlines network adequacy requirements for a health insurance plan.
HI Rev Stat § 453-1.3 — Practice of Telehealth: Medicine and Surgery generally:
Reimbursement for behavioral health services provided through telehealth shall be equivalent to reimbursement for the same services provided via face-to-face contact between a health care provider and a patient.
HI Rev Stat § 431:10A-116 — Coverage for telehealth: Individual Accident or Sickness Policies:
It is the intent of the legislature to recognize the application of telehealth as a reimbursable service by which an individual shall receive medical services from a health care provider without face-to-face contact with the provider.

HI Rev Stat § 432D-23 — Coverage for telehealth: Health Maintenance Organization Act:
It is the intent of the legislature to recognize the application of telehealth as a reimbursable service by which an individual shall receive medical services from a health care provider without face-to-face contact with the provider.
HI Rev Stat § 432:1-601 — Coverage for telehealth: Required Provision Benefits:
It is the intent of the legislature to recognize the application of telehealth as a reimbursable service by which an individual shall receive medical services from a health care provider without face-to-face contact with the provider.
HI Rev Stat § 323-3 — Practice by advanced registered nurses: Hospitals and Medical Facilities — General Provisions:
Each hospital in the State licensed under section 321-14.5 shall allow advanced practice registered nurses licensed pursuant to section 457-8.5 and qualified advanced practice registered nurses granted prescriptive authority pursuant to section 457-8.6 to practice at the hospital within the full scope of practice authorized under chapter 457, including practice as a primary care provider.
HI Rev Stat § 453-2 — License required; exceptions: Medicine and Surgery — Generally: Except as otherwise provided by law, no person shall practice medicine or surgery in the State, either gratuitously or for pay, or offer to practice medicine or surgery in the State, or advertise or announce one's self, either publicly or privately, as prepared or qualified to practice medicine or surgery in the State, or append the letters "Dr.", "M.D.", or "D.O." to one's name with the intent to imply that the person is a practitioner of medicine or surgery, without having a valid unrevoked license or a limited and temporary license obtained from the Hawaii medical board.

Appendix

IDAHO

Antitrust

ID Code §§ 39-4901 through 39-4904 — Health Planning Act:
A health care provider may negotiate and enter into cooperative agreements with other health care providers in the state if the likely benefits resulting from the agreements outweigh the disadvantages attributable to a reduction in competition that may result from such agreements... The attorney general shall issue a certificate of public advantage for a cooperative agreement if he determines that the applicants have demonstrated by clear and convincing evidence that the likely benefits resulting from the agreement outweigh any disadvantages attributable to a reduction in competition that may result from the agreement.
ID Code §§ 48-1501 through 40-1512 — Idaho Nonprofit Hospital Sale or Conversion Act:
States that nonprofit hospitals hold assets in charitable trust, and are dedicated to the specific charitable purposes set forth in the articles of incorporation of the nonprofit corporations or governing papers of the nonprofit entities operating such hospitals. Nonprofit hospitals have a substantial and beneficial effect on the provision of health care to the people of Idaho, providing as part of their charitable mission free or low-cost health care. The attorney general is entrusted by Law to bring actions on behalf of the public in the event of a breach of the charitable trust, pursuant to section 67-1401, Idaho Code.
ID Code §§ 48-601 through 48-619 — Idaho Consumer Protection Act:
States that the purpose of this act is to protect both consumers and businesses against unfair methods of competition and unfair or deceptive acts and practices in the conduct of trade or

commerce, and to provide efficient and economical procedures to secure such protection. It is the intention of the legislature that this chapter be remedial and be so construed. The attorney general may make rules and regulations interpreting the provisions of this act.

ID Code §§ 48-101 through 48-118 — Idaho Competition Act:

States that the Idaho legislature finds that fair competition is fundamental to the free market system. The unrestrained interaction of competitive forces will yield the best allocation of Idaho's economic resources, the lowest prices, the highest quality, and the greatest material progress, while at the same time providing an environment conducive to the preservation of our democratic and social institutions. The purpose of this chapter is to maintain and promote economic competition in Idaho commerce, to provide the benefits of that competition to consumers and businesses in the state, and to establish efficient and economical procedures to accomplish these purposes and policies. The provisions of this chapter shall be construed in harmony with federal judicial interpretations of comparable federal antitrust statutes and consistent with this chapter's purposes, as set forth in subsection (2) of this section. This chapter applies to conduct proscribed herein that affects Idaho commerce

ID Code §§ 48-201 through 48-206 — Anti-Price Discrimination Act:

It shall be unlawful for any person engaged in commerce, in the course of such commerce, either directly or indirectly, to discriminate in price between different purchasers of commodities of like grade and quality or to discriminate in price between different sections, communities or cities or portions thereof or between different locations in such sections, communities, cities or portions thereof in this state, where the effect of such discriminations may be substantially to lessen competition or tend to create a monopoly in any line of commerce, or to injure, destroy, or prevent competition with any person who either grants or knowingly receives the benefit of such discrimination, or with customers of either of them: provided, that nothing herein contained shall prevent differentials which make only due allowance for differences in the cost of manufacture, sale, or delivery, resulting from the differing methods or quantities in which such commodities are to such purchasers sold or delivered: and provided further, that nothing herein contained shall prevent persons engaged in selling goods, wares, or merchandise in commerce from selecting their own customers in bona fide transactions and not in restraint of trade: and provided further, that nothing herein contained shall prevent price changes from time to time where in response to changing conditions affecting the market for or the marketability of the goods concerned, such as but not limited to actual or imminent deterioration of perishable goods, obsolescence of seasonable goods, distress sales under court process, or sales in good faith in discontinuance of business in the goods concerned.

Competitive Behavior in Health Plan Contracting

ID Code § 41-2873 — Best price – Most Favored Nations clause prohibited: Organization and Corporate Procedures of Stock and Mutual Insurers:

No stock or mutual insurance company (hereafter, insurance company) may require, as an element of any health care provider participation contract, that any provider agree: (a) To the unnegotiated adjustment by the insurance company of the provider's contractual reimbursement rate to equal the lowest reimbursement rate the provider has agreed to charge any other payor; (b) To a requirement that the provider adjust, or enter into negotiations to adjust, his or her charges to the insurance company if the provider agrees to charge another payor lower rates; or (c) To a requirement that the provider disclose his or her contractual reimbursement rates from other payors.

ID Code § 41-3927 and **§41-3443** — Managed Care Reform:

Banning most favored nation clauses, a promise obtained by an insurer that the provider will not give a better price to another insurer.

ID Code § 41-3443 — Best price – most favored nations clause prohibited: Hospital and Service Corporations:
Prohibits the use of most favored nation clauses, a promise obtained by an insurer that the provider will not give a better price to another insurer.

Regulation Around Development of ACOs

ID Code § 56-263 — Medicaid managed care Plan: Public Assistance Law:
Authorizes the State Medicaid agency to develop a managed care plan for high cost Medicaid beneficiaries and permits contracts based on gainsharing, risk-sharing, or capitation.

Expansion of DOI Authority

ID Code § 41-5206 — Individual Health Insurance Availability Act:
Regulations around premium setting for health plans, including appropriate rates, appropriate rate increases. Requires health plans to have some degree of transparency around rate setting.

Creating or Reducing Barriers to New Entrants

ID Code §§ 54-5701 through 54-5713 — Idaho Telehealth Access Act:
The legislature finds telehealth services enhance access to health care, make delivery of health care more cost-effective and distribute limited health care provider resources more efficiently.

Appendix

ILLINOIS

Antitrust

740 ILCS § 175/4 — Civil actions for false claims: Illinois False Claims Act:
The Attorney General or the Department of State Police shall diligently investigate a civil violation under Section 3. If the Attorney General finds that a person violated or is violating Section 3, the Attorney General may bring a civil action under this Section against the person.
815 ILCS § 505/3 — Attorney General; General powers: Consumer Fraud and Deceptive Business Practices Act:
States that when it appears to the Attorney General that a person has engaged in, is engaging in, or is about to engage in any practice declared to be unlawful by this Act; when he receives a written complaint from a consumer or borrower of the commission of a practice declared to be unlawful under this Act; or when he believes it to be in the public interest that an investigation should be made to ascertain whether a person in fact has engaged in, is engaging in or is about to engage in, any practice declared to be unlawful by this Act, he may intervene.
740 ILCS §§ 10/1 through 10/12 — Illinois Antitrust Act:
The purpose of this Act is to promote the unhampered growth of commerce and industry throughout the State by prohibiting restraints of trade which are secured through monopolistic or oligarchic practices and which act or tend to act to decrease competition between and among persons engaged in commerce and trade, whether in manufacturing, distribution, financing, and service industries or in related for-profit pursuits.

Encouraging Price Transparency

77 Ill Adm Code 1010 — Illinois Health Care Cost Containment Council:
"Establishes the Council to control hospital costs and measure utilization by achieving the following objectives: a) development of measures which will increase hospital and licensed ambulatory surgical treatment center productivity and better control utilization, while continuing to provide quality health care services to all sectors of the citizenry, education and training of health care professionals, and research and development of improved and cost effective methods of treatment of ailments and management of facilities and operations; b) the study, recommendation and implementation of measures to contain health care costs; c) the encouragement of new and innovative methods of financing health care; and d) limitation of the increase in the cost of hospital care to no more than the rate of increase in prices in the general economy.
The Council will require quarterly basic reports in the aggregate on health care costs and utilization and trends in Illinois. The Council will also publish various reports to the Legislature on rising hospital costs. Prices for hospital charges will be available to the consumer and posted."
20 ILCS §§ 2215/4-1 through 2215/4-4 — Illinois Health Finance Reform Act:
Hospitals and The Department of Public Health establish a uniform system for the collection, analysis, and distribution of health care cost and utilization data. Also requires that hospitals make price information on the normal charge incurred for any procedure available to a prospective patient.
215 ILCS §§ 134/1 through 134/115 — Managed Care Reform and Patient Rights Act:
The "Managed Care Reform and Patient Rights Act," states that, among other things, a patient has the right to a examine and receive an reasonable explanation of the total bill for health care services rendered, regardless of the payer source. The Act also requires the provision of certain information by insurers to enrollees such as coverage terms and timely notice of nonrenewal or termination.
215 ILCS § 124/25 — Network transparency: Network Adequacy and Transparency Act:
A network plan shall post electronically an up-to-date, accurate, and complete provider directory for each of its network plans, with the information and search functions, as described in this Section.
225 ILCS. § 61/10 — Physician profiles: Patients' Right to Know Act:
The Department shall make available to the public a profile of each physician. The Department shall make this information available through an Internet web site and, if requested, in writing.
210 ILCS §§ 88/1 through 88/999 — Fair Patient Billing Act:
A law to promote fair and reasonable billing and collection practices amongst hospitals by providing a set of responsible standards. During hospital admission or as soon as is practicable, the hospital must provide insured patients with written notice that: (1) Patients may receive separate bills for services provided by health care professionals affiliated with the hospital. (2) Some hospital staff members may not be participating providers in the same insurance plan and networks as the hospital. (3) Patients may have a greater financial responsibility for services provided at the hospital by providers who are not under contract with their insurance plan. (4) Patient questions about coverage or benefit levels should be directed to their insurance plan.

Competitive Behavior in Health Plan Contracting

215 ILCS § 5/370H — Noninstitutional providers: Insurance:
Insurers/administrators must be willing to enter into agreements with any non-institutional providers who meet the established terms and conditions. The terms and conditions may not discriminate unreasonably against or among non-institutional providers.

Regulation Around Development of ACOs

305 ILCS § 5/5-30 — Care coordination: Public Act:
Requires that 50 percent of Medicaid beneficiaries in state medical assistance programs (including Medicaid and CHIP) be enrolled in risk-based coordinated care programs by January 1, 2015.

Certificates of Authority

210 ILCS § 26/1 through 26.99 — Accountable Care Organization Clinical Laboratory Testing Advisory Board Act:
Notwithstanding the requirement of this Act to establish a clinical laboratory testing advisory board, nothing contained in this Act shall be construed to require an accountable care organization's governing board to adopt a clinical laboratory testing guideline or protocol recommended by the accountable care organization's advisory board.

Expansion of DOI Authority

215 ILCS 93/25 — Small Employer Health Insurance Rating Act:
Insurance companies must file their proposed rates with the department of insurance, but the rates may go into effect without department approval. The department may have the ability to go back and disapprove a rate increase that was later deemed unreasonable, usually triggered by a consumer complaint process.

Creating or Reducing Barriers to New Entrants

215 ILCS §§ 124/1 through 124/99 — Network Adequacy and Transparency Act:
The network plan shall demonstrate to the Director a minimum ratio of providers to plan beneficiaries as required by the Department. The network plan shall demonstrate to the Director maximum travel and distance standards for plan beneficiaries, which shall be established annually by the Department in consultation with the Department of Public Health based upon the guidance from the federal Centers for Medicare and Medicaid Services. These standards shall consist of the maximum minutes or miles to be traveled by a plan beneficiary for each county type, such as large counties, metro counties, or rural counties as defined by Department rule. The maximum travel time and distance standards must include standards for each physician and other provider category listed for which ratios have been established.

20 ILCS § 3960 — Illinois Health Facilities Planning Act:
Illinois Health Facilities Planning Act: IL certificate of need law.

Telehealth

215 ILCS § 5/356z.22 — Coverage for telehealth services: Accident and Health Insurance:
Plans may not exclude telehealth services just because they are not in person.

Appendix

INDIANA

Antitrust

IN Code §§ 12-15-11-1 through 12-15-11-8 — Provider Agreements and *Competitive Bidding*:
A provider desiring to participate in the Medicaid program by providing to individuals eligible for Medicaid services, other than physician services provided by a managed care provider, shall file a

provider agreement with the office on forms provided by the office. After a provider signs a provider agreement under this chapter, the office may not exclude the provider from participating in the Medicaid program by entering into an exclusive contract with another provider or group of providers, except as provided under section 7 of this chapter.

Encouraging Price Transparency

IN Code §§ 16-39-5-1 through 16-39-5-4 — Release of Health Records to Third Parties and for Legitimate Business Purposes:
"Establishes the Council to control hospital costs and measure utilization by achieving the following objectives: a) development of measures which will increase hospital and licensed ambulatory surgical treatment center productivity and better control utilization, while continuing to provide quality health care services to all sectors of the citizenry, education and training of health care professionals, and research and development of improved and cost effective methods of treatment of ailments and management of facilities and operations; b) the study, recommendation and implementation of measures to contain health care costs; c) the encouragement of new and innovative methods of financing health care; and d) limitation of the increase in the cost of hospital care to no more than the rate of increase in prices in the general economy.
The Council will require quarterly basic reports in the aggregate on health care costs and utilization and trends in Illinois. The Council will also publish various reports to the Legislature on rising hospital costs. Prices for hospital charges will be available to the consumer and posted."
IN Code §§ 16-21-6-0.1 through 16-21-6-12 — Hospital Financial Disclosure Law:
Requires each hospital to submit the total charge for patient's stay to the state department. Copies of this report will be made publicly available and the department will create a consumer's guide to Indiana's hospitals.
IN Code § 27-8-10-0.5 — Cessation of association insurance operations; date: Comprehensive Health Insurance:
Balance billing under this chapter by a health care provider that is not a member of a health care provider network arrangement used by the association is prohibited after the later of the following.
IN Code § 27-13-15-1 — Contract requirements; enrollee coverage; payment of provider; application: Participating Providers; Contracts and Legal Actions:
A contract between a health maintenance organization and a participating provider of health care services: must be in writing; may not prohibit the participating provider from disclosing the terms of the contract as it relates to financial or other incentives to limit medical services by the participating provider or all treatment options available to an insured, including those not covered by the insured's policy; may not provide for a financial or other penalty to a provider for making a disclosure permitted under subdivision (2); and must provide that in the event the health maintenance organization fails to pay for health care services as specified by the contract, the subscriber or enrollee is not liable to the participating provider for any sums owed by the health maintenance organization.

Competitive Behavior in Health Plan Contracting

IN Code § 27-8-11-9 — Preferred provider agreement prohibition: Accident and Sickness Insurance–Reimbursement Agreements:
An agreement between an insurer and a provider under this chapter may not contain a provision that: prohibits, or grants the insurer an option to prohibit, the provider from contracting with another insurer to accept lower payment for health care services than the payment specified in

the agreement; requires, or grants the insurer an option to require, the provider to accept a lower payment from the insurer if the provider agrees with another insurer to accept lower payment for health care services; requires, or grants the insurer an option of, termination or renegotiation of the agreement if the provider agrees with another insurer to accept lower payment for health care services; or requires the provider to disclose the provider's reimbursement rates under contracts with other insurers.

Expansion of DOI Authority

IN Code § 27-8-5-1 — Policy of accident and sickness insurance; filing; review; conformity with federal act: Insurance:
Requires rate filing and prior approval. If the insurers file rates and forms and, if not disapproved within 30 days, then the rates are deemed approved.
IN Code § 27-8-4-7 — Filing of documents; disapproval of form of policy; effect; withdrawal of approval; review:
Vests the insurance commissioner with prior approval authority.

Creating or Reducing Barriers to New Entrants

IN Code §§ 16-29-1-1 through 16-29-5-1 — Health Facility Certificates of Need; Comprehensive Care Beds:
Outlines requirements for certificates of need.
IN Code § 27-13-7-22 — Coverage for telemedicine services required: Requirements for Group Contracts, Individual Contracts, and Evidence of Coverage:
An individual contract or a group contract must provide coverage for telemedicine services in accordance with the same clinical criteria as the individual contract or the group contract provides coverage for the same health care services delivered to an enrollee in person.
IN Code § 16-18-2-348 — Telemedicine: Health — General Provisions and Definitions — Definitions:
“Telemedicine”, for purposes of IC 16-36-1, means a specific method of delivery of services, including medical exams and consultations and behavioral health evaluations and treatment, including those for substance abuse, using videoconferencing equipment to allow a provider to render an examination or other service to a patient at a distant location. The term does not include the use of the following:
(1) A telephone transmitter for transtelephonic monitoring.
(2) A telephone or any other means of communication for the consultation from one (1) provider to another provider."
IN Code § 27-13-36-2.5 — Discrimination on basis of provider's license or certification prohibited: Summary of Orders and Supervision:
A health maintenance organization may not discriminate against a provider acting within the scope of the provider's license or certification with respect to the following.

Appendix

IOWA

Encouraging Price Transparency

IA Code § 135.166 — Health data — collection and use — collection from hospitals: Department of Public Health:
Memorandum of understanding with department of public health concerning transparency and disclosure of information by hospitals.
IA Code § 514C.16 — Emergency room services: Special Health and Accident Insurance Coverages:
The legislation protects consumers who would otherwise face balance billing for care by out-of-network providers in emergency rooms. The protections are limited to emergency department settings.

Regulation Around Development of ACOs

IA Code §§ 249N1 through 249N8 — IA Health and Wellness Plan:
Creates the healthy IA plan accountable care provider network, which shall include all providers enrolled in the medical assistance program. Proposed Law contains various relevant provisions concerning health benefit plans, premiums, etc.

Expansion of DOI Authority

IA Code § 513C5 — Restrictions relating to premium rates: Individual Health Insurance Market Reform:
Restrictions on premium rates for individual health insurance.
IA Code § 514A — Filing requirement — prior approval:
Vests the insurance commissioner with prior approval authority.

Creating or Reducing Barriers to New Entrants

IA Code §§ 135.61 through 135.83 — Health Facilities Council:
Certificate of Need guidelines and principles.
IA Code § 514C11 — Services provided by licensed physician assistants and licensed advanced registered nurse practitioners: Special Health and Accident Insurance Coverages:
A policy or contract providing for third-party payment or prepayment of health or medical expenses shall include a provision for the payment of necessary medical or surgical care and treatment provided by a physician assistant licensed pursuant to chapter 148C, or provided by an advanced registered nurse practitioner licensed pursuant to chapter 152 and performed within the scope of the license of the licensed physician assistant or the licensed advanced registered nurse practitioner if the policy or contract would pay for the care and treatment if the care and treatment were provided by a person engaged in the practice of medicine and surgery or osteopathic medicine and surgery under chapter 148.

Appendix

KANSAS

Antitrust

KSA §§ 65-4955 through 65-4961 — Health Care Provider Cooperation:
A health care provider may negotiate and enter into cooperative agreements with other health care providers in the state if the likely benefits resulting from the agreements outweigh any disadvantages attributable to a reduction in competition that may result from the agreements.
KSA §§ 50-158 through 50-164 — Kansas Restraint of Trade Act:
States that the attorney general may conduct research, hold public hearings, make inquiries and publish studies relating to antitrust, monopolies, combinations and other subjects relating to restraint of trade.
KSA §§ 50-101 through 50-110 — Restraint of Trade:
Outlines actions that can be taken by the Attorney General when unlawful actions Occur.
KSA §§ 16-2001 through 16-2005 — Competitive Bid Protection Act:
Unless otherwise required by law, each governmental entity within this state that contracts for public works construction shall ensure that neither the awarding governmental entity nor any agent responsible for procuring a contract directly between the governmental entity and a contractor shall not adhere to anticompetitive practices.

Encouraging Price Transparency

KSA §§ 65-6801 through 65-6809 — Health Care Data:
Requires all health care providers and third-party payors to provide "the information necessary for a review and comparison of utilization patterns, cost, quality and quantity." Regulations made by department of health and environment.

Expansion of DOI Authority

KSA § 40-2215 — Forms and premium rates, filing, duties of commissioner; procedure; rules and regulations, violations, penalties: Insurance:
Provides that no health insurance policy can be used in the state until approved by the insurance commissioner. Vests the insurance commissioner with prior approval authority.

Creating or Reducing Barriers to New Entrants

KSA §§ 40-2,210 through 40-2,216 — Kansas Telemedicine Act:
No individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society, health maintenance organization or the Kansas medical assistance program shall exclude...
KSA § 40-2250 — Insurance coverage to include reimbursement for services performed by advanced practice registered nurses: Uniform Policy Provisions:
Notwithstanding any provision of an individual or group policy or contract for health and accident insurance delivered within the state, whenever such policy or contract shall provide for reimbursement for any services within the lawful scope of practice of a licensed advanced practice registered nurse within the state of Kansas, the insured, or any other person covered by the policy or contract, shall be allowed and entitled to reimbursement for such service irrespective of whether it was provided or performed by a duly licensed physician or a licensed advanced practice registered nurse.
KSA § 65-4101 — Practice of physician assistant; direction and supervision of physician; prescription of drugs; identification to patient of physician assistant; rules and regulations; "drug" defined: Physician Assistants Licensure Act:

A person licensed as a physician assistant may perform, only under the direction and supervision of a physician, acts which constitute the practice of medicine and surgery to the extent and in the manner authorized by the physician responsible for the physician assistant and only to the extent such acts are consistent with rules and regulations adopted by the board which relate to acts performed by a physician assistant under the responsible physician's direction and supervision. A physician assistant may prescribe drugs pursuant to a written protocol as authorized by the responsible physician.

Appendix

KENTUCKY

Encouraging Price Transparency

KRS § 216.2929 — Data on Health-care services charges and quality and outcome measures to be publicly available on cabinet's web site–Reports required by board: Health Data Collection:
Requires, inter alia, publication of a report pertaining to comparative health care charges, quality, and outcomes, and the effectiveness of its activities relating to educating consumers and containing costs.
KRS § 216.2921 — Duties of cabinet - Chief administrative officer - Secretary or employee not subject to personal liability: Health Data Collection:
Directs the Cabinet for Health and Family Services to collect, analyze, and disseminate information on the cost, quality and outcomes of health services provided by health facilities and providers in state.
KRS § 304.17A-510 — Notification by insurer offering managed care plans of availability of printed document: Health Benefit Plans
An insurer that offers a managed care plan shall notify an enrollee of a current participating provider directory providing information on a covered person's access to primary care health care providers.

Expansion of DOI Authority

KRS § 304 — Filing of rates:
Vests the insurance commissioner with prior approval authority.

Competitive Behavior in Health Plan Contracting

KRS § 304.17A-560 — Most-favored-nation provision: Managed Care Plans:
Bans most favored nation clauses in provider contracts, a promise obtained by an insurer that the provider will not give a better price to another insurer.
KRS § 304.17A-527 — Filing of provider agreements, risk-sharing arrangements, and subcontract agreements with commissioner — Contents — Disclosure of financial information not required: Health Benefits Plans:
Requires specific contract provisions including a hold harmless clause and continuity of care clause. Also provides that financial information obtained by the department shall be a "trade secret" and thus limiting requirements to release price information.

KRS § 304.17A-577 — Disclosure of payment or fee schedule to managed care Plan Healthcare provider – Disclosure of schedule change – Confidentiality of payment information: Managed Care Plans:
Insurers issuing a managed care plan must, upon request, provide or make available to the health care provider payment or fee schedules. Information cannot be shared without prior written consent of the insurer.
KRS § 304.17A-270 — Nondiscrimination against provider in geographic coverage area: Health Benefits Plan:
A health insurer shall not discriminate against any provider who is located within the geographic coverage area of the plan and who is willing to meet the terms and conditions for participation established by the plan, including the Kentucky State Medicaid program and Medicaid partnerships.

Creating or Reducing Barriers to New Entrants

KRS §§ 216B.010 through 216B.990. Licensure and Regulation of Health Facilities and Services: Outlines requirements for certificates of need.
KRS § 304.17A-138 — Telehealth coverage and reimbursement; requirements for Health benefit Plan; benefits subject to deductible, copayment, or coinsurance payment subject to provider network arrangements; administrative regulations: Health Benefit Plans — Miscellaneous Provisions:
A health benefit plan shall reimburse for covered services provided to an insured person through telehealth as defined in Section 4 of this Act. Telehealth coverage and reimbursement shall be equivalent to the coverage for the same service provided in person unless the telehealth provider and the health benefit plan contractually agree to a lower reimbursement rate for telehealth services.

Appendix

LOUISIANA

Antitrust

LA Rev Stat §§ 40:2254.1 through 40:2254.12 — Certificates of Public Advantage:
The purpose of this Part is to provide the state, through the department, with direct supervision and control over the implementation of cooperative agreements, mergers, joint ventures, and consolidations among health care facilities for which certificates of public advantage are granted. The department may not issue a certificate unless the department finds that the agreement is likely to result in lower health care costs or is likely to result in improved access to health care or higher quality health care without any undue increase in health care costs.
LA Rev Stat §§ 40:2115.11 through 40:2115.23 — Review and Approval of Hospital Acquisitions:
States that the health of the people of our state is a most important public concern. The state has an interest in assuring the continued existence of accessible, affordable health care facilities that are responsive to the needs of the communities in which they exist. The state also has a responsibility to protect the public interest in nonprofit hospitals by making certain that the charitable assets of those hospitals are managed prudently. Therefore, no not-for-profit hospital shall be acquired by any person unless and until the acquisition is reviewed and approved by the attorney general.

LA Rev Stat § 22:1877 — Complaint notice; billing correction and refund; penalty: Health Care Consumer Billing and Disclosure Protection Act:
States that any enrollee or insured who receives a bill or consolidated activity statement and bill from a contracted health care provider in violation of R.S. 22:1874(A), or a health insurance issuer acting on behalf of an enrollee or insured, may file a complaint with the Consumer Protection Division of the Department of Justice. The enrollee or insured, or health insurance issuer acting on behalf of the enrollee or insured, shall provide to the attorney general a copy of the original bill or consolidated activity statement and bill issued pursuant to R.S. 22:1873 and such additional information that may be requested by the attorney general, documenting an attempt by a contracted health care provider to collect or the collection of any amount from the enrollee or insured that is the liability of the health insurance issuer or that is in excess of the contracted reimbursement rate. In the event it is determined that billing activity was based on information received from the health insurance issuer, the contracted health care provider shall not be in violation, and the attorney general shall refer the violation to the commissioner.
LA Rev Stat § 51:1404 — Powers and duties: Unfair Trade Practices and Consumer Protection Law:
The Louisiana Attorney General's Office, Public Protection Division, Consumer Protection Section shall have duties to investigate, conduct studies and research to conduct public or private hearings into commercial and trade practices in the distribution, financing and furnishing of goods and services to or for the use of consumers. The attorney general may receive information and documentary material and may receive and otherwise investigate complaints with respect to acts or practices declared to be unlawful by this Chapter or other laws of this state and inform the public with respect thereto. The attorney general may institute legal proceedings and take such other actions provided for herein or which are necessary or incidental to the exercise of his powers and functions.
LA Rev Stat § 22:1964 — Methods, acts, and practices which are defined herein as unfair or deceptive: Insurance:
Amendment to Unfair Trade Practices law. Contains provisions regarding insurance. Significantly, it defines specific behavior as unlawful "tying." Tying, which shall mean the following: (a) The requirement by a health and accident agent or group health and accident insurer, individual health and accident insurer, or health maintenance organization, as a condition to the offer or sale of a health benefit plan to a group or individual insured, that such insured purchase any other insurance policy. (b) Tying of a purchase of a health and life insurance policy or policies to another insurance product. “Tying” is the requirement by any small employer health insurance carrier or individual health insurance carrier, as a condition to the offer or sale of a health benefit plan, health maintenance organization, or prepaid limited health care service plan to a small employer, as defined by this Code or to an individual, that such employer or individual purchase any other insurance product.

Encouraging Price Transparency

LA Rev Stat § 22:1880 — Balance billing disclosure: Health Care Consumer Billing and Disclosure Protection Act:
Each health insurance issuer shall provide balance billing disclosure notices. Each health care facility shall also provide notice regarding nonemergency services to a patient.
LA Rev Stat §§ 22:1020.1 through 22:1020.6 — Network Provider Directory Accessibility and Accuracy Act:
The directory of network providers required pursuant to this Subpart shall be furnished in printed form to any covered person upon request.
LA Rev Stat §§ 40:1173.1 through 40:1173.3 — Louisiana Consumer's Right to Know Act:

The “Louisiana Consumer’s Right to Know Act,” provides for the creation of a useful and comprehensive health service information database and directs the Department of Health and Hospitals to identify comparison information.

Competitive Behavior in Health Plan Contracting

LA Rev Stat § 22:263 — Requirements of provider contracts; prohibited incentives; definitions: Insurance:
Sets out general contract requirements between health maintenance organizations and health care providers.

Expansion of DOI Authority

LA Rev Stat § 22:971 — Patient's bill of rights: Insurance:
Patient's Bill of Rights: Very general statement regarding the need for creating a patient's bill of rights. Of particular significance is a provision stating that "the Department of Insurance shall establish and maintain an information collection program to track and evaluate state and federal legislation to provide for a uniform patient bill of rights." There is also a general statement about holding managed care organizations account- able for decisions which harm patients, which could be viewed as a general regulation around ACOs and other managed care orgs.
LA Stat § 22:972 — Health and accident policy provisions:
Insurance companies must file their proposed rates with the department of insurance, but the rates may go into effect without department approval. The department may have the ability to go back and disapprove a rate increase that was later deemed unreasonable, usually triggered by a consumer complaint process.
LA Rev Stat §§ 22:1091 through 22:1099 — Rate Review:
The provisions of this Subpart shall apply to any health benefit plan which provides coverage in the small group market or individual market, including any policy or subscriber agreement covering residents of this state.

Creating or Reducing Barriers to New Entrants

LA Rev Stat § 40:2116 — Facility need review: Facility Need Review:
Facility Need Review guidelines and principles.
LA Rev Stat §§ 22:1019.1 through 22:1019.3 — Network Adequacy Act:
The purpose and intent of this Subpart is to establish standards for the creation and maintenance of networks by health insurance issuers and to ensure the adequacy, accessibility, and quality of health care services offered to covered persons under a health benefit plan by establishing requirements for written agreements between health insurance issuers offering health benefit plans and participating providers regarding the standards, terms, and provisions under which such participating providers will provide services to covered persons.
LA Rev Stat §§ 40:1223.1 through 40:1223.4 — Louisiana Telehealth Access Act:
Each state agency or professional or Occupational licensing board or commission that regulates the practice of a healthcare provider, as defined in this Part, may promulgate, in accordance with the Administrative Procedure Act, any rules necessary to provide for, promote, and regulate the use of telehealth in the delivery of healthcare services within the scope of practice regulated by the licensing entity.
LA Rev Stat § 37:1276 — Telemedicine license: Medicine, Surgery, Midwifery:

"A. The board shall issue a telemedicine license to allow the practice of medicine across state lines to an applicant who holds a full and unrestricted license to practice medicine in another state or territory of the United States.
B. The board shall establish by rule in accordance with the Administrative Procedure Act the requirements for licensure under this Section provided the rules include the following:
(1) The physician licensed under this Section shall not open an office in this state, shall not meet with patients in this state, and shall not receive calls in this state from patients.
(2) The physician, when examining a patient by telemedicine, shall establish a bona fide physician-patient relationship by:
(a) Conducting an appropriate examination of the patient as determined by the board.
(b) Establishing a diagnosis through the use of accepted medical practices including but not limited to patient history, mental status, and appropriate diagnostic and laboratory testing.
(c) Discussing with the patient any diagnosis as well as the risks and benefits of various treatment options.
(d) Ensuring the availability for appropriate follow-up care.
(e) Fulfilling any other requirements as deemed appropriate and necessary by the board."
Scope of Practice
LA Rev Stat § 37:1360.28 — Supervision of physician assistants: Physician Assistants:
Supervision of a physician assistant shall be continuous but shall not be construed as necessarily requiring the physical presence of the supervising physician at the time and place that the services are rendered.
LA Rev Stat § 22:1037 — Health insurance coverage for activities performed by a registered nurse first assistant: State Mandated Health Benefits:
Any hospital, health, or medical expense insurance policy, hospital or medical service contract, employee welfare benefit plan, health maintenance organization subscriber agreement, health and accident insurance policy, or any other insurance contract of this type, including a group insurance plan and a self-insurance plan that provides medical and surgical benefits which are delivered, issued for delivery, or renewed in this state on or after January 1, 2004, shall not deny coverage of perioperative services rendered by a registered nurse first assistant if the insurer covers the same such first assistant perioperative services when they are rendered by an advanced practice nurse, a physician assistant, or a physician other than the operating surgeon.

Appendix

MAINE

Antitrust
22 MRS §§ 1841 through 1852 — Hospital and Health Care Provider Cooperation Act:
States that the Legislature finds that it is necessary and appropriate to encourage hospitals and other health care providers to cooperate and enter into agreements that will facilitate cost containment, improve quality of care and increase access to health care services. This Act provides processes for state review of overall public benefit, for approval through certificates of public advantage and for continuing supervision. It is the intent of the Legislature that a certificate of public advantage approved under this chapter provide state action immunity under applicable federal antitrust laws.
5 MRS § 194-A — Nonprofit hospital and medical service organizations: Attorney General:

States that the Attorney General is the sole person authorized to represent the charitable interests of beneficiaries of the charitable obligations of a nonprofit hospital and medical service organization and any health insurance affiliate in any proceeding before any court or any administrative agency. The Attorney General may enforce the organization's charitable obligations in an action in Superior Court under the Attorney General's charitable authority.

5 MRS §§ 205-A through 214 — Maine Unfair Trade Practices Act:

States that unfair methods of competition and unfair or deceptive acts or practices in the conduct of any trade or commerce are declared unlawful. The Attorney General may make rules and regulations interpreting this section. Such rules and regulations shall not be inconsistent with the rules, regulations and decisions of the Federal Trade Commission and the Federal Courts interpreting the provisions of 15 U.S.C. 45(a)(1) (The Federal Trade Commission Act) as from time to time amended. Evidence of a violation of a rule or regulation made by the Attorney General shall constitute prima facie evidence of an act or practice declared to be unlawful by this chapter in any action thereafter brought under this chapter.

10 MRS § 1107 — Investigation by Attorney General: Monopolies and Profiteering:

States that the Attorney General upon the Attorney General's own initiative or upon petition of 50 or more citizens of this State, shall investigate all seeming violations of sections 1102-A and 1105 to 1107, all contracts, combinations or conspiracies in restraint of trade or commerce, and all monopolies, and may require, by summons, the attendance and testimony of witnesses and the production of books and papers before the Attorney General relating to any such matter under investigation.

Encouraging Price Transparency

22 MRS §§ 8701 through 8717 — Maine Health Data Organization:

The purposes of the organization are to create and maintain a useful, objective, reliable and comprehensive health information database that is used to improve the health of Maine citizens and to issue reports, as provided in section 8712. This database must be publicly accessible while protecting patient confidentiality and respecting providers of care. The organization shall collect, process, analyze and report clinical, financial, quality and restructuring data as defined in this chapter.

22 MRS § 1718-B — Consumer information regarding Health care entity prices: General Provisions:

A health care entity shall have available to patients the prices of the health care entity's most frequently provided health care services and procedures. The prices stated must be the prices that the health care entity charges patients directly when there is no insurance coverage for the services or procedures or when reimbursement by an insurance company is denied. A health care entity shall prominently display in a location that is readily accessible to patients information on the price transparency tools available from the publicly accessible website.

Right-to-Shop

22 MRS § 1718-C — Estimate of the total price of a single medical encounter for an uninsured patient: General Provisions:

Upon the request of an uninsured patient, a health care entity, as defined in section 1718-B, subsection 1, paragraph B, shall provide within a reasonable time of the request an estimate of the total price of medical services to be rendered directly by that health care entity during a single medical encounter.

22 MRS § 1718-D — Prohibition on balance billing for surprise bills: General Provisions:

An out-of-network provider reimbursed for a surprise bill under Title 24-A, section 4303-C, subsection 2, paragraph B may not bill an enrollee for health care services beyond the applicable coinsurance, copayment, deductible or other out-of-pocket cost expense that would be imposed

for the health care services if the services were rendered by a network provider under the enrollee's health plan.

24-A MRS § 4318-A — Comparable Health care service incentive program: Health Plan Requirements:

Beginning January 1, 2019, a carrier offering a health plan in this State shall establish, at a minimum, for all small group health plans as defined in section 2808-B, subsection 1, paragraph G compatible with a health savings account authorized under federal law, a health plan design in which enrollees are directly incentivized to shop for low-cost, high-quality participating providers for comparable health care services. Incentives may include, but are not limited to, cash payments, gift cards or credits or reductions of premiums, copayments or deductibles. A small group health plan design created under this section must remain available to enrollees for at least 2 consecutive years, except that any changes made to the program after 2 years, including, but not limited to, ending the incentive, may not be construed as a change to the small group health plan design for the purpose of guaranteed renewability under section 2808-B, subsection 4 or section 2850-B. A multiple-employer welfare arrangement is not considered a carrier for the purposes of this section.

24-A MRS § 4318-B — Access to lower-priced services: Health Plan Requirements:

Beginning January 1, 2019, if an enrollee covered under a health plan other than a health maintenance organization plan elects to obtain a covered comparable health care service as defined in section 4318-A, subsection 1, paragraph A from an out-of-network provider at a price that is the same or less than the statewide average for the same covered health care service based on data reported on the publicly accessible health care costs website of the Maine Health Data Organization, the carrier shall allow the enrollee to obtain the service from the out-of-network provider at the provider's charge and, upon request by the enrollee, shall apply the payments made by the enrollee for that comparable health care service toward the enrollee's deductible and out-of-pocket maximum as specified in the enrollee's health plan as if the health care services had been provided by an in-network provider. A carrier may use the average price paid to a network provider for the covered comparable health care service under the enrollee's health plan in lieu of the statewide average price on the Maine Health Data Organization's publicly accessible website as long as the carrier uses a reasonable method to calculate the average price paid and the information is available to enrollees through a website accessible to the enrollee and a toll-free telephone number that provide, at a minimum, information relating to comparable health care services. The enrollee is responsible for demonstrating to the carrier that payments made by the enrollee to the out-of-network provider should be applied toward the enrollee's deductible or out-of-pocket maximum pursuant to this section. The carrier shall provide a downloadable or interactive online form to the enrollee for the purpose of making such a demonstration and may require that copies of bills and proof of payment be submitted by the enrollee. For the purposes of this section, "out-of-network provider" means a provider located in Massachusetts, New Hampshire or this State that is enrolled in the MaineCare program and participates in Medicare.

24-A MRS § 4303-C — Protection from surprise bills: Health Plan Requirements:

A carrier shall require an enrollee to pay only the applicable coinsurance, copayment, deductible or other out-of-pocket expense that would be imposed for health care services if the services were rendered by a network provider. A carrier shall reimburse the out-of-network provider or enrollee, as applicable, for health care services rendered at the average network rate under the enrollee's health care plan as payment in full, unless the carrier and out-of-network provider agree otherwise;

24-A MRS § 4303-D — Provider directories: Health Plan Requirements:

Requires carriers to make provider directories available electronically and update them on a monthly basis.

24-A MRS § 4303 — Plan requirements: Health Plan Requirements:
A protection against balance billing by participating providers. An enrollee's responsibility for payment under a managed care plan must be limited. Establishes requirements for health plan contracts. Bans the use of most favored nation clauses.

Regulation Around Development of ACOs

24-A MRS § 4320-H — Payment reform pilot project: Health Plan Requirements:
Allows insurance carriers which offer health plans to implement payment reform strategies with providers through ACOs to reduce costs and improve quality. Gives the superintendent power to approve pilot projects between a carrier and an ACO. See also 02-031 CMR Ch. 855 §3 (regulation promulgated pursuant to the statute).

Competitive Behavior in Health Plan Contracting

24-A MRS § 4303(17) — Prohibition on "most favored nation" clauses:
Bans most favored nation clauses, a promise obtained by an insurer that the provider will not give a better price to another insurer.

Expansion of DOI Authority

24-A MRS § 2808-B — Small group Health Plans: Group and Blanket Health Insurance:
The following requirements apply to the rating practices of carriers providing small group health plans. This subsection does not apply to policies issued before January 1, 1998 to eligible groups that employed, on average, 25 to 50 eligible employees until their first renewal date on or after January 1, 1998. Rates subject to this subsection must be filed for approval by the superintendent. The superintendent shall disapprove any premium rates filed by any carrier, whether initial or revised, for a small group health plan unless it is anticipated that the aggregate benefits estimated to be paid under all the small group health plans maintained in force by the carrier for the period for which coverage is to be provided will return to policyholders at least 75% of the aggregate premiums collected for those policies, as determined in accordance with accepted actuarial principles and practices and on the basis of incurred claims experience and earned premiums.
24-A MRS § 2736-C — Individual Health Plans: Health Insurance Contracts:
Outlines rating practices of carriers providing individual health plans.
24-A MRS § 2736 — Rate filings on individual health insurance policies:
Vests prior approval authority in the insurance commissioner only for subsets of the insurance market.

Creating or Reducing Barriers to New Entrants

24-A MRS § 4316 — Coverage for telemedicine services: Health Plan Requirements:
Prohibits carriers from requiring out-of-pocket costs for telemedicine services in amounts that exceed those required for in-person services.
32 MRS § 2594-A — Assistants: General Provisions:
Nothing in this chapter may be construed as prohibiting a physician from delegating to the physician's employees or support staff certain activities relating to medical care and treatment carried out by custom and usage when these activities are under the direct control of the physician.

MARYLAND

Antitrust

MD Code State Gov't §§ 6.5-101 through 6.5-401 — Attorney General; Acquisition of Nonprofit Health Entities:
A person may not engage in an acquisition of a nonprofit health entity unless the transferor and the transferee receive the approval of the appropriate regulating entity. The Attorney General, the Department, and the Administration shall adopt regulations to carry out this title.
MD Code Com Law §§ 11-201 through 11-213 — Antitrust Act:
Maryland statutes that complement federal laws on restraints of trade. § 11-203 exempts hospital mergers or consolidations or joint ownerships from antitrust statutes if these activities were previously approved by the MD Health Care Commission under § 19-129.
MD Code Com Law §§ 13-101 through 13-501 — Consumer Protection Act:
Provides minimum standards for the protection of consumers in the State.
MD Code Com Law § 19-129 — Merger or consolidation of hospitals: Health Planning and Development:
Discusses the conditions in which a merger or consolidation of hospitals is acceptable.

Encouraging Price Transparency

MD Code Health-Gen §§ 19-133 through 19-136 —Medical Care Data Collection:
Permits Commission to establish a Maryland medical care data base that compiles statewide data on health services rendered by health care practitioners and facilities selected by the Commission. The Commission will publish an annual report that describes the variation in fees charged and includes information about the charge for procedures, health care costs, utilization, or resource use.
MD Code Ins § 15-112.3 — Multi-carrier common online provider directory information system: Health Insurance, General Provisions:
The Commissioner may designate a multi-carrier common online provider directory information system developed by a nonprofit alliance of health plans and trade associations if the system is available to providers nationally; the system is available to providers at no charge; the nonprofit alliance has a well-established mechanism for outreach to providers.
MD Ins Code § 15-116 — Health care services: Health Insurance, General Provisions:
A carrier, as a condition of a contract with a health care provider or in any other manner, may not prohibit a health care provider from discussing with or communicating to an enrollee, subscriber, public official, or other person information that is necessary or appropriate for the delivery of health care services.
MD Ins Code § 15-140 — Health care during transitions from one carrier to another: Health Insurance, General Provisions:
During transitions, the rates and methods of payment shall ensure that an enrollee is not subject to balance billing and the copayments, deductibles, and any coinsurance required of an enrollee for the services rendered in accordance with this section are the same as those that would be required if the enrollee were receiving the services from a participating provider of the receiving carrier or managed care organization.
MD Code Health-Gen §§ 19-101 through 19-111 — Maryland Health Care Commission:

Describes the independent Maryland Health Care Commission and its functions, some of which include: cost containment, developing a regulatory structure, and publicly disclosing medical claims data.

MD Code Health-Gen § 19-207 — Powers and duties of Commission: Health Services Cost Review Commission, Part I Definitions, General Provisions:

The Commission shall periodically participate in or do analyses and studies that relate to health care costs, the financial status of any facility, or any other appropriate matter. In consultation with the Maryland Health Care Commission, it shall annually publish each acute care hospital's severity-adjusted average charge per case for the 15 most common inpatient diagnosis-related groups.

MD Code Health-Gen § 19-2109 — Duties of Commission: Maryland Community Health Resources Commission:

The commission shall encourage the establishment and use of community resources, work with community health resources, hospital systems, and others to develop a unified information and data management system for use by all community health resources that is integrated with the local hospital systems to track the treatment of individual patients and that provides real-time indicators of available resources; and work in cooperation with clinical education and training programs, area health education centers, and telemedicine centers to enhance access to quality primary and specialty health care for individuals in rural and underserved areas referred by community health resources.

MD Code Health-Gen § 19-716 — Duty to provide information to members, general public: Health Maintenance Organizations:

Annually, each health maintenance organization shall provide to its members and make available to the general public, in clear, readable, and concise form information required by this section and § 15-1206 of the Insurance Article.

Competitive Behavior in Health Plan Contracting

MD Ins Code §§ 27-101 through 27-105 — Trade Practices and Other Prohibited Practices: General Provisions:

Bans unfair or deceptive trade practices in the business of insurance, as defined in the title (§27-101 through 27-1001 defines unfair practices, but there are limited references to market power or provider consolidation).

MD Ins Code § 15-112 — Provider panels:

A carrier may not include in a contract with a provider, ambulatory surgical facility, or hospital a most favored nation clause. Banned most favored nations in 2006.

Monitoring/Regulating Prices

MD Code Health-Gen §§ 19-101 through 19-111 — Maryland Health Care Commission:

Describes the independent Maryland Health Care Commission and its functions, some of which include: cost containment, developing a regulatory structure, and publicly disclosing medical claims data.

MD Code Health-Gen §§ 19-201 through 19-227 — Health Services Cost Review Commission:

Established a Health Services Cost Review Commission with duties that include periodically participating in or doing analyses and studies that relate to: (i) Health care costs; (ii) The financial status of any facility; or (iii) Any other appropriate matter. In consultation with the Maryland Health Care Commission, annually publish each acute care hospital's severity- adjusted average charge per case for the 15 most common inpatient diagnosis-related groups.

MD Code Health-Gen § 19-720 — Health Services Cost Review Commission: Health Maintenance Organizations:
"The State Health Services Cost Review Commission promptly shall give the Commissioner and the Secretary any financial information that the Commission acquires about each facility that is:
(1) Under the jurisdiction of the Commission; and
(2) Subject to this subtitle."
MD Code Ins § 15-604 — Rates for payments to hospitals; Compliance with all-payor model contract: Required Reimbursement of Institutions:
Requiring all payers to reimburse Maryland hospitals based on the rates established by the HSCRC.

Regulation Around Development of ACOs

MD Ins Code § 15-1902 — Contract between carrier and a clinically integrated organization:
Defines a clinically integrated organization and permits that carriers may pay them for care coordination activities and alternative payment methods such as bonuses, incentives, or bundled payments for medically appropriate care. Permits the Commissioner, in consultation with the MD Health Care Commission, to promulgate regulations regarding these payments and incentives.

Expansion of DOI Authority

MD Ins Code §§ 11-601 through 11-60 — Benefit Plan Premium Rate Review:
Insurance carriers must receive prior approval from the Commissioner before charging premiums to contract holders or individuals covered under a health benefit plan. Carriers must provide annual notice and post notice on their websites to inform an insured or enrollee that they may access information and submit comments about proposed rate increases on the Maryland Insurance Administration's website.
MD Code Health–Gen § 19-108 — Regulations specifying comprehensive standard health benefit plan:
Vests the insurance commissioner with prior approval authority.

Creating or Reducing Barriers to New Entrants

MD Code Health-Gen §§ 19-114 through 19-130 — Part II. Health Planning and Development: Certificate of Need guidelines and principles.
MD Code Health-Gen § 19-319 — Qualifications for licenses: Licensing:
Must have CON in order to be licensed as a hospital or residential treatment center.
MD Ins Code § 15-139 — Health care services delivered through telehealth: Health Insurance, General Provisions:
Plans must cover telehealth services and may not exclude coverage solely because it is provided via telehealth.
MD Ins Code § 15-701 — Licensed Health care providers: Required Reimbursement for Services of Health Care Providers:
Notwithstanding any other provision of a policy, contract, or certificate subject to this subsection, if the policy, contract, or certificate provides for reimbursement for a service that is within the lawful scope of practice of a health care provider licensed under the Health Occupations Article, the insured or any other person covered by or entitled to reimbursement under the policy, contract, or certificate is entitled to reimbursement for the service.
MD Code Com Law §§ 13-101 through 13- 501 —Advanced Practice Registered Nurse Compact:
The general purposes of this compact are to:

(i) Facilitate the states' responsibility to protect the public's health and safety;
(ii) Ensure and encourage the cooperation of party states in the areas of APRN licensure and regulation, including promotion of uniform licensure requirements;
(iii) Facilitate the exchange of information between party states in the areas of APRN regulation, investigation and adverse actions;
(iv) Promote compliance with the laws governing APRN practice in each jurisdiction;
(v) Invest all party states with the authority to hold an APRN accountable for meeting all state practice laws in the state in which the patient is located at the time care is rendered through the mutual recognition of party state licenses;
(vi) Decrease redundancies in the consideration and issuance of APRN licenses; and
(vii) Provide opportunities for interstate practice by APRNs who meet uniform licensure requirements.

MD Ins Code § 15-702 — Dentists, physicians, and podiatrists under self-funded group insurance Plans: Required Reimbursement for Services of Health Care Providers:
Notwithstanding any other provision of a self-funded group insurance plan subject to this section, if the plan provides for reimbursement for a service that is within the lawful scope of practice of a physician, dentist, or podiatrist, the plan may not prohibit a person covered by the plan from being reimbursed for the service regardless of whether the service is performed by a physician, dentist, or podiatrist.

MD Ins Code § 15-708 — Nurse anesthetists: Required Reimbursement for Services of Health Care Providers:
If the policy, contract, or certificate provides for reimbursement for a service that is within the lawful scope of practice of a nurse anesthetist, the insured or any other person covered by the policy, contract, or certificate is entitled to reimbursement for the service regardless of whether the service is performed by a physician or nurse anesthetist.

MD Ins Code § 15-712 — Physician assistants: Required Reimbursement for Services of Health Care Providers:
Unless a policy, contract, or certificate described in § 15-701(a) of this subtitle expressly provides for reimbursement for a service that is within the lawful scope of practice of a physician assistant certified under the Health Occupations Article, the provisions of the Health Occupations Article that govern the certification and regulation of physician assistants may not be construed to entitle the insured or any other person covered by the policy, contract, or certificate to reimbursement for the service.

Appendix

MASSACHUSETTS

Antitrust

MA Gen Laws Ch 12 § 11N — Monitoring Health care market trends; investigation of unfair methods of Competition or anti-competitive behavior; exemption or waiver from federal law: Department of the Attorney General, and the District Attorneys:
The attorney general shall monitor trends in the health care market including, but not limited to, trends in provider organization size and composition, consolidation in the provider market, payer contracting trends and patient access and quality issues in the health care market. The attorney general may obtain the following information from a private health care payer, public health care payer, provider or provider organization (i) any information that is required to be submitted under

sections 8, 9 and 10 of chapter 12C, (ii) filings, applications and supporting documentation related to any cost and market impact review under section 13 of chapter 6D (iii) filings, applications and supporting documentation related to a determination of need application filed under section 25C of chapter 111; and (iv) filings, applications and supporting documentation submitted to the federal Centers for Medicare and Medicaid Services or the Office of the Inspector General for any demonstration project.

MA Gen Laws Ch 93A §§ 1 through 11 — Regulation of Business Practices for Consumers Protection:
States that whenever the attorney general has reason to believe that any person is using or is about to use any method, act, or practice declared by section two to be unlawful, and that proceedings would be in the public interest, he may bring an action in the name of the commonwealth against such person to restrain by temporary restraining order or preliminary or permanent injunction the use of such method, act or practice.

MA Gen Laws Ch 93 § 1 through 14A — The Massachusetts Antitrust Act:
Encourages free and open competition by prohibiting restraints on trade and monopolistic practices.

MA Gen Laws Ch 176D § 3A — Unfair methods of Competition and unfair or deceptive acts or practices in the business of insurance; certain business entities: Unfair Methods of Competition and Unfair and Deceptive Acts and Practices in the Business of Insurance:
Describes unfair methods of competition or deceptive practices in the business of insurance.

MA Gen Laws Ch 176G § 9 — Trade regulation practices; application of law: Health Maintenance Organizations:
Extends state laws related to restraint of trade to HMOs.

MA Gen Laws Ch 176G § 27 — Merger or acquisition of control: Health Maintenance Organizations:
The state insurance commissioner should not approve mergers and acquisitions involving an HMO if it reduces competition or leads to a monopoly.

MA Gen Laws Ch 6D § 13 — Notice of material changes to operations or governance structure of provider or provider organization; cost and market impact review: Health Policy Commission:
Requires notification to the commission if any material changes that include mergers and acquisitions impact the Commonwealth's ability to meet cost benchmarks. Requires Commission to conduct a cost and market impact review.

Encouraging Price Transparency

MA Gen Laws Ch 12C §§ 1 through 23 — Center for Health Information and Analysis:
Regulated that the state consumer website will have information comparing the quality, price and cost of health care services.

MA Gen Laws Ch 32A § 27 — Toll-free telephone number and website providing customers with estimated or maximum allowed amount or charge for proposed admission, procedure or service: Contributory Group General or Blanket Insurance for Persons in the Service of the Commonwealth:
The commission shall require any carriers or third party administrators with whom it contracts to provide a toll-free telephone number and website that enables consumers to request and obtain from the carrier or third party administrator, in real time, the estimated or maximum allowed amount or charge for a proposed admission, procedure or service and the estimated amount the insured will be responsible to pay for a proposed admission, procedure or service that is a medically necessary covered benefit, based on the information available to the carrier or third party administrator at the time the request is made.

MA Gen Laws Ch 176A § 37 — Disclosure of patient-level data and contracted prices of individual health care services by carriers to providers: Nonprofit Hospital Service Corporations:

Requires every nonprofit hospital service corporation, to the extent permitting by law, to disclose patient-level data to providers in their network solely for the purpose of carrying out treatment, coordinating care among providers, etc.
MA Gen Laws Ch 176B § 24 — Disclosure of patient-level data and contracted prices of individual health care services by carriers to providers: Medical Service Corporations:
Every medical service corporation shall disclose patient-level data to providers in their network solely for the purpose of carrying out treatment, coordinating care among providers and managing the care of their own patient panel
MA Gen Laws Ch 176J § 17 — Disclosure of patient-level data and contracted prices of individual health care services by carriers to providers: Small Group Health Insurance
Every carrier shall disclose patient-level data to providers in their network solely for the purpose of carrying out treatment, coordinating care among providers and managing the care of their own patient panel.
MA Gen Laws Ch 176O § 7 — Information provided by carrier upon enrollment or upon request: Health Insurance Consumer Protections:
A carrier shall provide to at least one adult insured in each household upon enrollment, and to a prospective insured upon request, a list of health care providers in the carrier's network, organized by specialty and by location and summarizing on its internet website for each such provider such as, the provider price relativity, among other measures.
MA Gen Laws Ch 32A § 27 — Toll-free telephone number and website providing customers with estimated or maximum allowed amount or charge for proposed admission, procedure or service: Contributory Group General or Blanket Insurance for Persons in the Service of the Commonwealth:
The commission shall require any carriers or third party administrators with whom it contracts to provide a toll-free telephone number and website that enables consumers to request and obtain from the carrier or third party administrator, in real time, the estimated or maximum allowed amount or charge for a proposed admission, procedure or service and the estimated amount the insured will be responsible to pay for a proposed admission, procedure or service that is a medically necessary covered benefit, based on the information available to the carrier or third party administrator at the time the request is made.

Competitive Behavior in Health Plan Contracting

MA Gen Laws Ch 176O § 9A — Agreements or contracts between carrier and Health care provider prohibited if containing certain provisions: Health Insurance Consumer Protections:
Bans contracts that limit steering and tiering, require all-or-nothing contracting, and include gag clauses.
MA Gen Laws 176D § 3 — Unfair methods of competition and unfair or deceptive acts or practices:
Bans most favored nation clauses, a promise obtained by an insurer that the provider will not give a better price to another insurer.

Monitoring/Regulating Prices

MA Gen Laws Ch 6D — Health Policy Commission:
The collective statutes describing the MA Health Policy Commission, including holding public hearing related to its activities on cost analysis and containment, the creation of the health care cost growth benchmark, and its market oversight functions.
MA Gen Laws Ch 6A § 16M — MassHealth payment policy advisory board; Composition; powers and duties; staff: Executive Offices:

Reviews and evaluates rates and payment systems by the office of Medicaid and recommend Title XIX rates and rate methodologies.

Creating or Reducing Barriers to New Entrants

MA Gen Laws Ch 6A § 16T — Health Planning council; advisory committee; identification and distribution of Health care resources; determination of need; report: Executive Offices:
Develops a state health plan that identifies the needs of the Commonwealth in health care services, providers, programs and facilities; the resources available to meet those needs; and the priorities for addressing those needs.

Regulation Around Development of ACOs

MA Gen Laws Ch 6D, § 15 — Certification as accountable care organization (ACO); standards: Health Policy Commission:
The commission shall establish minimum standards for certified ACOs.

Expansion of DOI Authority

MA Gen Laws Ch 175 § 117C — Determination of premium rates with respect to credit life insurance and credit accident and Health insurance; filing; reports: Insurance:
The following method of determination of premium rates with respect to credit life insurance and credit accident and health insurance is required only for such insurance written in connection with obligations, other than loans secured by first liens on real property, which are subject to section twelve G of chapter two hundred and fifty-five, section ten of chapter two hundred and fifty-five B, section fourteen A of chapter two hundred and fifty-five C, or subsection C of section twenty-six of chapter two hundred and fifty-five D, for which an identifiable charge is paid by insured persons.
MA Gen Laws Ch 176J § 12 — Small business group purchasing cooperatives; regulations governing establishment, oversight and certification: Small Group Health Insurance:
Rates offered by carriers in group purchasing are the same as those for individual and small group plans.

Creating or Reducing Barriers to New Entrants

MA Gen Laws Ch 111 § 25C — Determination of need for construction of Health care facility or change in service of facility: Public Health:
If substantial capital expenditures for construction of a health care facility substantially changes the service of the facility, it will need to file and be approved for a determination of need.
Tiered Network
MA Gen Laws Ch 176J § 11 — Reduced or selective network Plans; tiered network Plans; smart tiering Plans: Small Group Health Insurance:
A carrier that offers a health benefit plan that: (i) provides or arranges for the delivery of health care services through a closed network of health care providers; and (ii) as of the close of any preceding calendar year, has a combined total of 5,000 or more eligible individuals, eligible employees and eligible dependents, who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses or eligible individuals, shall offer to all eligible individuals and small businesses in at least **1** geographic area at least **1** plan with either: (1) a reduced or selective network of providers; (2) a smart tiering plan in which health services are tiered and member cost sharing is based on the tier placement of the services; or, (3)

a plan in which providers are tiered and member cost sharing is based on the tier placement of the provider.
MA Gen Laws Ch 32B § 22 — Copayments, deductibles, tiered provider network copayments and other cost-sharing Plan design features; increases: Contributory Group General or Blanket Insurance for Persons in the Service of Counties, Cities, Towns and Districts, and Their Dependents:
Governments offering this insurance may generally include copayments, deductibles, tiered provider network copayments and other cost-sharing plan design features that are no greater in dollar amount than the copayments, deductibles, tiered provider network copayments and...
MA Gen Laws Ch 176O § 9A — Agreements or contracts between carrier and Health care provider prohibited if containing certain provisions: Health Insurance Consumer Protections:
Prohibits agreements or contracts that limit the ability of the insurer to introduce or modify a select network plan or tiered network plan by granting the health care provider a guaranteed right of participation.
MA Gen Laws Ch 176J § 15 — Display by insurer offering tiered network Plan of cost-sharing differences for enrollees in various tiers in promotional and agreement material: Small Group Health Insurance:
An insurer offering a tiered network plan shall clearly and conspicuously indicate, in all promotional and agreement materials, the cost-sharing differences for enrollees in the various tiers.
MA Gen Laws Ch 175 § 47BB — Coverage for telemedicine services: Insurance:
Defines telemedicine and defines when an insurer may limit coverage of telemedicine services.
MA Gen Laws Ch 176R §§ 1 through 6 — Consumer Choice of Nurse Practitioner Services:
Defines terms and the scope of practice of Nurse Practitioner services.

Appendix

MICHIGAN

Antitrust

MI Comp Laws §§ 445.901 through 445.922 — Consumer Protection Act:
Defines unlawful or unfair acts of trade. The attorney general may promulgate rules to implement this act under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328. The rules shall not create an additional unfair trade practice not already enumerated by this section.

Encouraging Price Transparency

MI Comp Laws § 333.17757 — Price information; notice; receipt evidencing transactions; omission; retention of copy of receipt; rules: Public Health Code:
Upon request, pharmacist must provide price information for drugs sold at pharmacy, as well as comparative information about prices of brand name vs. generic drugs.
MI Comp Laws § 400.105f — Michigan Health care cost and quality advisory committee:
Requires the director of the department of community health and the director of the department of insurance and financial services to establish a Michigan health care cost and quality advisory committee that will issue a report by December 31, 2014 with recommendations on the creation of a database on health care costs and health care quality in Michigan.

Competitive Behavior in Health Plan Contracting

MI Comp Laws § 550.1400 — Use of most favored nation clause in provider contract: The Nonprofit
Health Care Corporation Reform Act:
Statute barring health care corporations and insurers and HMOs from using most favored nation clauses in provider contracts.
MI Comp Laws § 500.3405a — Use of most favored nation clause: Disability Insurance Policies:
Beginning January 1, 2014, an insurer or a health maintenance organization shall not use a most favored nation clause in any provider contract, including a provider contract in effect on January 1, 2014.

Monitoring/Regulating Prices

MI Comp Laws § 550.1504 — Reimbursement arrangements; goals; definitions; supplemental efforts: General Insurance Laws:
Goals of reimbursement arrangements with health care providers; Discusses goals of reimbursement arrangements with health care providers with respect to ensuring reasonable cost and quality of services. General Nonprofit Health Care Corporation Reform Act contains various provisions regarding premium rates.

Expansion of DOI Authority

MI Comp Laws § 550 — Submission of new or revised certificate and applicable proposed rates; approval or disapproval; exemption; circumstances and conditions; notice; implementation of certificates and rates:
Vests the insurance commissioner with prior approval authority.

Creating or Reducing Barriers to New Entrants

MI Comp Laws §§ 333.22201 through 333.22260 — Public Health Code:
Outlines circumstances under which providers are required to receive a certificate of need.
MI Comp Laws § 550 — Provider network: The Nonprofit Health Care Corporation Reform Act:
Beginning January 1, 2014, a health care corporation shall establish and maintain a provider network that, at a minimum, satisfies any network adequacy requirements imposed by the commissioner pursuant to federal law.
MI Comp Laws § 500.3428 — Provider network: Disability Insurance Policies:
An insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall establish and maintain a provider network that, at a minimum, satisfies any network adequacy requirements imposed by the director under federal law.
MI Comp Laws § 550.1401k — Telemedicine services; provisions; definition; applicability: The Nonprofit Health Care Corporation Reform Act:
A group or nongroup health care corporation certificate shall not require face-to-face contact between a health care professional and a patient for services appropriately provided through telemedicine, as determined by the health care corporation.

Appendix

Antitrust

MN Stat §§ 325D01 through 325D72 — Restraint of Trade:
Identifies unlawful discrimination and competition, trade practices, uniform deceptive trade practices, combinations in restraint of trade, among other unlawful acts.

Encouraging Price Transparency

MN Stat § 62J.041 — Interim health plan company cost containment goals: Health Care Cost Containment — Cost Controls:
The commissioner of health shall establish cost containment goals for the increase in net expenditures by each health plan company for calendar years 1994, 1995, 1996, and 1997.
MN Stat § 62J.17 — Expenditure reporting: Health Care Cost Containment — Cost Controls:
Expenditure reporting. Each hospital, outpatient surgical center, diagnostic imaging center, and physician clinic shall report annually to the commissioner on all major spending commitments, in the form and manner specified by the commissioner. The report shall include the following information: a description of major spending commitments made during the previous year, including the total dollar amount of major spending commitments and purpose of the expenditures.
MN Stat §§ 62J.301 through 62J.321 — Data Collection and Research Initiatives:
The commissioner of health shall conduct data and research initiatives in order to monitor and improve the efficiency and effectiveness of health care in Minnesota. The commissioner shall collect data from health care providers, health plan companies, and individuals in the most cost-effective manner, which does not unduly burden them.
MN Stat § 62J.63 — Center for Health Care Purchasing Improvement: Health Care Administrative Simplification Act:
Establishes a Center for Health Care Purchasing Improvement within the Department of Health with the goal of facilitating the state's development and usage of more common strategies and approaches to promote greater transparency of health care costs, quality, and greater accountability for health care results and improvement.
MN Stat § 62J.72 — Disclosure of Health care provider information: Patient Protection Act: During open enrollment and upon enrollment, requires health plans, health care network cooperatives, and health care providers to provide general information in a written format about the way providers are reimbursed for providing care. Requires more specific information be made available in writing upon request.
MN Stat § 62J.71 — Prohibited provider contracts: Patient Protection Act:
Prohibits agreements that include health care providers being barred from making recommendations about treatment options or making recommendations regarding a health insurer. It also prohibits agreements in which the health care provider is barred from receiving information regarding the reimbursement methodology.
MN Stat § 62J.81 — Disclosure of payments for Health care services: Patient Protection Act:
Disclosure of Payments for Health Care Services: Requires healthcare providers to give consumers a good faith estimate of the allowable payment the provider has agreed to accept from the consumer's health plan company for the services specified by the consumer, specifying the amount of the allowable payment due from the health plan company at the consumer's request.
Transparency Website

MN Stat § 62J.82 — Hospital information reporting disclosure: Patient Protection Act:
Hospital Information Reporting Disclosure: The Minnesota Hospital Association shall develop a Web-based system, available to the public free of charge, for reporting hospital performance and price to Minnesota residents.
MN Stat § 62J.823 — Hospital pricing transparency: Patient Protection Act:
Requires any hospital to provide a written estimate of the cost of a specific service or stay upon the request of a patient, doctor, or the patient's representative. This should include service codes or name/ type of procedures and the methods used for the estimate.
MN Stat § 62U.04 — Payment reform; Health care costs; quality outcomes: Health Care Payment and Pricing Reform:
Requires 1) the development of tools to improve costs and quality outcomes, 2) the calculation of health care costs and quality 2) a provider peer grouping system and advisory committee 3) provider peer grouping 4) providing encounter data every 6 months 5) submitting price data 6) consumer engagement 7) innovations to improve quality and manage costs 8) review and use of data collected.
MN Stat § 62K.11 — Balance billing prohibited: Minnesota Health Plan Market Rules:
A network provider is prohibited from billing an enrollee for any amount in excess of the allowable amount the health carrier has contracted for with the provider as total payment for the health care service. A network provider is permitted to bill an enrollee the approved co-payment, deductible, or coinsurance. A network provider is permitted to bill an enrollee for services not covered by the enrollee's health plan as long as the enrollee agrees in writing in advance before the service is performed to pay for the noncovered service.
MN Stat § 62Q.645 — Efficiency reports and distribution of information: Health Plan Companies:
For health plan companies with annual premiums in Minnesota exceeding $50,000,000, the Commissioner of Health is authorized to compile entity specific administrative efficiency reports of the health plan company and publish such information on the web.
MN Stat § 144.651 — Health Care Bill of Rights: Patient Bill of Rights
Disclosure of services available. Patients and residents shall be informed, prior to or at the time of admission and during their stay, of services which are included in the facility's basic per diem or daily room rate and that other services are available at additional charges. Facilities shall make every effort to assist patients and residents in obtaining information regarding whether the Medicare or medical assistance program will pay for any or all of the aforementioned services.
MN Stat §§ 144.698 through 144.702 — Minnesota Health Care Cost Information Act of 1984:
Directs the Commissioner of Health to encourage hospitals and providers “to publish prices for procedures and services that are representative of the diagnoses and conditions for which citizens of this state seek treatment” for community benefit, in order to foster price competition among hospitals and providers.

Competitive Behavior in Health Plan Contracting

MN Stat § 62A.64 — Health insurance; prohibited agreements: Accident and Health Insurance – Prohibited Agreements:
Prohibits most favored nation clauses in contracts with health care providers, a promise obtained by an insurer that the provider will not give a better price to another insurer.
MN Stat § 62J.73 — Prohibition on exclusive arrangements: Patient Protection Act:
Beginning February 1, 2013, an insurer or a health maintenance organization shall not use a most favored nation clause in any provider contract, including a provider contract in effect on February 1, 2013, unless the most favored nation clause has been filed with and approved by the commissioner. Beginning February 1, 2013, an insurer or a health maintenance organization shall

not enforce a most favored nation clause in any provider contract without the prior approval of the commissioner.

Monitoring/Regulating Prices

MN Stat § 62U.05 — Provider pricing for baskets of care: Health Care Payment and Pricing Reform:
Outlines provisions for commissioner to establish baskets of care episodes with corresponding quality guidelines and healthcare providers to establish a set price for these baskets.

Regulation Around Development of ACOs

MN Stat § 256B.0755 — Integrated Health partnership demonstration project: Medical Assistance for Needy Persons:
Requires the Commissioner to develop and authorize a demonstration project to test alternative and innovative health care delivery systems in public programs.
MN Stat § 256B.0758 — Health care delivery pilot program: Medical Assistance for Needy Persons:
The commissioner may establish a health care delivery pilot program to test alternative and innovative integrated health care delivery networks, including accountable care organizations or a community-based collaborative care network created by or including North Memorial Health Care. If required, the commissioner shall seek federal approval of a new waiver request or amend an existing demonstration pilot project waiver.

Expansion of DOI Authority

MN Stat § 62J.74 — Enforcement: Patient Protection Act:
Permits commissioners of health and commerce to scrutinize contracts and arrangements of the health care entities they regulate to ensure compliance with 62J.70 to 62J.73. Permits others to bring this to the attention of the commissioners and authorizes the commissioner to null and void any contracts or arrangements.
MN Stat § 62Q.645 — Efficiency reports and distribution of information: Health Plan Companies:
The commissioner may use reports submitted by health plan companies, service cooperatives, and the public employee insurance program created in section 43A.316 to compile entity specific administrative efficiency reports; may make these reports available on state agency Web sites.
MN Stat § 62Q.746 — Access to certain information regarding providers: Minnesota Health Plan Contracting Act:
Provides commissioner access to health plan information on providers, network design, performance, size, and other operations.
MN Stat §§ 72A.17 through 72A.32 — Regulation of Trade Practices:
Outlines regulation of trade practices in the business of insurance.
MN Stat § 62a — Policy forms:
Vests the insurance commissioner with prior approval authority.

Creating or Reducing Barriers to New Entrants

MN Stat § 144.551 — Hospitals and Other Health Care Institutions:
Prohibits the construction of new hospitals or expansion of bed capacity at existing hospitals without legislative approval. This Law replaced the state's certificate of need program that had provided a case-by-case review.

MN Stat § 144.552 — Hospitals and Other Health Care Institutions:
Defines the public interest review as the process for hospitals seeking exemptions to the moratorium.
MN Stat § 62K.10 — Geographic accessibility; provider network adequacy: Minnesota Health Plan Market Rules: Each designated provider network must include a sufficient number and type of providers, including providers that specialize in mental health and substance use disorder services, to ensure that covered services are available to all enrollees without unreasonable delay.
MN Stat §§ 62A.67 through 62A — Minnesota Telemedicine Act:
A health plan sold, issued, or renewed by a health carrier for which coverage of benefits begins on or after January 1, 2017, shall include coverage for telemedicine benefits in the same manner as any other benefits covered under the policy, plan, or contract, and shall comply with the regulations of this section.
MN Stat § 147.033 — Telemedicine: Minnesota Medical Practice Act:
A physician not licensed to practice medicine in this state may provide medical services to a patient located in this state through interstate telemedicine if the following conditions are met:
(1) the physician is licensed without restriction to practice medicine in the state from which the physician provides telemedicine services;
(2) the physician has not had a license to practice medicine revoked or restricted in any state or jurisdiction;
(3) the physician does not open an office in this state, does not meet with patients in this state, and does not receive calls in this state from patients; and
(4) the physician annually registers with the board, on a form provided by the board.

Appendix

MISSISSIPPI

Antitrust
MS Code § 75-21-7 — Penalty for violation of anti-trust laws: Trusts and Combines in Restraint or Hindrance of Trade:
Certificate of Public Advantage/Cooperative Agreement
MS Code § 41-9-307 — Cooperative agreements; application for certificate of public advantage; issuance of certificate; monitoring; revocation of certificate; termination or withdrawal from agreement; amendment of agreement; regulations: Rural Health Availability Act:

Encouraging Price Transparency
MS Code § 41-95-7 — Mississippi Health Finance Authority Board; duties and responsibilities; Mississippi Health Care Purchasing Pool: Mississippi Health Policy Act of 1994:
Requires any health care provider, health care facility, state agency, insurance company or related entity to report information necessary for the Mississippi Health Finance Authority to analyze expenditures and other factors that affect the quality and cost of health services.
MS Code § 25-15-17. Payment of benefits:
The legislation protects consumers who would otherwise face balance billing for care by out-of-network providers in emergency rooms. The protections are limited to emergency department settings.

Expansion of DOI Authority

MS Code § 83-9-3 — Policy form; fees; expedited form and rate review procedure:
Vests the insurance commissioner with prior approval authority.

Creating or Reducing Barriers to New Entrants

MS Code §§ 41-7- 171 through 41-7-209 — Health Care Certificate of Need Law of 1979:
Law establishes guidelines for health care Certificate of Need.
MS Code §§ 83-9-351 through 83-9-353 — Coverage for Telemedicine Services:
Definitions associated with coverage and reimbursement of telemedicine services and remote patient monitoring services.
Scope of Practice
MS Code § 83-41-214 — Payment by third parties of certified nurse practitioners: Provisions Common to Hospital, Medical or Surgical Insurance:
A policy or contract providing for third-party payment or prepayment of health or medical expenses shall include a provision for the payment of necessary medical or surgical care and treatment provided by a duly certified nurse practitioner and performed within the scope of the license of the certified nurse practitioner if the policy or contract would pay for the care and treatment if the care and treatment were provided by a person engaged in the practice of medicine and surgery or osteopathic medicine and surgery.

Appendix

MISSOURI

Antitrust

MO Rev Stat §§ 191.900 through 191.914 — Health and Welfare:
The attorney general shall have authority to investigate alleged or suspected violations of sections 191.900 to 191.910, and shall have all powers provided by sections 407.040 to 407.090 in connection with investigations of alleged or suspected violations of sections 191.900 to 191.910, as if the acts enumerated in subsections 1 to 3 of section 191.905 are unlawful acts proscribed by chapter 407, provided that if the attorney general exercises such powers, the provisions of section 407.070 shall also be applicable; and may exercise all of the powers provided by subsections 1 and 2 of section 570.410 in connection with investigations of alleged or suspected violations of sections 191.900 to 191.910, as if the acts enumerated in subsections 1 to 3 of section 191.905 involve "public assistance" as defined by section 578.375.
MO Rev Stat §§ 416.011 through 416.161 — Missouri Antitrust Law:
States that every contract, combination or conspiracy in restraint of trade or commerce in this state is unlawful. It is unlawful to monopolize, attempt to monopolize, or conspire to monopolize trade or commerce in this state. It is unlawful for any person* engaged in trade or commerce in this state, in the course of such trade or commerce, to lease or make a sale or contract for sale of any commodity, whether patented or unpatented, for use, consumption, or resale within this state, or fix a price charged therefor, or discount from, or rebate upon, such price, on the condition, agreement, or understanding that the lessee or purchaser thereof shall not use or deal in the commodities of a competitor or competitors of the lessor or seller, where the effect of such lease, sale, or contract for such sale or such condition, agreement, or understanding may be

to substantially lessen competition or tend to create a monopoly in any line of trade or commerce in this state.

Encouraging Price Transparency

MO Rev Stat § 376.465 — Missouri Health insurance rate transparency act–intent, definitions–filing of rates–rates for grandfathered Plans–public availability–determination of unreasonability, notice–publishing of final rates–rulemaking authority–applicability of section: Missouri Health Insurance Rate Transparency Act:
For health benefit plans described under subsection 7 of this section, the director shall publish final rates on the department's website no earlier than thirty days prior to the first day of the annual open enrollment period in the individual market for the applicable calendar year. The final rate is the rate that will be implemented by the health carrier on a specified date.
MO Rev Stat § 192.667 — Health care providers, financial data, submission of data on nosocomial infections to be collected, rules, recommendation–federal system may be implemented–use of data by department of Health and senior services, duties, restrictions, penalty–publication of information, when–failure to provide information, effect–public reports required, when, requirements–rulemaking authority:
Requires all health care providers [includes hospitals and ambulatory surgical centers] to provide charge data to the Department.
MO Rev Stat § 376.690 — Unanticipated out-of-network care, claim procedure - limitation on amount billed to patient - external arbitration process - rulemaking authority:
This statute helps protect patients from surprise billing for emergency room visits.

Expansion of DOI Authority

MO Stat § 354 — Premiums, dues or fees subject to restrictions--violation, hearing--order prohibiting:
Insurance companies must file their proposed rates with the department of insurance, but the rates may go into effect without department approval. The department may have the ability to go back and disapprove a rate increase that was later deemed unreasonable, usually triggered by a consumer complaint process.

Creating or Reducing Barriers to New Entrants

MO Rev Stat §§ 197.300 through 197.367 — Missouri Certificate of Need Law:
Prohibits health care providers from acquiring, replacing, or adding to their facilities and equipment, except in specified circumstances, without the prior approval of the Missouri Health Facilities Need Committee through the state's Certificate of Need program.
MO Rev Stat § 354.603 — Sufficiency of Health carrier network, requirements, criteria - access Plan filed with the department, when: Community-Based Health Maintenance Organizations:
A health carrier shall maintain a network that is sufficient in number and types of providers to assure that all services to enrollees shall be accessible without unreasonable delay.
Telehealth
MO Rev Stat § 335.175 — Utilization of telehealth by nurses established–definition of telehealth–rulemaking authority–sunset provision: Nurses:
No later than January 1, 2014, there is hereby established within the state board of registration for the healing arts and the state board of nursing the "Utilization of Telehealth by Nurses."
MO Rev Stat §§ 208.670 through 208.686 — Telehealth:

Establishes a statewide program that permits reimbursement under the MO HealthNet program for home telemonitoring services.

Appendix

MONTANA

Competitive Behavior in Health Plan Contracting

MT Code § 33-22-1704 — Preferred provider agreements authorized: Preferred Provider Agreements:
A preferred provider agreement must provide all providers with the opportunity to participate on the basis of a competitive bid.

Expansion of DOI Authority

MT Code § 33-22-107 — Premium increase restriction – exception – notice of rate increase and policy changes: General Provisions:
Requires health insurance issuers delivering or issuing for delivery group or individual health insurance coverage to give a group policyholder at least 60 days' advance notice and an individual policyholder at least 45 days' advance notice of a change in rates or a change in terms or benefits.
Mont — Health insurance rates -- filing required -- use:
Insurance companies must file their proposed rates with the department of insurance, but the rates may go into effect without department approval. The department may have the ability to go back and disapprove a rate increase that was later deemed unreasonable.

Creating or Reducing Barriers to New Entrants

MT Code §§ 50-5-301 through 50-5-310 — Certificate of Need:
Requirements for certificate of need.
MT Code §§ 33-36-202 through 33-36-213 — Part 2. Network Adequacy:
A health carrier offering a managed care plan in this state shall maintain a network that is sufficient in numbers and types of providers to ensure that all services to covered persons are accessible without unreasonable delay. Sufficiency in number and type of provider is determined in accordance with the requirements of this section. Covered persons must have access to emergency care 24 hours a day, 7 days a week.
MT Code §§ 37-8-422 through 37-8-424 — Nursing Licensing:
Scope of Practice for nurse licensing.
MT Code § 37-20-403 — Physician assistant as agent of supervising physician — degree of supervision required — scope of practice: Physicians Assistants:
A supervising physician, office, firm, institution, or other entity may bill for a service provided by a supervised physician assistant.

Appendix

Antitrust

NE Rev Stat §§ 71-7701 through 71-7711 — Health Care Facility-Provider Cooperation Act:
Allows the department to issue a certificate of public advantage for a cooperative agreement if it determines that the applicants have demonstrated by clear and convincing evidence that the likely benefits resulting from the agreement outweigh any disadvantages attributable to a reduction in competition that may result from the agreement.

NE Rev Stat § 84-212 — Attorney General; antitrust matters; powers; duties; damages; proof; distribution: Attorney General, State Officers:
States that the Attorney General shall have and retain all his common-Law powers with respect to dealing with antitrust matters, and all related statutes of this state shall be deemed to be supplementary to such powers. He shall have authority to bring civil actions in the name of the state against anyone found violating either state or federal antitrust laws, and may recover treble damages in such actions.

NE Rev Stat §§ 59-1601 through 59-1623 — Consumer Protection Act:
States that unfair methods of competition and unfair or deceptive acts or practices in the conduct of any trade or commerce, monopolies, constricts and conspiracies in restraint of trade, acquisitions to lessen competition, and transactions or deals not to use commodities of a seller, shall be unlawful.

NE Rev Stat §§ 71-20,100 through 71-20,114 — Nonprofit Hospital Sale Act:
No person shall engage in the acquisition of a hospital owned by a nonprofit corporation without first having applied for and received the approval of the department and without first having notified the Attorney General and, if applicable, received approval from the Attorney General pursuant to the Nonprofit Hospital Sale Act.

NE Rev Stat § 44-4111 — Contracts with preferred providers; procedure; discrimination prohibited: Preferred Providers:
Insurers and participants may contract for health services with preferred providers through a process of competitive bidding or through individual negotiations with preferred providers. After completion of such bidding process or individual negotiations, an insurer or participant may offer to providers the terms and conditions of a preferred provider contract. Providers willing and qualified to meet the terms and conditions of a preferred provider contract offered by an insurer or participant may agree to provide health services pursuant to such contract.

Encouraging Price Transparency

NE Rev Stat § 71-2075 — Written estimate of charges; when required; notice:
Requires hospitals and ambulatory surgical centers to provide a written estimate of the average charges for health services.

NE Rev Stat § 44-1317 — Health carrier; disclosure; format; contents:
Provides that each health carrier shall include a description of the external review procedures in or attached to the policy/outline of coverage given to covered persons. Sets out disclosure and format requirements.

Right-to-Shop

NE Rev Stat §§ 44-1401 through 44-1414 — Nebraska Right to Shop Act:
An insurance carrier shall establish an interactive mechanism on its publicly accessible web site that enables an enrollee to request and obtain from the insurance carrier information on the payments made by the insurance carrier to network providers for health care services. The

interactive mechanism must allow an enrollee seeking information about the cost of a particular health care service to compare costs among network providers.
NE Rev Stat §§ 71-9201 through 71-9204 — Nebraska Health Care Transparency Act:
Directs the Director of Insurance to appoint a Health Care Database Advisory Committee to make recommendations regarding the creation and implementation of the Nebraska Health Care Data Base. The Database will provide a tool for objective analysis of health care costs and quality, promote transparency for health care consumers, and facilitate the reporting of health care and health quality data.

Monitoring/Regulating Prices

NE Rev Stat § 44-5258 — Premium rates; requirements; limitation on transfers; director; powers; disclosures required; small employer carrier; duties:
Provides that premium rates for health benefit plans subject to the Small Employer Health Insurance Availability Act shall be subject to numerous provisions—e.g. the index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than 20%.
NE Rev Stat § 44-7506 — Rating systems and prospective loss costs; filing required:
All insurance rating systems and prospective loss costs must be filed with the director of insurance in accordance with further provisions of the statute.

Expansion of DOI Authority

NE Rev Stat § 44-710 — Sickness and accident insurance policy; form; approval; exception; premium rates and classification of risks; filing requirements:
Vests the insurance commissioner with prior approval authority.

Creating or Reducing Barriers to New Entrants

NE Rev Stat §§ 71-5801 through 71-5848.01 — Nebraska Health Care Certificate of Need Act:
Requirements for certificate of need.
NE Rev Stat §§ 44-7101 through 44-7112 — Managed Care Plan Network Adequacy Act:
A health carrier providing a managed care plan shall maintain a network that is sufficient in numbers and types of providers to assure that all health care services to covered persons will be accessible without unreasonable delay.
NE Rev Stat §§ 71-8501 through 71-8512 — Nebraska Telehealth Act:
Before an initial telehealth consultation, the provider must inform the patient in writing of the details laid out in this provision.
NE Rev Stat § 44-7,107 — Telehealth; coverage: General Provisions Covering Life, Sickness, and Accident Insurance:
Any insurer offering (1) any individual or group sickness and accident insurance policy, certificate, or subscriber contract delivered, issued for delivery, or renewed in this state, (2) any hospital, medical, or surgical expense-incurred policy, or (3) any self-funded employee benefit plan to the extent not preempted by federal law, shall not exclude, in any policy, certificate, contract, or plan offered or renewed on or after August 24, 2017, a service from coverage solely because the service is delivered through telehealth as defined in section 44-312 and is not provided through in-person consultation or contact between a licensed health care provider and a patient.

Appendix

Antitrust

NV Rev Stat §§ 598A.010 through 598A.280 — Nevada Unfair Trade Practice Act:
States that the free, open and competitive production and sale of commodities and services is necessary to the economic well-being of the citizens of the State of Nevada. It is the policy of this state and the purpose of this chapter to: (a) Prohibit acts in restraint of trade or commerce, except where properly regulated as provided by law. (b) Preserve and protect the free, open and competitive nature of our market system. (c) Penalize all persons engaged in such anticompetitive practices to the full extent allowed by law, in accordance with the penalties provided herein.
NV Rev Stat §§ 598.0903 through 598.0999 — Deceptive Trade Practices – General Provisions:
States that when the Commissioner, Director or Attorney General has cause to believe that any person has engaged or is engaging in any deceptive trade practice, he or she may: 1. Request the person to file a statement or report in writing under oath or otherwise, on such forms as may be prescribed by the Commissioner, Director or Attorney General, as to all facts and circumstances concerning the sale or advertisement of property by the person, and such other data and information as the Commissioner, Director or Attorney General may deem necessary. 2. Examine under oath any person in connection with the sale or advertisement of any property. 3. Examine any property or sample thereof, record, book, document, account or paper as he or she may deem necessary. 4. Make true copies, at the expense of the Consumer Affairs Division of the Department of Business and Industry, of any record, book, document, account or paper examined pursuant to subsection 3, which copies may be offered into evidence in lieu of the originals thereof in actions brought pursuant to NRS 598.097 and 598.0979. 5. Pursuant to an order of any district court, impound any sample of property which is material to the deceptive trade practice and retain the property in his or her possession until completion of all proceedings as provided in NRS 598.0903 to 598.0999, inclusive.

Encouraging Price Transparency

NV Rev Stat § 439A.220 — Information concerning hospitals: Establishment of program; information to be collected, maintained and provided through program: Programs To Increase Awareness Of Information Concerning Hospitals And Surgical Centers For Ambulatory Patients:
Department of Health and Human Services shall establish a program to increase public awareness of health care information concerning hospitals in order to assist customers in comparing facilities on care and price.
NV Rev Stat § 439A.240 — Information concerning surgical centers for ambulatory patients: Establishment of program; information to be collected, maintained and provided through program: Programs To Increase Awareness Of Information Concerning Hospitals And Surgical Centers For Ambulatory Patients:
The Department of Health and Human Services shall establish and maintain a program to increase public awareness of health care information concerning the surgical centers for ambulatory patients in this State.
NV Rev Stat § 439A.260 — Department to collect and maintain information and make summary of information available to certain persons; information to be aggregated: Programs To Increase Awareness Of Information Concerning Hospitals And Surgical Centers For Ambulatory Patients:

The Department shall collect and maintain all information that it receives from the hospitals and surgical centers for ambulatory patients in this State.
NV Rev Stat § 439A.270 — Internet website for information concerning hospitals and surgical centers for ambulatory patients: Establishment; information to be included on website; presentation of information on website; duties of Department: Programs To Increase Awareness Of Information Concerning Hospitals And Surgical Centers For Ambulatory Patients:
The Department of Heath and Human Services shall establish and maintain an Internet website that includes the information concerning the charges imposed and the quality of the services provided by the hospitals and surgical centers for ambulatory patients in this State.
NV Rev Stat § 439B.400 — Hospital must maintain and use uniform list of billed charges; exception: Miscellaneous Provisions:
Hospital must maintain and use uniform list of billed charges: requires a uniform list of billed charges.
NV Rev Stat §§ 439B.745 through 439B.760 — [Effective January 1, 2020.]
An Act relating to health care; limiting the amount a provider of health care may charge a person who has health insurance for certain medically necessary emergency services provided when the provider is out-of-network; requiring an insurer to arrange for the transfer of a person who has health insurance to an in-network facility under certain circumstances; prescribing procedures for determining the amount that an insurer is required to pay a provider of health care which is out-of-network for certain medically necessary emergency services provided to an insured; requiring the reporting of certain information related to that process; and providing other matters properly relating thereto.

Competitive Behavior in Health Plan Contracting

NV Rev Stat § 598A.060 — Prohibited acts: Nevada Unfair Trade Practice Act:
Identifies tying arrangements, consisting of contracts in which the seller or lessor conditions the sale or lease of commodities or services on the purchase or leasing of another commodity or service, as a prohibited act.

Expansion of DOI Authority

NV Rev Stat §§ 679B.600 through 679B.700 — Investigations:
The Commissioner shall establish a program within the Division to investigate any act or practice which: 1. Violates the provisions of NRS 686A.010 to 686A.310, inclusive; or 2. Defrauds or is an attempt to defraud an insurer. The Commissioner, through his or her investigators, shall investigate fraudulent claims for benefits under an insurance policy.
NV Rev Stat §§ 686B.010 through 686B — Rates and Service Organizations — Rates and Essential Insurance:
The Commissioner shall consider each proposed increase or decrease in the rate of any kind or line of insurance or subdivision thereof.

Creating or Reducing Barriers to New Entrants

NV Rev Stat § 439A.100 — Approval of Director required for certain projects; criteria for review of application: Administration; Approval of Projects:
Certificate of Need guidelines and principles.
NV Rev Stat §§ 629.510 & 629.515 — Telehealth: Except as otherwise provided in this subsection, before a provider of health care who is located at a distant site may use telehealth to direct or manage the care or render a diagnosis of a patient who is located at an originating site in this

State or write a treatment order or prescription for such a patient, the provider must hold a valid license or certificate to practice his or her profession in this State, including, without limitation, a special purpose license issued pursuant to NRS 630.261.

Appendix

NEW HAMPSHIRE

Antitrust

NH Rev Stat §§ 356:1 through 356:14 — Combinations and Monopolies:
The establishment, maintenance or use of monopoly power, or any attempt to establish, maintain or use monopoly power over trade or commerce for the purpose of affecting competition or controlling, fixing or maintaining prices is unlawful.
NH Rev Stat § 151:31 — Disclosure of Information; Hospitals and Physician Hospital Organizations:
Hospitals have to report information on their financial relationships with providers, contract negotiations, physicians employed, among other things, to the attorney general. The attorney general may review contracts resulting from the relationships set forth.
NH Rev Stat § 21-M:9 — Consumer Protection and Antitrust Bureau: Department of Justice:
There is established in the division of public protection a consumer protection and antitrust bureau. Duties include receiving, investigating and attempting to resolve complaints by individual consumers of unfair or deceptive business practices; bringing civil and criminal actions in the name of the state to redress unfair or deceptive trade or business practices.
NH Rev Stat §§ 417:1 through 417:17 — Unfair Insurance Trade Practices:
The purpose of this chapter is to regulate trade practices in the business of insurance, in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945 (Public Law 15, 79th Congress), by defining or providing for the determination of all such practices which constitute in this state unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

Encouraging Price Transparency

NH Rev Stat § 420-G:11 — Disclosure: Portability, Availability and Renewability of Health Coverage:
Requires health carriers operating in small employer or individual market to make reasonable disclosure in solicitation and sales materials provided to individuals and small employers.
NH Rev Stat § 420-G:11a — Development of a Comprehensive Health Care Information System: Portability, Availability and Renewability of Health Coverage:
Develops the New Hampshire all-payer claims database to be available as a resource for insurers, employers, providers, purchasers of health care, and state agencies to continuously review health care utilization, expenditures, and performance in New Hampshire and to enhance the ability of New Hampshire consumers and employers to make informed and cost-effective health care choices.
NH Rev Stat § 329:31-b — Prohibition on Balance Billing; Payment for Reasonable Value of Services: Physicians and Surgeons – Miscellaneous Provisions:
When a commercially insured patient is covered by a managed care plan as defined under RSA 420-J:3, XXV, a health care provider performing anesthesiology, radiology, emergency medicine, or pathology services shall not balance bill the patient for fees or amounts other than

copayments, deductibles, or coinsurance, if the service is performed in a hospital or ambulatory surgical center that is in-network under the patient's health insurance plan. This prohibition shall apply whether or not the health care provider is contracted with the patient's insurance carrier.
NH Rev Stat §§ 126:25 through 126:34 — Health Care Data:
Requires that licensed health care facilities provide specified data to the commissioner of health and human services, including financial information, utilization data, demographic information, and charge data.
NH Rev Stat § 151:31 — Disclosure of Information; Hospitals and Physician Hospital Organizations:
Requires hospitals to make an annual report to the Attorney General for his/her review, including the following information: The hospital's financial relationship with physician hospital organizations; the number and type of providers employed by the hospital; the frequency of contract negotiations with providers and physician hospital organizations, and other things.

Competitive Behavior in Health Plan Contracting

NH Rev Stat § 417:4 — Unfair methods, acts, and practices defined: Unfair Trade Practices:
Defines most favored nation clauses as an unfair trade method. Prohibits most favored nation or equally favored nation provisions in any contract for medical care provider services.

Expansion of DOI Authority

NH Rev Stat § 415:24 — Modifications for Accident and Health Insurance Policies: Accident and Health Insurance:
Requires that any rate modifications on individual accident and health policy forms shall be filed with the insurance commissioner prior to implementation.
NH Rev Stat § 415:1 — Filing Policies and Rates:
Vests the insurance commissioner with prior approval authority.

Creating or Reducing Barriers to New Entrants

NH Rev Stat — Network Adequacy: Managed Care Law:
A health carrier shall maintain a network that is sufficient in numbers, types, and geographic location of providers to ensure that all services to covered persons will be accessible without unreasonable delay.
NH Rev Stat § 415-J:3 — New Hampshire Telemedicine Act:
I. It is the intent of the general court to recognize the application of telemedicine for covered services provided within the scope of practice of a physician or other health care provider as a method of delivery of medical care by which an individual shall receive medical services from a health care provider without in-person contact with the provider.
NH Rev Stat § 329:1-D — Telemedicine: Physicians and Surgeons: II. An insurer offering a health plan in this state may not deny coverage on the sole basis that the coverage is provided through telemedicine if the health care service would be covered if it were provided through in-person consultation between the covered person and a health care provider.
NH Rev Stat §§ 326-B:1 through 326-B:28 — Nurse Practice Act: III. Nothing in this section shall be construed to prohibit an insurer from providing coverage for only those services that are medically necessary and subject to the terms and conditions of the covered person's policy.
NH Rev Stat §§ 329:1 through 329:1-c — Physicians and Surgeons:
Any person shall be regarded as practicing medicine under the meaning of this chapter who shall diagnose, treat, perform surgery, or prescribe any treatment of medicine for any disease or human ailment.

NH Rev Stat § 328-D:1 — Definitions: Physicians Assistants:
Establishes physician assistant licensure and discipline procedures; Defines scope of practice.

Appendix

NEW JERSEY

Antitrust

NJ Rev Stat § 26:2H-7.11 — Additional requirements for nonprofit hospitals relative to acquisitions; exemptions; procedures: Health Care Facilities Planning Act:
States that in addition to the requirements of P.L.1971, c.136 (C.26:2H-1 et seq.) concerning certificate of need and licensure requirements, a nonprofit hospital licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall satisfy the requirements of this act before applying to the Superior Court of New Jersey for approval prior to entering into a transaction that results in the acquisition of the hospital as defined in this act. The proposed acquisition shall be subject to the prior review of the Attorney General, in consultation with the Commissioner of Health, pursuant to the provisions of this section. The Attorney General shall review the application in furtherance of his common Law responsibilities as protector, supervisor, and enforcer of charitable trusts and charitable corporations.
NJ Rev Stat §§ 56:9-1 through 56:9-19 — New Jersey Antitrust Act:
Every contract, combination in the form of trust or otherwise, or conspiracy in restraint of trade or commerce, in this State, shall be unlawful. It shall be unlawful for any person to monopolize, or attempt to monopolize, or to combine or conspire with any person or persons, to monopolize trade or commerce in any relevant market within this State. The Attorney General shall investigate suspected violations of, and institute such proceedings as are hereinafter provided for violation of the provisions of this act. The Attorney General may direct the county prosecutor of any county in which such proceedings may be brought to aid and assist him in the conduct of such investigations and proceedings.

Encouraging Price Transparency

NJ Rev Stat § 26:2H-5 — Commissioners powers: Health and Vital Statistics:
The commissioner is directed to establish a uniform statewide reporting system for health care facility utilization and costs.
NJ Rev Stat § 26:2S-15 — Reporting requirements; quality outcomes measures; consumer satisfaction; results available to public: Health Care Quality Act:
States that a carrier offering a managed care plan must comply with department reporting requirements with respect to quality outcomes measures and consumer satisfaction surveys and shall make available to the public, upon request, the results.
NJ Rev Stat §§ 26:2H-12.39 through 26:2H-12.45 — Health Care Facility-Associated Infection Reporting and Prevention Act:
States that the commissioner shall make available to the public on an official website the information reported in a format that is appropriate to enable comparison among hospitals and shall include information that measures infection rates.
NJ Rev Stat § 26:2SS — Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability:

Designed to protect consumers against surprise medical bills from out-of-network providers. The law requires healthcare facilities and providers to provide certain disclosures.

Competitive Behavior in Health Plan Contracting

NJ Admin Code § 11:24C-4.3 — Provider agreements: Provider Networks:
Bans most favored nation clauses in health insurance contracts, a promise obtained by an insurer that the provider will not give a better price to another insurer.
NJ Admin Code § 11:24B-5 — General provisions:
Bans most favored nation clauses in health insurance contracts, a promise obtained by an insurer that the provider will not give a better price to another insurer.

Monitoring/Regulating Prices

NJ Rev Stat §§ 26:2H-18.70 through 26:2H-18 — Health Care Reform Act of 1992:
Major health care reform statute that eliminated a system in which the state set payment rates based on hospital costs and prevented cost competition, replacing it with one in which price competition was encouraged. It is claimed that this statute laid the ground work for provisions of the ACA, because after this legislation took effect, premiums went up, causing healthy individuals to drop coverage.

Regulation Around Development of ACOs

NJ Rev Stat §§ 30:4D-8.1 through 30:4D-8.15 — Medical Assistance and Health Services Act:
The Department of Human Services shall establish a three-year Medicaid ACO Demonstration Project in which nonprofit corporations organized with the voluntary support and participation of local general hospitals, clinics, pharmacies, health centers, qualified primary care and behavioral health care providers, and public health and social services agencies may apply to the department for certification and participation in the project. The department shall consult with the Department of Health and Senior Services with respect to establishment and oversight of the demonstration project.

Expansion of DOI Authority

NJ Rev Stat § 17B:18-5 — Approval of certificate by commissioner; recording and filing:
Insurance companies must file their proposed rates with the department of insurance, but the rates may go into effect without department approval. The department may have the ability to go back and disapprove a rate increase that was later deemed unreasonable.

Creating or Reducing Barriers to New Entrants

NJ Admin Code §§ 8:33-3.1 through 8:33-3 — Types of Certificate of Need Applications:
Certificate of Need guidelines and principles.
NJ Rev Stat §§ 26:2H-1 through 26:2H-26 — Health Care Facilities Planning Act:
Certificate of Need guidelines and principles.
NJ Rev Stat §§ 45:1-56 through 45:1-66 — Telemedicine and Telehealth:
States that a provider who establishes a relationship with a patient may remotely provider health care services to a patient through the use of telemedicine.

NEW MEXICO

Antitrust

NM Stat §§ 57-1-1 through 57-1-19 — Restraints of Trade:
States that if the attorney general has reasonable cause to believe that a person has information or may be in possession, custody or control of any document or other tangible object relevant to a civil investigation for violation of Section 57-1-1 or 57-1-2 NMSA 1978, he may, before bringing any action, apply to the district court of Santa Fe county for approval of a civil investigative demand, demanding, in writing, such person to appear and be examined under oath, to answer written interrogatories under oath, or to produce the document or object for inspection and copying.
NM Stat §§ 57-12-1 through 57-12-26 — Unfair Trade Practices Act:
Unfair or deceptive trade practices and unconscionable trade practices in the conduct of any trade or commerce are unlawful. Whenever the attorney general has reasonable belief that any person is using, has used or is about to use any method, act or practice which is declared by the Unfair Practices Act to be unlawful, and that proceedings would be in the public interest, he may bring an action in the name of the state alleging violations of the Unfair Practices Act.
NM Stat §§ 57-14-1 through 57-14-9 — Price Discrimination Act:
It is unlawful for any person engaged in commerce, either directly or indirectly, intentionally, for the purpose of destroying competition or eliminating a competitor, to: (1) discriminate in price between different purchasers of commodities of like grade and quality; or (2) discriminate in price between different sections, communities or cities in this state where the effect is to lessen competition substantially, to create a monopoly in any line of commerce or to injure, destroy or prevent competition with any person who grants or knowingly receives the benefit of the discrimination, or with customers of either.

Encouraging Price Transparency

NM Stat § 59A-57-6 — Fairness to Health care providers; gag rules prohibited; grievance procedure for providers: Patient Protection Act:
No managed health care plan may: adopt a gag rule or practice that prohibits a health care provider from discussing a treatment option with an enrollee even if the plan does not approve of the option; include in any of its contracts with health care providers any provisions that offer an inducement, financial or otherwise, to provide less than medically necessary services to an enrollee; or require a health care provider to violate any recognized fiduciary duty of his profession or place his license in jeopardy.
NM Stat §§ 24-14A-1 through 24-14A-10 — Health Information Systems:
The "Health Information System Act," creates a health information system for the purpose of facilitating the collection, analysis and dissemination of health information to assist in health planning, policymaking, and to assist consumer in making informed healthcare decisions.

Competitive Behavior in Health Plan Contracting

NM Stat § 59A-22A-5 — Fairness to Health care providers; gag rules prohibited; grievance procedure for providers: Patient Protection:

Explicitly allows health care insurers to issue plans which provide incentives for insured to use preferred providers. Also provides that if a plan provides differences in benefit levels payable to preferred providers compared to others, such differences shall not "unfairly deny payment for covered services and shall be no greater than necessary to provide a reasonable incentive for covered persons to use the preferred provider."
NM Stat § 59A-46-51 — Health maintenance organizations; direct services: Health Maintenance Organizations:
Provides general requirements re reimbursement for direct services—e.g. reimbursement for direct services at a level not less than 85% of premiums across all health product lines.

Monitoring/Regulating Prices

NM Stat § 59A-18-13.2 — Health insurance; Health care Plan rates filing requirements: The Insurance Contract:
Requires filing of all health insurance or health care plan rates.

Regulation Around Development of ACOs

2012 NM SJM 32 —Would require the Human Services Department to conduct a study on the potential benefits and costs of applying the ACO model to the state's Medicaid health care delivery system. Last activity 2/5/2012.

Expansion of DOI Authority

NM Stat § 59A-18-13 — Health insurance; health care plan rates filing requirements:
Vests the insurance commissioner with prior approval authority.

Creating or Reducing Barriers to New Entrants

NM Stat §§ 24-1G-1 through 24-1G-4 — New Mexico Telehealth and Health Information Technology Commission Act:
"The purpose of creating a telehealth and health information technology commission is to encourage a single, coordinated statewide effort to create a telehealth and health information technology system that:
A. provides and supports health care delivery, diagnosis, consultation, treatment, transfer of medical data and education when distance separates a patient and a health care provider; multiple health care providers involved in patient care; and health care providers and educational or professional activities;
B. addresses the problems of provider distribution in medically underserved areas of the state;
C. strengthens the health infrastructure;
D. attracts and retains health care providers in rural areas; and
E. helps reduce costs associated with health care and make health care more affordable."
NM Stat § 24-25-4 — Telehealth authorized; procedure: New Mexico Telehealth Act:
The delivery of health care via telehealth is recognized and encouraged as a safe, practical and necessary practice in New Mexico.

Appendix

Antitrust

NY Gen Bus Law §§ 340 through 347 — Monopolies:
States that every contract, agreement, arrangement or combination whereby a monopoly in the conduct of any business, trade or commerce or in the furnishing of any service in this state, is or may be established or maintained, or whereby Competition or the free exercise of any activity in the conduct of any business, trade or commerce or in the furnishing of any service in this state is or may be restrained or whereby For the purpose of establishing or maintaining any such monopoly or unlawfully interfering with the free exercise of any activity in the conduct of any business, trade or commerce or in the furnishing of any service in this state any business, trade or commerce or the furnishing of any service is or may be restrained, is hereby declared to be against public policy, illegal and void.
NY Comp Codes R & Regs 10 §§ 83-2.1- 83-2.16 — Certificate of Public Advantage:
Parties that have received a certificate of public advantage issued by the department shall be provided state action immunity under Federal antitrust laws and immunity from private claims under state antitrust laws and may negotiate, enter into, and conduct business pursuant to, a cooperative agreement or a planning process covered by a duly issued certificate of public advantage.
NY Gen Bus Law §§ 349, **350**, & **350-C through 350-E** — Consumer Protection from Deceptive Acts and Practices:
States that deceptive acts or practices in the conduct of any business, trade or commerce or in the furnishing of any service in this state are hereby declared unlawful. Whenever the attorney general shall believe from evidence satisfactory to him that any person, firm, corporation or association or agent or employee thereof has engaged in or is about to engage in any of the acts or practices stated to be unlawful he may bring an action in the name and on behalf of the people of the state of New York to enjoin such unlawful acts or practices and to obtain restitution of any moneys or property obtained directly or indirectly by any such unlawful acts or practices.
Antitrust — Improved Integration of Health Care and Financing:
In order to promote improved quality and efficiency of, and access to, health care services and to promote improved clinical outcomes to the residents of New York, it shall be the policy of the state to encourage, where appropriate, cooperative, collaborative and integrative arrangements including but not limited to, mergers and acquisitions among health care providers or among others who might otherwise be competitors, under the active supervision of the commissioner.
NY Ins Law §§ 2400 through 2409 — Unfair Methods of Competition and Unfair and Deceptive Acts and Practices:
The purpose of this article is to regulate trade practices in the business of insurance, including the business of life settlements, in accordance with the intent of congress as expressed in Public Law 15, 79th Congress, by defining, or providing for the determination of, all such practices in this state that constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.
NY Pub Auth Law § 2878 — Statement of non-collusion in bids or proposals to public authority: Contracts of Public Authorities:
Statement of non-collusion in bids or proposals to public authority. Every bid or proposal hereafter made to a public authority or to any official of any public authority created by the state or any political subdivision, where competitive bidding is required by statute, rule, regulation or local law, for work or services performed or to be performed or goods sold or to be sold, shall

contain the following statement subscribed by the bidder and affirmed by such bidder as true under the penalties of perjury: Non-collusive bidding certification.

Encouraging Price Transparency

NY Pub Health Law §§ 350.1 through 350.5 — All Payer Database:
Creates an all-payer claims database that will provide policymakers, researchers, and consumers with a comprehensive, health-focused, data warehousing and analytic solution for New York State.
NY Fin Serv Law §§ 601 through 608— Emergency Medical Services and Surprise Bills:
The superintendent shall establish a dispute resolution process by which a dispute for a bill for emergency services or a surprise bill may be resolved. The superintendent shall have the power to grant and revoke certifications of independent dispute resolution entities to conduct the dispute resolution process. The superintendent shall promulgate regulations establishing standards for the dispute resolution process, including a process for certifying and selecting independent dispute resolution entities. An independent dispute resolution entity shall use licensed physicians in active practice in the same or similar specialty as the physician providing the service that is subject to the dispute resolution process of this article. To the extent practicable, the physician shall be licensed in this state.

Competitive Behavior in Health Plan Contracting

NY Pub Health Law § 4406-C — Prohibitions: Health Maintenance Organization:
Health plan contract prohibitions: sets out various prohibitions for health plan contracts.
NY Pub Health Law §§ 4500 through 4503 — Medical Referral Services:
Medical referral services, organized as profit making enterprises within this state, have been found to be engaged in the practice of medicine, have been sharing fees received for referrals with doctors and hospitals to whom patients are referred, have been otherwise compensating doctors and hospitals for accepting patients referred to them, have been giving medical advice by telephone to persons seeking referrals and have been advertising their services, all in violation of the standards of ethics and public policy applicable to the practice of medicine and which would be violations of standards of professional conduct if the acts were performed by physicians. Such profit making referral services have consistently engaged in practices inimical to the public interest which would be prohibited to physicians and have engaged in relationships with physicians which are in violation of the laws and public policy of this state and which have permitted physicians to benefit indirectly from acts and practices which would be prohibited to them directly. It is hereby declared to be the public policy of this state that the public health, safety and welfare of the citizens of this state require that such profit making medical referral service organizations be declared to be invalid and unlawful in this state.

Regulation Around Development of ACOs

NY Pub Health Law §§ 2999-N through 2999-R — Accountable Care Organizations:
Declaration of findings regarding ACO—namely, that they promote effective allocation of health care resources and better the quality and accessibility of health care.
NY Comp Codes R & Regs 10 § 1003.3 — Certificate of authority: Accountable Care Organizations:
The commissioner may issue a certificate of authority if the applicant has met the requirements of article 29-E of the Public Health Law and this Part, except that a Medicare-only ACO need not meet such requirements except as provided in section 2999-r of the Public Health Law and specifically in this Part.

Expansion of DOI Authority

NY Ins Law § 213 — New York state health care quality and cost containment commission: Vests the insurance commissioner with prior approval authority.

Creating or Reducing Barriers to New Entrants

NY Pub Health Law §§ 2800 through 2826— (Public Health) Hospitals: Certificate of Need guidelines and principles.
NY Pub Health Law §§ 2999-cc & 2999-dd— Telehealth Delivery of Services: Health care services delivered by means of telehealth shall be entitled to reimbursement.

Appendix

NORTH CAROLINA

Antitrust

NC Gen Stat §§ 75-1 through 75-145 — Monopolies, Trusts and Consumer Protection: The Attorney General of the State of North Carolina shall have power, and it shall be his duty, to investigate, from time to time, the affairs of all corporations or persons doing business in this State, which are or may be embraced within the meaning of the statutes of this State defining and denouncing trusts and combinations against trade and commerce, or which he shall be of opinion are so embraced, and all other corporations or persons in North Carolina doing business in violation of law; and all other corporations of every character engaged in this State in the business of transporting property or passengers, or transmitting messages, and all other public service corporations of any kind or nature whatever which are doing business in the State for hire.
NC Gen Stat §§ 58-63-1 through 58-63-75 — Unfair Trade Practices: The purpose of this Article is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945 (Public Law 15, 79th Congress), by defining, or providing for the determination of, all such practices in this State which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined. (1949, c. 1112.)

Encouraging Price Transparency

NC Gen Stat § 131E- 214 through 131E-214.4 — Medical Care Data: Requires statewide data processor to compile a report comparing the prices of the 35 most common surgical procedures using data from hospitals/surgical facilities. Requires the provision of information to the public on the costs of the most frequently reported diagnostic related groups for hospital inpatient care and the most common procedures provided in hospital outpatient settings. Also requires each hospital to provide this information to the Department of Health and Human Services; also requires a report that includes a comparison of the 35 most frequently reported charges of hospitals.
NC Gen Stat § 131E-91 — Fair billing and collections practices for hospitals and ambulatory surgical facilities: Hospitals and facilities must provide an itemized bill in clear and understandable language to patients upon request, and gives hospitals 45 days to reimburse

patients for overbilling. The law also provides for rules to prevent against abusive collections agency processes.
NC Gen Stat § 131E-214.4 — Statewide data processor: Medical Care Data
Provides that a statewide data processor shall make available annually to the Division, at no charge, a report that includes a comparison of the 35 most frequently reported charges of hospitals and freestanding ambulatory surgical centers.

Competitive Behavior in Health Plan Contracting

NC Gen Stat § 58-50-295 — Health Care Providers:
Prohibits most favored nation clauses, a promise obtained by an insurer that the provider will not give a better price to another insurer, in contracts with health care providers.
NC Gen Stat § 131E-97.3 — Confidentiality of Competitive Health care information:
Provision regarding trade secrets in this bill: the bill specifically excluded from public records act compelled disclosure of competitive health information/ contracts not covered by the act.

Regulation Around Development of ACOs

NC Gen Stat § 58-3-7 — General Regulations for Insurance:
States that insurance regulations in this chapter shall not apply to any accountable care organization approved by the Centers for Medicare and Medicaid Services (CMS) to participate in Medicare programs established under 42 U.S.C. § 1315a or 42 U.S.C. § 1395jjj. This exemption is limited to the activities performed by the accountable care organization pursuant to its agreement with CMS for participation in Medicare programs established under 42 U.S.C. § 1315a or 42 U.S.C. § 1395jjj.

Expansion of DOI Authority

NC Gen Stat § 58-51-95 — Approval by Commissioner of forms, classification and rates; hearing; exceptions:
Vests the insurance commissioner with prior approval authority.

Creating or Reducing Barriers to New Entrants

NC Gen Stat §§ 131E-175 through 131E-191.1 — Certificate of Need:
Provides scope, validity and use of certificate of need and limitations.
NC Gen Stat § 90-18 — Physical examination by nurse practitioners and physician assistants: Practice of Medicine:
Whenever a statute or State agency rule requires that a physical examination shall be conducted by a physician, the examination may be conducted and the form signed by a nurse practitioner or a physician's assistant, and a physician need not be present.
NC Gen Stat § 90-18 — Limitations on anesthesiologist assistants: Practice of Medicine:
"Anesthesiologist assistants are authorized to provide anesthesia services under the supervision of an anesthesiologist licensed under Article **1** of this Chapter under the following conditions:
(1) The North Carolina Medical Board has adopted rules governing the provision of anesthesia services by an anesthesiologist assistant consistent with the requirements of subsection (c) of this section.
(2) The anesthesiologist assistant holds a current license issued by the Board or is a student anesthesiologist assistant participating in a training program leading to certification by the

National Commission for Certification of Anesthesiologist Assistants and licensure as an anesthesiologist assistant under G.S. 90-9.4."
NC Gen Stat § 90-18.1 — Limitations on physician assistants: Practice of Medicine:
States the conditions under which physicians assistants can write prescriptions, to compound and dispense drugs, order medications, tests and treatments, among other activities.
NC Gen Stat § 90-18.2 — Limitations on nurse practitioners: Practice of Medicine:
States the conditions under which nurse practitioners can write prescriptions, to compound and dispense drugs, order medications, tests and treatments, among other activities.
NC Gen Stat § 90-18 — Physician assistants receiving, prescribing, or dispensing prescription drugs without charge or fee: Practice of Medicine:
The North Carolina Medical Board shall have sole jurisdiction to regulate and license physician assistants receiving, prescribing, or dispensing prescription drugs under the supervision of a licensed physician without charge or fee to the patient.
NC Gen Stat § 90-18.1 — Limitations on physician assistants: Practice of Medicine:
Conditions of licensure for physician assistants, including education.

Appendix

NORTH DAKOTA

Antitrust

NDCC §§ 10-33-01 through 10-33-149 — Nonprofit Corporations:
States that unless otherwise limited in its articles, a corporation has a general purpose of engaging in any lawful nonprofit activity. A corporation may be incorporated under this chapter for any lawful nonprofit purpose, unless another statute requires incorporation under a different law. A corporation of this type engaging in conduct that is regulated by another statute is subject to the limitations of the other statute, except it may not: a. Be formed for a purpose involving pecuniary gain to its members, other than to members that are nonprofit organizations, subdivisions, units, or agencies of the United States, a state, or a local government; or b. Pay dividends or other pecuniary remuneration, directly or indirectly, to its members, excluding members that are nonprofit organizations or subdivisions, units, or agencies of the United States, a state, or a local government.
NDCC §§ 51-09-01 through 51-09-06 — Nonprofit Corporations:
Any person, firm, company, association, corporation, or limited liability company, foreign or domestic, doing business in this state and engaged in the production, manufacture, or distribution of any commodity in general use, that, for the purpose of destroying the business of a competitor in any locality, intentionally shall discriminate between different sections, communities, or cities of this state by selling such commodity at a lower rate in one section, community, or city than is charged therefor by said party in another section, community, or city, after making due allowance for the difference, if any, in the grade or quality and in the actual cost of transportation from the point of production, if a raw product, or from the point of manufacture, if a manufactured product, is guilty of unfair discrimination.
NDCC §§ 51-10-01 through 51-10-08 — Unfair Trade Practices Law:
States that when it appears to the attorney general that a person has engaged in, or is engaging in, any practice declared to be unlawful by this chapter or when the attorney general believes it to be in the public interest that an investigation should be made to ascertain whether a person in

fact has engaged in, is engaging in, or is about to engage in, any such practice the attorney general may take certain actions.
NDCC §§ 54-12-01 through 54-12-35 — Attorney General: Outlines the duties of the Attorney General, as well as other aspects such as pay and the divisions. The consumer protection and antitrust division is responsible for enforcing the consumer fraud laws and act with regard to the use or employment by any person of any deceptive act or practice, fraud, false pretense, false promise, or misrepresentation with the intent that others rely thereon in connection with the sale or advertisement of any merchandise, whether or not any person has in fact been misled, deceived, or damaged thereby, and shall make full investigation of such activities and maintain adequate facilities for filing reports, examining persons and merchandise in regard thereto, and storing impounded books, records, accounts, papers, and samples of merchandise relating to same. The division shall cooperate with other governmental agencies, national, state, or local, and with all peace officers of the state in regard thereto. The division also shall investigate antitrust violations and enforce antitrust laws
NDCC §§ 51-08.1-01 through 51-08.1-12 — Uniform State Antitrust Act:
A contract, combination, or conspiracy between two or more persons in restraint of, or to monopolize, trade or commerce in a relevant market is unlawful. The establishment, maintenance, or use of a monopoly, or an attempt to establish a monopoly, of trade or commerce in a relevant market by any person, for the purpose of excluding competition or controlling, fixing, or maintaining prices, is unlawful.
NDCC § 54-44.4-05 — Competitive, limited competitive, non-competitive, and negotiated purchases – Exempt records: State Purchasing Practices:
Except as otherwise provided in section 44-08-01, chapter 25-16.2, and this chapter, purchasing contracts must be awarded through a competitive bidding process to the lowest responsible bidder considering conformity with specifications, terms of delivery, and quality and serviceability, unless it is determined to be advantageous to the state to select a contractor through a competitive proposal process using other or additional criteria

Competitive Behavior in Health Plan Contracting

NDCC §§ 26.1-47-01 through 26.1-47-11 — Preferred Provider Organizations:
Explicitly allows for insurers to enter into preferred provider agreements, subject to certain conditions.
NDCC § 26.1-04-03 — Unfair methods of Competition and unfair or deceptive acts or practices defined: Prohibited Practices in Insurance Business:
Unfair methods of competition and unfair or deceptive acts or practices: Defines what are essentially most favored nation clauses as unfair reimbursement/unfair method of competition, among other provisions.

Expansion of DOI Authority

NDCC § 26.1-17-26 — Procedure for submitting rate filings:
Vests the insurance commissioner with prior approval authority.

Creating or Reducing Barriers to New Entrants

NDCC § 26.1-36-9 — Coverage of telehealth services: Accident and Health Insurance:
"A policy form meeting the requirements of subsection 1 of section 26.1-36-14 must be approved notwithstanding any other Law which specifies the contents of a policy, if the policy form provides the policyholders and claimants protection not less favorable than they would be

entitled to under such laws."
NDCC § 54-52.1-04 — Coverage of telehealth services: Uniform Group Insurance Program:
Notwithstanding the provisions of section 54-52.1-04, the board may contract with one or more health maintenance organizations to provide eligible employees the option of membership in a health maintenance organization. If it makes such a contract, the board may not require that the health maintenance organization be federally qualified if the health maintenance organization has a certificate of authority issued by the North Dakota insurance commissioner. The contract or contracts must be included in the uniform group insurance program.
NDCC § 26.1-36-09 — Service of advanced registered nurse practitioner — Direct reimbursement required: Accident and Health Insurance:
The insured or any person covered by a health insurance policy, health service contract, or evidence of coverage on an individual, group, blanket, franchise, or association basis issued, delivered, executed, or renewed by an insurance company, nonprofit health service corporation, or health maintenance organization which provides for reimbursement or payment for services that are within the scope of practice of an advanced registered nurse practitioner who has received an advanced license under rules adopted by the North Dakota board of nursing is entitled to reimbursement or payment for services performed by an advanced registered nurse practitioner and the advanced registered nurse practitioner is entitled to direct reimbursement by the insurer.
NDCC § 50-24.1-32 — Medical assistance — Services provided by physician assistants and advanced registered nurse practitioners: Medical Assistance for Needy Persons:
The medical assistance program must recognize physician assistants and advanced registered nurse practitioners as primary care providers with the same rights and responsibilities given primary care physicians under the medical assistance program. Any care provided by the physician assistant or advanced registered nurse practitioner as a primary care provider under the medical assistance program must be within the scope of the physician assistant's or advanced registered nurse practitioner's respective license.

Appendix

OHIO

Antitrust
Ohio Rev Code §§ 1331.01 through 1331.99 — Monopolies:
States that no person shall issue or own trust certificates, and no person shall enter into a combination, contract, or agreement, the purpose and effect of which is to place the management or control of such combination, or the product or service thereof, in the hands of a trustee with the intent to limit or fix the price or lessen the production or sale of an article or service of commerce, use, or consumption, to prevent, restrict, or diminish the manufacture or output of such article or service, or refuse to buy from, sell to, or trade with any person because such person appears on a blacklist issued by, or is being boycotted by, any foreign corporate or governmental entity.

Encouraging Price Transparency
Ohio Rev Code §§ 4769.01 through 4769.10 — Balance Billing of Medicare Beneficiaries:

No health care practitioner, and no person that employs any health care practitioner, shall balance bill for any supplies or service provided to a Medicare beneficiary.
Ohio Rev Code §§ 3727.33 through 3727.42 — Hospitals
Requires hospitals to periodically submit information on certain inpatient and outpatient service measures and performance indicators regardless of who pays for the services. Hospitals must make such information available to the public.

Competitive Behavior in Health Plan Contracting

Ohio Rev Code § 3963.03 — Information required in contracts – disclosure form – proposed contracts: Health Care Contracts:
Required contents of health care contracts with a summary disclosure form that information is to be in writing, disclosure of utilization management, quality improvement, or similar program; disclosures required by other laws not affected.
Ohio Rev Code § 3963.11 — Prohibited conduct by contracting entities: Health Care Conduct:
Prohibits most favored nation clauses, a promise obtained by an insurer that the provider will not give a better price to another insurer.
Ohio Rev Code §§ 4731.65 through 4731.71 — Conflicts of Interest Limitations on Patient Referrals:
No holder of a license under this chapter to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery shall refer a patient to a person for a designated health service if the license holder, or a member of the license holder's immediate family, has either of the following financial relationships with the person: (1) An ownership or investment interest in the person whether through debt, equity, or other means; (2) Any compensation arrangement involving any remuneration, directly or indirectly, overtly or covertly, in cash or in kind.

Monitoring/Regulating Prices

Ohio Rev Code § 3924.04 — Limits on premium rates - low claim rates: Small Employer Health Benefit Plans; Provision of Health Care Coverage:
Regulation around the premium rates in health benefit plans. See section 3924.27 for rates for individuals in group plans.

Expansion of DOI Authority

Ohio Rev Code § 3923 — Approval or disapproval of premium rates:
Vests the insurance commissioner with prior approval authority.

Creating or Reducing Barriers to New Entrants

Ohio Rev Code §§ 3702.51 through 3702.68 — Certificate of Need Program:
Certificate of Need guidelines and principles.
Ohio Rev Code § 4731 — Telemedicine certificate: Physicians; Limited Practitioners:
"A person who wishes to practice telemedicine in this state shall file an application with the state medical board, together with a fee of three hundred five dollars and shall comply with sections 4776.01 to 4776.04 of the Revised Code. If the board, in its discretion, decides that the results of the criminal records check do not make the person ineligible for a telemedicine certificate, the board may issue, without examination, a telemedicine certificate to a person who meets all of the following requirements:

(1) The person holds a current, unrestricted license to practice medicine and surgery or osteopathic medicine and surgery issued by another state that requires license holders to complete at least fifty hours of continuing medical education every two years.
(2) The person's principal place of practice is in that state.
(3) The person does not hold a license issued under this chapter authorizing the practice of medicine and surgery or osteopathic medicine and surgery in this state.
(4) The person meets the same age, moral character, and educational requirements individuals must meet under sections 4731.09 and 4731.14 of the Revised Code and, if applicable, demonstrates proficiency in spoken English in accordance with section 4731.142 of the Revised Code."
Ohio Rev Code §§ 4723.01, 4723.02, 4723.06, 4723.43, 4723.48, & 4723 — Nurses:
"Practice of nursing as a registered nurse" means providing to individuals and groups nursing care requiring specialized knowledge, judgment, and skill derived from the principles of biological, physical, behavioral, social, and nursing sciences. Such nursing care includes:
(1) Identifying patterns of human responses to actual or potential health problems amenable to a nursing regimen;
(2) Executing a nursing regimen through the selection, performance, management, and evaluation of nursing actions;
(3) Assessing health status for the purpose of providing nursing care;
(4) Providing health counseling and health teaching;
(5) Administering medications, treatments, and executing regimens authorized by an individual who is authorized to practice in this state and is acting within the course of the individual's professional practice;
(6) Teaching, administering, supervising, delegating, and evaluating nursing practice."
Ohio Rev Code §§ 4730.01 through 4730.03, 4730.19 through 4730.20, 4730.21, & 4730 — Physician Assistants:
Describes the role of a physicians assistant and that the supervising physician assumes legal liability for the services provided by the physicians assistant.

Appendix

OKLAHOMA

Competitive Behavior in Health Plan Contracting
OK Admin Code 63 § 63-1-120 — Confidentiality of data - Disclosure upon court order - Immunity from liability: Public Health and Safety:

Expansion of DOI Authority
36 OK Stat § 309.2 — Nature and frequency of examinations–Reports in lieu of examinations: Insurance Department; Insurance Commissioner; State Board for Property and Casualty Rates:
The Insurance Commissioner or an examiner may conduct an examination, including a financial and market conduct examination, under Sections 309.1 through 309.7 of this title of any company as often as the Commissioner deems appropriate but shall at a minimum, conduct a financial examination of every domestic insurer licensed in this state not less frequently than once every five (5) years.

36 OK Stat § 2606 — Filing of forms and rates; disapproval: Vests the insurance commissioner with prior approval authority.

Creating or Reducing Barriers to New Entrants

OK Admin Code §§ 63-1-880.1 through 63-1-880.12 — Psychiatric and Chemical Dependency Facility Certificate of Need Act:
Certificate of need guidelines and principles.
OK Stat §§ 63-1-850 through 63-1-859.1 — Long-Term Care Certificate of Need Act
Lists the requirements for the Department of Health to issue a Certificate of Need for a long-term facility.
63 OK Stat § 1-2702 — Oklahoma Telemedicine Network – Duties: Oklahoma Public Health Code – Telemedicine:
Authorizes the Department to develop a statewide telehealth network. The system shall address where telemedicine would be most useful and the technologies that would make it most effective. The Center for Telemedicine shall establish a telehealth website.
36 OK Stat §§ 6801 through 6804 — Oklahoma Telemedicine Act:
Telemedicine services must be covered at the same rate as in person services. However, state Medicaid programs are allowed to make capitation adjustments.

Appendix

OREGON

Antitrust

Antitrust Laws; State AG Authority
OR Rev Stat §§ 646.705 through 646.836 — Antitrust Law:
States that the Legislative Assembly deems it to be necessary and the purpose of ORS 646.705 to 646.805 and 646.990 is to encourage free and open competition in the interest of the general welfare and economy of the state, by preventing monopolistic and unfair practices, combination and conspiracies in restraint of trade and commerce, and for that purpose to provide means to enjoin such practices and provide remedies for those injured by them. Without limiting the scope of ORS 646.705 to 646.805 and 646.990, it is the legislative purpose that it apply to intrastate trade or commerce, and to interstate trade or commerce involving an actual or threatened injury to a person or property located in this state. The decisions of federal courts in construction of federal law relating to the same subject shall be persuasive authority in the construction of ORS 646.705 to 646.805 and 646.990.
OR Rev Stat §§ 646.605 through 646.656 — Unlawful Trade Practices:
Provides prohibition and enforcement provisions of unlawful trade practices.

Encouraging Price Transparency

OR Rev Stat §§ 413.006 through 413.016 — Oregon Health Policy Board:
Establishes the Oregon Health Policy Board within the Oregon Health Authority to develop and oversee health care costs, quality and access for Oregonians.
OR Rev Stat § 413.023 — Establishment of Oregon Health Authority:

Among other things, the Authority is authorized to create an all-claims, all-payer database to collect health care data and monitor and evaluate health care reform in Oregon and to provide comparative cost and quality information to consumers, providers and purchasers of health care about Oregons health care systems and health plan networks in order to provide comparative information to consumers. The Authority may also develop uniform contracting standards for the purchase of health care.

OR Rev Stat § 442.025 — Findings and policy: Health Planning — Administration:
The achievement of reasonable access to quality health care at a reasonable cost is a priority of the State of Oregon. To that end, most of the problems with that are the inability of many citizens to pay for care and the inflated cost of care. The act authorizes the collection of data to address these problems.

OR Rev Stat §§ 442.400 through 442.463 — Health Care Costs:
The Office is directed to conduct studies relating to costs of healthcare facilities including methods of reducing costs, utilization review, peer review, quality control, and financial status (the Office has authority to prescribe regulations for mandatory uniform financial reporting). Licensed health facilities are obligated to file utilization information with the Office in an annual report as required by rule.

OR Rev Stat § 442.466 — Health care data reporting by Health insurers: Health Care Data Reporting:
Required the Administrator of the Office for Oregon Health Policy and Research to establish and maintain a program that requires reporting entities to report health care data for multiple purposes. The authority shall, using only data collected under this section from reporting entities described in ORS 442.464 (1) to (3), post to its website health care price information including the median prices paid by the reporting entities to hospitals and hospital outpatient clinics for, at a minimum, the 50 most common inpatient procedures and the 100 most common outpatient procedures.

OR Rev Stat § 656.248 — Medical service fee schedules; basis of fees; application to service provided by managed care organization; resolution of fee disputes; rules: Workers' Compensation Law:
States that The Director of the Department of Consumer and Business Services must promulgate a process for establishing fee schedules, including the circumstances under which fees can be updated.

OR Rev Stat §§ 743B.280 through 743B.287 — Individual and Group – Out-of-Pocket Costs: An insurer must make the information required by this section (cost-sharing information) available to enrollees and in-network providers through an interactive website and by toll-free telephone.

Competitive Behavior in Health Plan Contracting

OR Rev Stat § 243.879 — Reimbursement methodology for payment to hospitals: Public Employee Rights and Benefits – Oregon Educators Benefit Board:
A carrier that contracts with the Oregon Educators Benefit Board shall reimburse a claim for the cost of a hospital service or supply that is covered by, or is similar to a service or supply that is covered by, the Medicare program in an amount that does not exceed: For claims submitted by in-network hospitals, 200 percent of the amount paid by Medicare for the service or supply; or for claims submitted by out-of-network hospitals, 185 percent of the amount paid by Medicare for the service or supply.

OR Rev Stat § 243.256 — Reimbursement methodology for payment to hospitals: Public Employee Rights and Benefits – Benefit Plans (Generally):
A carrier that contracts with the Public Employee Benefit Board shall reimburse a claim for the cost of a hospital service or supply that is covered by, or is similar to a service or supply that is

covered by, the Medicare program in an amount that does not exceed: For claims submitted by in-network hospitals, 200 percent of the amount paid by Medicare for the service or supply; or for claims submitted by out-of-network hospitals, 185 percent of the amount paid by Medicare for the service or supply.

Monitoring/Regulating Prices

OR Rev Stat § 743.018 — Filing of rates for life and Health insurance; rules:
Requires insurers to file with the Director of the Department of Consumer and Business Services all schedules and tables of premium rates for life and health insurance to be used in the state.

Regulation Around Development of ACOs

OR Rev Stat §§ 414.620 through 414.704 — Oregon Integrated and Coordinated Care Delivery System (Coordinated Care Organizations):
The authority shall establish requirements for coordinated care organizations.

Expansion of DOI Authority

OR Rev Stat § 743 — Filing of rates for life and health insurance; rules:
Vests the insurance commissioner with prior approval authority.

Creating or Reducing Barriers to New Entrants

OR Rev Stat § 442.315 — Certificate of Need; rules; fees; enforcement; exceptions; letter of intent: Certificates of Need for Health Services:
Certificate of Need guidelines and principles.
OR Rev Stat § 442.325 — Certificate for Health care facility of Health maintenance organization; exempt activities; policy relating to Health maintenance organizations: Certificates of Need for Health Services:
A certificate of need shall be required for the development or establishment of a health care facility of any new health maintenance organization.
OR Rev Stat § 442.347 — Rural hospital required to report certain actions: Certificates of Need for Health Services:
Provides reporting requirements for rural hospitals exempted from certificate of need.
OR Rev Stat § 442.344 — Exemptions from requirements: Certificates of Need for Health Services:
Provides exemptions under certificate of need laws.
OR Rev Stat § 442.342 — Waiver of requirements; rules; penalties: Certificates of Need for Health Services:
If it meets certain revenue requirements a hospital can apply for a waiver regarding the certificate of need requirements.
OR Rev Stat § 442.362 — Reporting of proposed capital projects by hospitals and ambulatory surgical centers: Certificates of Need for Health Services:
The state may adopt rules requiring reporting entities within the state to publicly report proposed capital projects such as proposed projects involving ambulatory surgical centers and hospitals.
OR Rev Stat § 414.645 — Network Adequacy; member transfers: Oregon Integrated and Coordinated Care Delivery System (Coordinated Care Organizations):
A coordinated care organization that contracts with the Oregon Health Authority must maintain a network of providers sufficient in numbers and areas of practice and geographically distributed in

a manner to ensure that the health services provided under the contract are reasonably accessible to members.
OR Rev Stat § 743B.505 — Provider networks; rules: Individual and Group – Provider Panels:
An insurer shall contract with a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of essential community providers for low-income, medically underserved individuals in the plan's service area in accordance with the network adequacy standards established by the Department of Consumer and Business Services
OR Rev Stat § 441.056 — Credentialing telemedicine providers: Licensing and Supervision of Facilities and Organizations:
States that the Oregon Health Authority shall prescribe a rule the information and documents that a governing body of an originating-site hospital may request for credentialing a telemedicine provider located at a distant site.
OR Rev Stat § 677.510 — Board approval of using services of physician assistant; supervision; practice agreement; pain management education: Physician Assistants:
"A supervising physician or a supervising physician organization may apply to the board to use the services of a physician assistant. The application must:
(a) If the applicant is not a supervising physician organization, state the name and contact information of the supervising physician;
(b) If the applicant is a supervising physician organization:
(A) State the names and contact information of all supervising physicians; and
(B) State the name of the primary supervising physician required by subsection (5) of this section;
(c) Generally describe the medical services provided by each supervising physician;
(d) Contain a statement acknowledging that each supervising physician has reviewed statutes and rules relating to the practice of physician assistants and the role of a supervising physician; and (e) Provide such other information in such a form as the board may require."
OR Rev Stat § 677.515 — Medical services rendered by physician assistant: Physician Assistants:
"A physician assistant licensed under ORS 677.512 may provide any medical service, including prescribing and administering controlled substances in schedules II through V under the federal Controlled Substances Act:
(a) That is delegated by the physician assistant s supervising physician or supervising physician organization;
(b) That is within the scope of practice of the physician assistant;
(c) That is within the scope of practice of the supervising physician or supervising physician organization;
(d) That is provided under the supervision of the supervising physician or supervising physician organization;
(e) That is generally described in and in compliance with the practice agreement; and
(f) For which the physician assistant has obtained informed consent as provided in ORS 677.097, if informed consent is required."
OR Rev Stat § 743A.036 — Services provided by certified nurse practitioner or licensed physician assistant: Health Insurance: Reimbursement of Claims:
Whenever any policy of health insurance provides for reimbursement for a primary care or mental health service provided by a licensed physician, the insured under the policy is entitled to reimbursement for such service if provided by a licensed physician assistant or a certified nurse practitioner if the service is within the lawful scope of practice of the physician assistant or nurse practitioner.
OR Rev Stat § 678.370 — Clinical nurse specialists; certificates: Professional Nurses (Clinical Nurse Specialists):

A certified clinical nurse specialist is authorized to prescribe drugs for the use of and administration to other persons if approval has been given under ORS 678.390. The authority to prescribe and dispense prescription drugs shall be included within the scope of practice of certified clinical nurse specialists as defined by rules of the board.
OR Rev Stat § 677.505 — Application of provisions governing physician assistants to other Health professions: Physician Assistants:
Provides applicability of provisions under the chapter to other health professions.

Appendix

PENNSYLVANIA

Antitrust

62 PS §§ 4501 through 4509 — Antibid-Rigging:
It is unlawful for any person to conspire, collude or combine with another in order to commit or attempt to commit bid-rigging involving: A contract for the purchase of equipment, goods, services or materials or for construction or repair let or to be let by a government agency. A subcontract for the purchase of equipment, goods, services or materials or for construction or repair with a prime contractor or proposed prime contractor for a government agency.
35 PS § 449.15 — Antitrust provisions: Health Care Cost Containment Act:
Exempts persons or entities required to submit data or information under the Health Care Cost Containment Act from antitrust laws regarding that data or information
73 PS §§ 201-1 - 201-9.2 — Unfair Trade Practices and Consumer Protection Law:
Enforces competition through the state Attorney General or a District Attorney.
71 PS §§ 732-201 through 732-208 — Office of Attorney General:
Establishes the office of the Attorney General as well as the AG authority.

Encouraging Price Transparency

40 PS § 991.2113 — Medical gag clause prohibition: Managed Care Plan Requirements:
No managed care plan may penalize or restrict a health care provider from discussing: the process that the plan or any entity contracting with the plan uses or proposes to use to deny payment for a health care service; medically necessary and appropriate care with or on behalf of an enrollee, including information regarding the nature of treatment; risks of treatment; alternative treatments; or the availability of alternate therapies, consultation or tests; or the decision of any managed care plan to deny payment for a health care service. A provision to prohibit or restrict disclosure of medically necessary and appropriate health care information contained in a contract with a health care provider is contrary to public policy and shall be void and unenforceable.
35 PS §§ 449.1 through 449.19 —Health Care Cost Containment Act:
The "Health Care Cost Containment Act," implements a number of cost containment, transparency, and health care reform measures designed to study and increase consumer access to quality and affordable care.
35 PS § 449.31 — Balance billing by Health care practitioners prohibited: Health Care Practitioners Medicare Fee Control Act:

Balance billing by health care practitioners is prohibited. It shall be unlawful for any health care practitioner, or any primary health center, corporation, facility, institution or other entity that employs a health care practitioner, to balance bill.
35 PS § 449.17b — Health Care Cost Containment Council Act Review Committee: Health Care Cost Containment Act:
Creates the independent committee known as the Health Care Cost Containment Council to complete a report using health care facilities' data.

Competitive Behavior in Health Plan Contracting

40 PS § 776.3 — Standards for policy provisions: Individual Accident and Sickness Insurance Minimum Standards:
Empowers the Insurance Commissioner to issue regulations around standard policy provisions for health and accident insurance, including areas that do not prohibit competition.
35 PS § 449.5 — Powers and duties of the council: Health Care Cost Containment Act:
Broadly empowers the council to promote competition in the health care and health insurance markets.

Monitoring/Regulating Prices

35 PS § 448.202 — Encouragement of Competition and innovation: Powers and Duties of the Department:
Authorizes the department of health to plan and review activities in order to foster competition and promote cost efficient, quality, and access to care.

Expansion of DOI Authority

40 PS §§ 3801.301 through 3801.315 — Federal Compliance:
Requires insurance companies to file individual rates and rates for small group health insurance policies to establish a base rate, and proposed changes affecting an increase or decrease of 10% annually must also be filed and approved by the department. Hospital plan corporations, professional health services plan corporations, and HMOs are similarly regulated. Notices related to rate reviews can be found here.
35 PS Health & Safety § 449 — Health Care Cost Containment Council Act Review Committee:
Vests prior approval authority in the insurance commissioner only for subsets of the insurance market.

Creating or Reducing Barriers to New Entrants

63 PS § 422 — Physician assistants: Medical Practice Act of 1985:
A physician assistant may perform a medical service delegated by an approved physician and as approved by the appropriate board. An approved physician is a physician identified in the written agreement required by subsection e.
63 PS § 422.36 — Physician assistant license: Medical Practice Act of 1985:
A physician assistant license empowers the holder to assist a medical doctor in the provision of medical care and services under the supervision and direction of that medical doctor.

Appendix

Antitrust

23 RI Gen Laws §§ 17.14-1 through 17.14-35 — The Hospital Conversion Act:
States that hospitals both not-for-profit and for-profit are merging and forming networks to achieve integration, stability and efficiency and the presence of these networks affects competition; There are concerns that hospital networks may engage in practices that affect the quality medical services in the community as a whole and for more vulnerable members of society in particular; In order to protect public health and welfare and public and charitable assets, it is necessary to establish standards and procedures for hospital conversions.
6 RI Gen Laws §§ 36-1 through 36-26— Antitrust Law:
The purposes of this chapter are (1) To complement the laws of the United States governing monopolistic and restrictive trade practices; and (2) To promote the unhampered growth of commerce and industry throughout the state by prohibiting unreasonable restraints of trade and monopolistic practices, inasmuch as these have the effect of hampering, preventing, or decreasing competition. It is intended, that as a result, the prices of goods and services to consumers will be fairly determined by free-market competition in activities affecting trade or commerce in this state, including the manufacturing, distribution, financing, and service sectors of the economy, except as otherwise provided by the statutes, regulations, and judicial decisions of this state. The general assembly intends to fully exercise its power to affect and regulate commerce in order to effectuate the purpose of this chapter.

Encouraging Price Transparency

23 RI Gen Laws §§ 17.17-1 through 17.17-11— Health Care Quality Program:
Establishes a database to promote price transparency and quality controls.
23 RI Gen Laws § 17.19-1 — Rights of patients: Licensing of Health Care Facilities
Respecting the rights of patients vis-à-vis health care facilities licensed by the state, a patient may request the identity of all health care practitioners that the facility has authorized to participate in the patient's treatment, may request to see the bill and have it explained to him, and shall be presented with an itemized copy of the bill within 30 days of discharge.
23 RI Gen Laws § 17-61 —Written estimates for hospital medical services: Health Care Facility Licensing Act of Rhode Island:
Requires that a hospital provide to a prospective patient, the requested cost estimate of their requested anticipated hospital services within five business days of request and the cost of any facility fee.
27 RI Gen Laws § 82-1 through 82-7 — Unanticipated Out-of-Network Bills for Health Care Services:
This chapter shall govern any unanticipated out-of-network bills for health care services as further provided for by the provisions of this chapter; provided, however, this chapter shall not apply to health care services, including emergency services, where health care provider fees are subject to schedules or other monetary limitations under any other law, including the workers' compensation law, and shall not preempt any such law.
27 RI Gen Laws § 20-15 —Itemized bills for services rendered: Nonprofit Medical Service Corporations:
Upon completion of medical services under the provisions of this chapter, each provider of those services shall upon request provide a copy of an itemized bill to each patient; provided, that

nothing contained in this section shall apply to any hospital operated by the state of Rhode Island, its departments, or agencies.

Competitive Behavior in Health Plan Contracting

27 RI Gen Laws § 18.8-3 — Certification of network Plans: Health Care Accessibility and Quality Assurance Act:
Includes a provision stating that a health care entity or network plan shall not include a most-favored-rate clause in a provider contract.
23 RI Gen Laws §§ 17.13-2 & 17.13-3— Accident and Sickness Insurance Policies:
Banning most favored nation clauses, a promise obtained by an insurer that the provider will not give a better price to another insurer.

Expansion of DOI Authority

27 RI Gen Laws § 20-6 — Rates charged subscribers–Reserves–Hearing by commissioner: Nonprofit Medical Service Corporations:
States that the rates proposed to be charged, or a rating formula proposed to be used, by any corporation organized under this chapter, to its subscribers, employers, the state or any political subdivision of the state, or individuals, shall be filed by the corporation at the office of the health insurance commissioner (hereinafter referred to as the "commissioner").
27 RI Gen Laws § 19-6 — Rates charged subscribers – Reserves: Nonprofit Hospital Service Corporations:
States that the rates proposed to be charged, or a rating formula proposed to be used, by any corporation organized under this chapter to employers, the state or any political subdivision of the state, or individuals, shall be filed by the corporation at the office of the health insurance commissioner (hereinafter referred to as the "commissioner").
27 RI Gen Laws § 18-54 — Health insurance rates:
Vests prior approval authority in the insurance commissioner only for subsets of the insurance market.
42 RI Gen Laws §§ 14.5-1 through 14.5-4 — The Rhode Island Health Care Reform Act of 2004 – Health Insurance Oversight:
Granted broad authority to the health insurance commissioner for health insurance oversight. The health insurance commissioner has additional duties, including establishing limits on rate increases.

Creating or Reducing Barriers to New Entrants

23 RI Gen Laws §§ 15-1 through 15-11 — Determination of Need for New Health Care Equipment and New Institutional Health Services:
Certificate of Need guidelines and principles.
23 RI Gen Laws §§ 15-1 through 15-11— Health Care Certificate of Need Act of Rhode Island:
The purpose of this chapter is to provide for the development, establishment, and enforcement of standards for the authorization and allocation of new institutional health services and new health care equipment.
Telehealth
27 RI Gen Laws §§ 81-1 through 81-5 — Telemedicine Coverage Act:
There is a need in this state to embrace efforts that will encourage health insurers and health-care providers to support the use of telemedicine, and that will also encourage all state agencies

to evaluate and amend their policies and rules to remove any regulatory barriers prohibiting the use of telemedicine services.

Scope of Practice

5 RI Gen L § 54-8— Permitted Health care practices by physician assistants: Physician Assistants: Physician assistants, depending upon their level of professional training and experience, as determined by a supervising physician, may perform health care services consistent with their expertise and that of the supervising physician, who is a licensed physician in solo practice, in group practice, or in health care facilities.

Appendix

SOUTH CAROLINA

Antitrust

SC Code §§ 44-7-500 through 44-7-590 — Health Care Cooperation Act:
The department shall issue a certificate of public advantage for a cooperative agreement if it determines that: (1) the applicants have demonstrated that the likely benefits resulting from the agreement outweigh the likely disadvantages from the agreement; and (2) reduction in competition likely to result from the agreement is reasonably necessary to obtain the benefits likely to result.

SC Code §§ 39-3-10 through 39-3-510 — Trusts, Monopolies and Restraints of Trade:
States that combinations lessening competition, monopolies and conspiracies for restraint of trade are unlawful. The Attorney General and the solicitor of each circuit in which an offense is committed, respectively, shall enforce the provisions of this article. The solicitor shall institute and conduct all suits begun in the circuit courts and upon appeal the Attorney General shall prosecute the suits in the Supreme Court or the court of appeals.

SC Code § 39-5-70 — Investigative demand by Attorney General: Unfair Trade Practices:
When it appears to the Attorney General that a person has engaged in, is engaging in, or is about to engage in any act or practice declared to be unlawful by this article, or when he believes it to be in the public interests that an investigation should be made to ascertain whether a person in fact has engaged in, is engaging in, or is about to engage in any act or practice declared to be unlawful by this article, he may execute in writing and cause to be served upon that person or any other person who is believed to have information, documentary material or physical evidence relevant to the alleged or suspected violation, an investigative demand requiring such person to furnish, under oath, a report in writing setting forth the relevant facts and circumstances of which he has knowledge, or to appear and testify or to produce relevant documentary material or physical evidence for examination and copying, at such reasonable time and place as may be stated in the investigative demand, concerning the advertisement, sale or offering for sale of any goods or services or the conduct of any trade or commerce that is the subject matter of the investigation.

Encouraging Price Transparency

SC Code § 44-6-170 — Collection and release of Health care related data; confidentiality; regulations to be promulgated; Data Oversight Council; Health Data Analysis Task Force; hospitals to provide required information; violations and penalties: Department of Health and Human Services:

Establishes a Data Oversight Council with the following duties: (1) make periodic recommendations to the committee and the General Assembly concerning the collection and release of health care-related data by the State which the council considers necessary to assist in the formation of health care policy in the State; (2) convene expert panels as necessary to assist in developing recommendations for the collection and release of health care-related data; (3) approve all regulations for the collection and release of health care-related data to be promulgated by the office; (4) approve release of health care-related data consistent with regulations promulgated by the office; and (5) recommend to the office appropriate dissemination of health care-related data reports, training of personnel, and use of health care-related data.

Expansion of DOI Authority

SC Code § 38-71-310 — Filing of forms and rates; approval or disapproval; withdrawal of approval; exceptions; loss ratio guarantee: Accident and Health Insurance:
Requires rate filing and prior approval. If the insurers file rates and forms and, if not disapproved within 90 days, then the rates are deemed approved.

Creating or Reducing Barriers to New Entrants

SC Code §§ 44-7-110 through 44-7-370 — State Certification of Need and Health Facility Licensure Act:
"The purpose of this article is to promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services which will best serve public needs, and ensure that high quality services are provided in health facilities in this State. To achieve these purposes, this article requires:
(1) the issuance of a Certificate of Need before undertaking a project prescribed by this article;
(2) adoption of procedures and criteria for submittal of an application and appropriate review before issuance of a Certificate of Need;
(3) preparation and publication of a State Health Plan;
(4) the licensure of facilities rendering medical, nursing, and other health care."
SC Code § 40-47-37 — Practice of telemedicine, requirements: General Provisions:
Outlines requirements around the practice of telemedicine.
SC Code § 40-47-960 — *Scope of Practice* guidelines; signature and filing requirements; contents: South Carolina Physician Assistants Practice Act:
Establishes licensure and discipline procedures for physicians assistants.
SC Code §§ 40-47-935 through 40-47-970 — South Carolina Physician Assistants Practice Act:
Establishes licensure and discipline procedures for physicians assistants.
SC Code §§ 40-33-44 through 40-33-116 — Nurse Practice Act:
Establishes licensure and discipline procedures for nurse professionals; Defines scope of practice.

Appendix

SOUTH DAKOTA

Antitrust

SD Codified Laws §§ 37-1-3.1 through 37-1-33 — Restraint of Trade, Monopolies and Discriminatory Trade Practices:
Notwithstanding § 37-1-5, any person or corporation buying commodities described therein in more than one section, community, locality, or first or second class municipality, may raise prices in any given section, community, locality, or municipality to but not above the prices paid by other persons or corporations buying such commodities in such section, community, locality, or municipality, when necessary to meet actual legitimate competition in such section, community, locality, or municipality, without being held to have violated the provisions of this chapter.

Encouraging Price Transparency

SD Codified Laws § 1-43-24 — Annual Health data system report available to public: Department of Health:
Requires public reporting through annual reports of data collected pursuant to §§ 1-43-19 to 1-43-21, inclusive. Any data released shall be presented in a manner such that no person may be identified.
SD Codified Laws § 1-43-32 — Contingent implementation of Comprehensive Health data system: Department of Health:
Requires that implementation of a comprehensive health data system is contingent on availability of state and federal funds.
SD Codified Laws §§ 34-12E-1 through 34-12E-13 — Disclosure of Health Care Charges:
Requires health care providers and facilities to disclose all fees and charges for health care procedures upon request of a patient. Each hospital licensed pursuant to SDCL chapter 34-12 shall report annually to the SDAHO the charge information for the inpatient all patient refined diagnosis related groups (APR DRG) for which there are at least ten cases rendered by the hospital during the twelve months preceding the report. Requires the SDAHO to develop a web-based system, available to the public at no cost, for reporting the charge information of hospitals.
SD Codified Laws § 1-43-19 — Comprehensive Health data system established–Purpose: Department of Health:
Requires the Department of Health to establish and maintain a comprehensive health data system for: (1) Health care planning, policy development, policy evaluation, and research by federal, state, and local governments; (2) Monitoring payments for health services by the federal and state governments; (3) Assessing and improving the quality of health care; (4) Measuring and optimizing access to health care; (5) Supporting public health functions and objectives; (6) Improving the ability of health plans, health care providers, and consumers to coordinate, improve, and make choices about health care; and (7) Monitoring costs at provider and plan levels.

Expansion of DOI Authority

SD Codified Laws 58-17-4.1 — Filing and approval of individual policy premium rates: Health Insurance Policies:
Requires rate filing and prior approval. If the insurers file rates and forms and, if not disapproved within 30 days then the rates are deemed approved.

Creating or Reducing Barriers to New Entrants

SD Codified Laws §§ 58-17F-1 through 58-7F-21 — Network Adequacy Standards:

In determining whether a health carrier has complied with any network adequacy provision of this chapter, the director shall give due consideration to the relative availability of healthcare providers in the service area and to the willingness of providers to join a network.

Appendix

TENNESSEE

Antitrust

TN Code §§ 68-11-1301 through 68-11-1310 — Hospital Cooperation Act of 1993:
States explicitly that hospitals may negotiate and enter into cooperative agreements with other hospitals, since the likely benefits outweigh any disadvantages attributable to a reduction in competition that may result from the agreements. Such agreements may apply to the department for a certificate of public advantage.
TN Code §§ 47-25-101 through 47-25-112 — Trusts – Unlawful Restraint of Trade and Discrimination:
All arrangements, contracts, agreements, trusts, or combinations between persons or corporations made with a view to lessen, or which tend to lessen, full and free competition in the importation or sale of articles imported into this state, or in the manufacture or sale of articles of domestic growth or of domestic raw material, and all arrangements, contracts, agreements, trusts, or combinations between persons or corporations designed, or which tend, to advance, reduce, or control the price or the cost to the producer or the consumer of any such product or article, are declared to be against public policy, unlawful, and void.

Encouraging Price Transparency

TN Code § 56-7-122 — Disclosure of agreements to limit services permitted: General Provisions:
A provider shall not be prohibited by a health plan, by contract or other- wise, from disclosing to a patient the existence of financial arrangements with the health plan that reward the provider for reducing or limiting the range and amount of medically necessary and appropriate services rendered to the patients enrolled in the health plan.
TN Code §§ 56-7-3301 through 56-7-3304 — Contracts with Health Care Providers:
Requires health insurance entities to establish and maintain an Internet web site, which shall be accessible to providers with whom the entity has a provider agreement or contract.
TN Code § 56-2-125 — Establishment and maintenance of an all payer claims database – Establishment of Tennessee Health information committee: General Requirements for Doing Business:
The commissioner shall establish and maintain an all payer claims database to enable the commissioner of finance and administration to improve accessibility, adequacy and affordability of health care and coverage; identify health and health care needs to inform public policy; determine the capacity and distribution of existing health care resources; evaluating the effectiveness of intervention programs on patient outcomes; reviewing costs among treatment settings and providers; providing publicly available information on health care providers' quality of care.
TN Code §§ 56-60-101 through 56-60-109 — Preferred Provider Organization Transparency Act:
Requires health insurance entities to establish and maintain an Internet web site, which shall be accessible to providers with whom the entity has a provider agreement or contract.

TN Code §§ 35-7-3501 through 35-7-3510 — Tennessee Right to Shop Act:
Beginning upon approval of the next health insurance rate filing on or after January 1, 2020, a carrier offering a health plan in this state to implement an incentive program that provides incentives for enrollees in a health plan who elect to receive a comparable healthcare service from a network provider that is covered by the health plan and that is paid less than the average allowed amount paid by that carrier to network providers for that comparable healthcare service before and after an enrollee's out-of-pocket limit has been met.
TN Code § 68-1-108 — Reports of claims data by licensed hospitals Penalties Waiver Licensure Civil liability: General Provisions:
Licensed Hospitals shall report claims data.

Competitive Behavior in Health Plan Contracting

TN Code § 56-7-1013— Access to Health carriers' payment policies – Rules – Fee Schedules: Health and Accident Insurance:
Provides that a healthcare provider receiving information pursuant to the statute shall not share the information with an unrelated person without prior written consent of the insurance carrier. A health insurance carrier seeking extraordinary relief shall not be required to establish irreparable harm with regard to the sharing of competitively sensitive information.

Regulation Around Development of ACOs

TN Code § 68-29-139 — Accountable care organization; clinical laboratory testing advisory board: Tennessee Medical Laboratory Act:
An accountable care organization that provides diagnosis and treatment for patients in this state shall establish a clinical laboratory testing advisory board to consider and recommend guidelines or protocols for clinical laboratory testing. The clinical laboratory testing advisory board may make recommendations to the ACO governance board for guidelines or protocol adoption for clinical laboratory testing used for diagnostic purposes, disease management, and pathologist consultation on episodes of care.

Expansion of DOI Authority

TN Code § 56-26-102 — Filing and approval of policy forms Loss ratio guarantee:
Vests the insurance commissioner with prior approval authority.

Creating or Reducing Barriers to New Entrants

TN Code §§ 63-19-101 through 63-19-115 — Physician Assistants Act:
Outlines scope of practice for Physicians Assistants.
TN Code §§ 68-11-1601 through 1633 — Tennessee Health Services and Planning Act of 2002: Certificate of Need guidelines and principles.
TN Code § 56-7-2356 — *Network Adequacy.* Mandated Insurer or Plan Coverage:
Each managed health insurance issuer that offers a plan that limits its enrollees' choice of providers shall maintain a network that is sufficient in numbers and types of providers to assure that all covered benefits to covered persons will be accessible without unreasonable delay. In the case of emergency services, covered persons shall have access to health care services twenty-four (24) hours per day, seven (7) days per week.
TN Code § 63-1-155 — Healthcare provider; telehealth or telemedicine; Healthcare provider-patient relationship; standard of professional practice; application: General Provisions:

For the purposes of this section, a healthcare provider-patient relationship with respect to telemedicine or telehealth is created by mutual consent and mutual communication, except in an emergency, between the patient and the provider.
TN Code § 56-7-2401— Mandated Scope of Practice:
Whenever any policy of insurance issued in this state provides for reimbursement for any service that is within the lawful scope of practice of a duly licensed optometrist, licensed psychologist designated as a health service provider, licensed psychological examiner, certified psychological assistant (supervised), licensed senior psychological examiner, podiatrist, person licensed to engage in independent practice as a licensed clinical social worker in accordance with a marital and family therapist, or a professional counselor. The insured or other person entitled to benefits under the policy shall be entitled to reimbursement for the services, not to exceed the percentage of reimbursement provided for psychiatrists in the policy, notwithstanding any other provision in the policy.
TN Code §§ 63-19-101 through 63-19-115 — Physician Assistants Act:
Establishes physician assistant licensing procedures; Defines scope of practice; Establishes discipline procedures.
TN Code §§ 63-7-101 through 63-7-128 — Nursing — General Provisions:
Nurses, Nursing – As enacted, clarifies that the definition of the practice of nursing does not prevent qualified registered nurses from making determinations that patients are experiencing emergency medical conditions, in certain circumstances.

Appendix

TEXAS

Antitrust

TX Health & Safety Code §§ 314.001 through 314.008 — Cooperative Agreements Among Hospitals:
Allows a hospital to negotiate and enter into cooperative agreements with other hospitals in the state if the likely benefits resulting from the agreement outweigh any disadvantages attributable to a reduction in competition that may result from the agreements. Acting through their boards of directors, a group of hospitals may conduct discussions or negotiations concerning cooperative agreements, provided that the discussions or negotiations do not involve price fixing or predatory pricing. Parties to a cooperative agreement may apply to the department for a certification of public advantage governing the cooperative agreement.
TX Bus & Com Code § 15.40 — Authority, Powers, and Duties of Attorney General: Texas Free Enterprise and Antitrust Act of 1983:
States that the attorney general may bring an action on behalf of the state or of any of its political subdivisions or tax supported institutions to recover the damages provided for by the federal antitrust laws, Title 15, United States Code provided that the attorney general shall notify in writing any political subdivision or tax supported institution of his intention to bring any such action on its behalf, and at any time within 30 days thereafter, such political subdivision or tax supported institution may, by formal resolution of its governing body or as otherwise specifically provided by applicable law, withdraw the authority of the attorney general to bring the intended action. In any action brought pursuant to this section on behalf of any political subdivision or tax supported institution of the state, the state shall retain for deposit in the general revenue fund of

the State Treasury, out of the proceeds, if any, resulting from such action, an amount equal to the expense incurred by the state in the investigation and prosecution of such action.
TX Ins Code § 848.205 — Independent Authority of the Attorney General: Healthcare Collaboratives:
States that the attorney general may: (1) investigate a health care collaborative with respect to anticompetitive behavior that is contrary to the goals and requirements of this chapter; and (2) request that the commissioner: (A) impose a penalty or sanction; (B) issue a cease and desist order; or (C) suspend or revoke the health care collaborative's certificate of authority. (b) This section does not limit any other authority or power of the attorney general.
TX Health & Safety Code §§ 4F 314 — Cooperative Agreements Among Hospitals:
Permits a hospital and any person who is a party to a cooperative agreement with a hospital to negotiate, enter into, and conduct business pursuant to a cooperative agreement without being subject to damages, liability, or scrutiny under any State antitrust Law if a certificate of public advantage is issued for the cooperative agreement.

Encouraging Price Transparency

TX Government Code § 531.0082 — Data Analysis Unit: Health and Human Services Commission:
Establishes a data analysis unit for the Medicaid program within the Texas Health and Human Services Commission. Data analysis functions will support: 1) improved contract management; 2) detecting data trends; and 3) identifying anomalies related to service utilization, providers, payment methodologies, and compliance with requirements in Medicaid and child health plan program managed care and fee-for-service con- tracts. Following 30 days after the close of each calendar quarter, the data analysis unit will report on its activities to the governor, lieutenant governor, and the appropriate legislative committee chairs.
TX Insurance Code §§ 38.351 through 38.358 — Data Collection and Reports:
Authorizes the Texas DOI to: **1**) collect data concerning health benefit plan reimbursement rates in a uniform format; and 2) disseminate, on an aggregate basis for geographical regions in this state, information concerning health care reimbursement rates derived from the data. This subchapter applies to the following: 1) an insurance company; 2) a group hospital service corporation; 3) a fraternal benefit society; 4) a stipulated premium company; 5) a reciprocal or interinsurance exchange; or 6) a health maintenance organization. This information is publicly reported on a website via the Texas DOI.
TX Insurance Code § 1456.007 — Health benefit plan estimate of charges: Disclosure of Provider Status:
Allows consumers to request a health care cost estimate from their health insurance company before receiving care.
TX Health & Safety Code §§ 1002.001 through 1002.202 — Data Collection and Reports:
Establishes the Texas Institute of Health Care Quality and Efficiency for the purposes of improving health care quality, accountability, education, and cost containment in this state by encouraging health care provider collaboration, effective health care delivery models, and coordination of health care services.
TX Health & Safety Code §§ 108.001 through 108.012 — Data Collection and Reports:
Establishes the Texas Health Care Information Council that will develop a statewide health care data collection system and make data available for public use, including computer-to-computer access for the public. The council will prioritize data collection efforts on inpatient and outpatient surgical and radiological procedures from hospitals, ambulatory surgical centers, and free-standing radiology centers. The council will report to the legislature, the governor, and the public on the charges and rate of change in the charges for health care services.
TX Health & Safety Code § 324.051 — Data Collection and Reports:

Requires the Department to make available on its Internet website a consumer guide to health care which includes information concerning facility pricing practices and the correlation between a facility's average charge and the actual, billed charge for an inpatient admission or outpatient surgical procedure.
TX Health & Safety Code § 324.101 — Facility policies: Billing of Facility Services and Supplies:
A health care facility must develop, implement and enforce a billing policy for services and supplies, addressing any facility discounts to an uninsured indigent consumer, providing of an itemized bill, providing of a conspicuous written disclosure at the time of admittance, and other material disclosures.
TX Ins Code § 1272.301 — Access to Out of Network Services: Delegation of Certain Functions by Health Maintenance Organization:
if medically necessary covered services are not available through network physicians or providers, the limited provider network or delegated entity, on the request of a network physician or provider, shall: (A) allow a referral to a non-network physician or provider; and (B) fully reimburse the non-network physician or provider at the usual and customary rate or an agreed rate.
TX Ins Code §§ 752.001 through 752.003 — General Provisions Regarding Statutory Durable Power of Attorney:
Relating to consumer protections against certain medical and health care billing by certain out-of-network providers.
TX Ins Code § 1271.008 — Balance billing prohibition notice: Benefits Provided by Health Maintenance Organizations; Evidence of Coverage; Charges:
A health maintenance organization shall provide written notice in accordance with this section in an explanation of benefits provided to the enrollee and the physician or provider in connection with a health care service or supply provided by a non-network physician or provider.
TX Ins Code § 1456.003 — Required Disclosure: Health Benefit Plan: Disclosure of Provider Status:
A health benefit plan must include notice when a facility based physician is not included in network and such a physician may not bill the enrollee for amounts not paid by the benefit plan.

Regulation Around Development of ACOs

TX Ins Code §§ 848.001 through 848.205 — Health Care Collaboratives:
Defines "health care collaborative" (essentially ACOs) and requires them to get approval from the insurance commissioner by obtaining a certificate of authority. One of the requirements for approval is that the collaborative has processes that contain costs without jeopardizing quality of patient care. The insurance commissioner forwards the application to the attorney general for concurrent review. The attorney general reviews whether collaborative is likely to reduce competition in any market for physician, hospital, or ancillary health care services due to: (A) the size of the health care collaborative; or (B) the composition of the collaborative, including the distribution of physicians by specialty within the collaborative in relation to the number of competing health care providers in the health care collaborative geographic market; and the pro-competitive benefits of the applicant's proposed health care collaborative are likely to substantially outweigh the anticompetitive effects of any increase in market power.

Expansion of DOI Authority

TX Ins Code § 1201.109 — Notice of Rate Increase for Major Medical Expense Insurance Policy: General Policy Standards and Provisions:
Requires individual health insurers to notify consumers 60 days before a premium rate increase takes effect.

TX Gov't Code § 533.013 — Premium Payment Rate Determination; Review and Comment: Texas Health Maintenance Organization Act:
Discusses considerations for premium payment rate determinations.
TX Ins Code § 560.002 — Use of certain rates prohibited; rate requirements: Prohibited Rates:
Mandates a system of rate review for health insurers and HMOs, providing that a rate must be just, fair, reasonable, and adequate. The rate may not be confiscatory, excessive for the risks to which the rate applies, or unfairly discriminatory.
TX Ins Code § 1507 — Rates:
Insurance companies must file their proposed rates with the department of insurance, but the rates may go into effect without department approval. The department may have the ability to go back and disapprove a rate increase that was later deemed unreasonable.

Creating or Reducing Barriers to New Entrants

TX Ins Code § 1305.302 — Accessibility and Availability Requirements: Workers' Compensation Health Care Network Act: The network shall ensure that the network's provider panel includes an adequate number of treating doctors and specialists, who must be available and accessible to employees 24 hours a day, seven days a week, within the network's service area. A network must include sufficient numbers and types of health care providers to ensure choice, access, and quality of care to injured employees. An adequate number of the treating doctors and specialists must have admitting privileges at one or more network hospitals located within the network's service area to ensure that any necessary hospital admissions are made.
TX Occ Code §§ 111.001 through 111.008 — Telemedicine and Telehealth:
Rules around use of telehealth.
TX Ins Code §§ 1455.001 through 1455.006 — Telemedicine and Telehealth:
Rules around use of telehealth.
TX Gov't Code § 531.02171 — Reimbursement for Certain Telehealth Services: Health and Human Services Commission:
Outlines reimbursement for telehealth services. It lists the providers that may be reimbursed.
TX Occ Code § 204.202 — Scope of Practice: Physician Assistants:
Outlines the Scope of Practice for physician assistants.
TX Occ Code § 157.0512 — Prescriptive Authority Agreement: Delegation to Advanced Practice Registered Nurses and Physician Assistants:
A physician may delegate to an advanced practice registered nurse or physician assistant, acting under adequate physician supervision, the act of prescribing or ordering a drug or device as authorized through a prescriptive authority agreement.
TX Ins Code § 843.312 — Physician Assistants and Advanced Practice Nurses: Texas Health Maintenance Organization Act:
A health maintenance organization cannot refuse to contract with an advanced practice nurse or physician's assistant who is authorized by an accepted in network physician to provide care.

Appendix

UTAH

Antitrust

UT Code §§ 76-10-3101 through 76-10-3118 — Utah Antitrust Act:

States that the Legislature finds and determines that competition is fundamental to the free market system and that the unrestrained interaction of competitive forces will yield the best allocation of our economic resources, the lowest prices, the highest quality and the greatest material progress, while at the same time providing an environment conducive to the preservation of our democratic, political and social institutions. The purpose of this act is, therefore, to encourage free and open competition in the interest of the general welfare and economy of this state by prohibiting monopolistic and unfair trade practices, combinations and conspiracies in restraint of trade or commerce and by providing adequate penalties for the enforcement of its provisions.

Encouraging Price Transparency

UT Code § 26-3-2 — Powers of department to collect and maintain Health data: Health Statistics:
Permits the Department of Health Organization to collect and maintain health data on, including but not limited to, health care costs and financing.
UT Code § 26- 21-20 — Requirement for hospitals to provide statements of itemized charges to patients: General Provisions:
Requires hospitals to provide a statement of itemized charges to any patient receiving medical care or other services from that hospital.
UT Code § 26-21-27 — Consumer access to Health care facility charges: General Provisions:
Licensed health care facilities must make available to consumers: (1) a list of prices charged by the facility available for the consumer that includes the facility's: (a) in-patient procedures; (b) out-patient procedures; (c) the 50 most commonly prescribed drugs in the facility; (d) imaging services; (e) implants; and (2) provide the consumer with information regarding any discounts the facility provides for: (a) charges for services not covered by insurance; or (b) prompt payment of billed charges.
UT Code §§ 26-33a-101 through 26-33a-116 — Utah Health Data Authority Act:
Establishes the Utah Health Data Committee to direct a statewide effort to collect, analyze, and distribute health care data to facilitate the promotion and accessibility of quality and cost-effective health care and also to facilitate interaction among those with concern for health care issues. Among other duties, the committee will explain the intended uses of and expect- ed benefits to be derived from the data, including (A) promoting quality health care; (B) managing health care costs; or (C) improving access to health care services.
UT Code § 31A-22-613.5 — Price and value comparisons of health insurance: Accident and Health Insurance:
The commissioner shall promote informed consumer behavior and responsible health benefit plans through the following requirements for insurers to meet.
UT Code § 31A-22-647 — Insurer shared savings program: Accident and Health Insurance:
PEHP shall, in accordance with Subsection (4), establish a savings reward program for a health plan that is: offered to state employees under Title 49, Chapter 20, Public Employees' Benefit and Insurance Program Act; and entered into or renewed on or after July 1, 2019.

Regulation Around Development of ACOs

UT Code § 26-18-405 — Waivers to maximize replacement of fee-for-service delivery model -- Cost of mandated program changes:
Permits the State Medicaid program to pursue waivers to replace fee-for- service delivery model with risk-based delivery models. This includes the following goals: a) Restructure the program's provider payment provisions to reward health care providers for delivering the most appropriate service at the lowest cost that maintains or improves recipient health status. This includes: 1)

Identifying evidence-based practices and other mechanisms necessary to reward providers for delivering the most appropriate services at the lowest cost; 2) Paying providers for packages of services delivered over entire episodes of illness; 3) Rewarding providers for delivering services that make the most positive contribution to maintaining and improving a recipient's health status; 4) Using providers that deliver the most appropriate services at the lowest cost; and b) Restructure the program to bring the rate of growth in Medicaid more in line with the overall growth in General Funds. c) Restructure the program's cost sharing provisions and add incentives to reward recipients for personal efforts to maintain and improve their health status. Utah used the authority under this statute to pursue ACOs in its Medicaid managed care program through a 1915(b) waiver.

UT Code § 26-18-408 — Incentives to appropriately use emergency department services: Medical Assistance Act:

Applied to the Utah Children's Health Insurance Program, the department shall evaluate accountable care organization's use of health care services.

UT Code § 26-36d-205 — Medicaid hospital adjustment under accountable care organization rates: Hospital Provider Assessment Act:

To preserve and improve access to hospital services, the division shall, for accountable care organization rates effective on or after April 1, 2013, incorporate an annualized amount equal to $154,000,000 into the accountable care organization rate structure calculation consistent with the certified actuarial rate range.

UT Code § 26-18-405.5 — Base budget appropriations for Medicaid accountable care organizations: Medical Assistance Act:

Regulations for determining the next fiscal year's budget for Medicaid accountable care organizations under the Department of Health.

Expansion of DOI Authority

UT Code § 31A-22-602 — Premium rates: Accident and Health Insurance:

Requires the company to send the rate adjustment to the state insurance board for filing but does not require insurance companies to receive approval for a new insurance rate. In some instances, Utah's DOI has prior approval authority, i.e., for changes in rating methodology.

Creating or Reducing Barriers to New Entrants

UT Code § 53B-17-105 — Utah Education and Telehealth Network: Educational Telecommunications:

There is created the Utah Education and Telehealth Network, or UETN. UETN shall, in consultation with health care providers from a variety of health care systems, explore and encourage the development of telehealth services as a means of reducing health care costs and increasing health care quality and access, with emphasis on assisting rural health care providers and special populations.

UT Code § 26-59-103 — Telehealth Pilot Project Grant Program: Telehealth Pilot Program:

"(a) determine how telehealth services can best be used in the state to:

(i) increase access or convenience to health care, including specialized health care;

(ii) increase timeliness in crisis intervention;

(iii) reduce costs associated with obtaining health care; and (iv) increase access to health care by rural populations and other underserved populations;

(b) determine the best practices for providing telehealth services in the state; and

(c) identify the types of health care services for which telehealth services may be most beneficial." **UT Code §§ 26-60-101 through 26-60-105** — Telehealth Act:

A provider offering telehealth services shall act within the scope of telehealth practice provisions at all times.
UT Code § 58-70a-501 — *Scope of Practice*: Physicians Assistant Act:
The scope of practice for a physicians assistant practicing in Utah.

Appendix

VERMONT

Antitrust

18 VSA § 9420 — Conversion of nonprofit hospitals: Claims Processing and Contracting Standards:
States that the State has a responsibility to assure that the assets of nonprofit entities, which are impressed with a charitable trust, are managed prudently and are preserved for their proper charitable purposes. A nonprofit hospital may convert a qualifying amount of charitable assets only with the approval of the Green Mountain Care Board, and either the Attorney General or the Superior Court, pursuant to the procedures and standards set forth in this section.
9 VSA § 2458 — Restraining prohibited acts: Consumer Protection:
States that whenever the Attorney General or a State's Attorney has reason to believe that any person is using or is about to use any method, act, or practice declared by section 2453 of this title to be unlawful, or has reason to believe that any person has violated any assurance of discontinuance entered into pursuant to section 2459 of this title, and that proceedings would be in the public interest, the Attorney General, or a State's Attorney if authorized to proceed by the Attorney General, may bring an action in the name of the State against such person to restrain by temporary or permanent injunction the use of such method, act, or practice or to dissolve a domestic corporation or revoke the certificate of authority granted a foreign corporation.
9 VSA § 2461C — Predatory pricing: Consumer Protection:
No person, with the intent to harm competition, shall price goods or services in a manner that tends to create or maintain a monopoly or otherwise harms competition. A violation of this subsection is deemed to be an unfair method of competition in commerce and a violation of section 2453 of this title. The Attorney General shall adopt rules when necessary and proper to carry out the purposes of this section.
11B VSA § 11.02 — Limitations on mergers by public benefit corporations: Merger:
Without the prior approval of the Superior Court of Washington County in a proceeding of which the Attorney General has been given written notice, a public benefit corporation may merge only with certain organizations.
8 VSA § 4595 — Change in control; material transactions; redomestication; establishment or acquisition of control of insurance Company subsidiary: Nonprofit Medical Service Corporation:
No corporation permitted to engage in business under this chapter shall merge or consolidate with, sell, transfer, or exchange more than a 10 percent interest in the corporation or its assets to, or sell, transfer, or exchange more than 10 percent of its subscribers to, or otherwise transfer or commit more than a 10 percent interest in itself to, any other person, whether accomplished through one transaction or a series of transactions, without the Commissioner's prior written approval.
8 VSA § 4523 — Change in control; material transactions; redomestication; establishment or acquisition of control of insurance Company subsidiary: Nonprofit Hospital Service Corporations:

No corporation permitted to engage in business under this chapter shall merge or consolidate with, sell, transfer, or exchange more than a 10 percent interest in the corporation or its assets to, or sell, transfer, or exchange more than 10 percent of its subscribers to, or otherwise transfer or commit more than a 10 percent interest in itself to, any other person, whether accomplished through one transaction or a series of transactions, without the Commissioner's prior written approval.

18 VSA § 9405C — Notice of acquisition: Quality, Resource Allocation, and Cost Containment:

Each hospital shall provide notice to the Office of the Attorney General at least 90 days or as soon as practicable prior to the effective date of a transaction through which the hospital will acquire a medical practice.

Encouraging Price Transparency

18 VSA § 9405b — Hospital community reports: Quality, Resource Allocation, And Cost Containment:

Requires hospitals to submit community reports in a standard format, including measures of quality and measures that provide valid, reliable, useful, and efficient information for payers and the public for the comparison of charges for higher volume health care services. The community report will be published on a website by the Commissioner.

18 VSA § 9410 — Health care database: Quality, Resource Allocation, And Cost Containment:

Requires the development of a unified health care database that includes (A) determining the capacity and distribution of existing resources; (B) identifying health care needs and informing health care policy; (C) evaluating the effectiveness of intervention programs on improving patient outcomes; (D) comparing costs between various treatment settings and approaches; (E) providing information to consumers and purchasers of health care; and (F) improving the quality and affordability of patient health care and health care coverage. The health care database will have a consumer health care price and quality information component to empower consumers to make economical and medically appropriate decisions. Health insurers, providers, facilities, and governmental agencies shall file reports, data, schedules, statistics, or other information determined by the Board to be necessary to carry out the purposes of this section.

33 VSA § 6502 — Balance billing prohibited:

A physician who agrees to treat a Medicare or General Assistance beneficiary shall not balance bill the beneficiary except as hereinafter provided.

Competitive Behavior in Health Plan Contracting

18 VSA § 9418e — Most favored nation clauses prohibited: Claims Processing and Contract Standards:

Forbids contracting entities to offer, enter into, or amend a contract that includes a most favored nation clause.

Monitoring/Regulating Prices

18 VSA §§ 9451 through 9457 — Hospital Budget Review:

The board shall conduct review of hospital proposed budgets and establish a budget for each hospital, considering utilization and expenditure analysis and requiring teaching hospital to file an analysis that reflects a reduction in net revenue needs from non-Medicaid payers. Budgets shall promote efficient and economic operation of the hospital and reflect performance of prior years.

Expansion of DOI Authority

8 VSA § 4062 — Filing and approval of policy forms and premiums:
Requires rate filing and prior approval. If the insurers file rates and forms and, if not disapproved within 30 days, then the rates are deemed approved.

Regulation Around Development of ACOs

18 VSA § 9382 — Oversight of accountable care organizations: Green Mountain Care Board: The Green Mountain Care Board shall adopt rules pursuant to 3 V.S.A. chapter 25 to establish standards and processes for reviewing, modifying, and approving the budgets of ACOs with 10,000 or more attributed lives in Vermont. To the extent permitted under federal law, the Board shall ensure the rules anticipate and accommodate a range of ACO models and sizes, balancing oversight with support for innovation.
18 VSA § 9572 — Meetings of an accountable care organization's governing body: All-Payer Model and Accountable Care Organizations:
Meetings of an accountable care organization's governing body shall be open to the public and shall provide members of the public an opportunity to comment.
18 VSA § 9371 — Principles for Health care reform: Green Mountain Care Board:
Vermont's health delivery system must seek continuous improvement of health care quality and safety and of the health of the population and promote healthy lifestyles. The system therefore must be evaluated regularly for improvements in access, quality, and cost containment.
18 VSA § 9375 — Duties: Green Mountain Care Board:
The Board must adopt by rule pursuant to 3 V.S.A. chapter 25 such standards as the Board deems necessary and appropriate to the operation and evaluation of accountable care organizations pursuant to this chapter, including reporting requirements, patient protections, and solvency and ability to assume financial risk.
18 VSA § 9383 — Expenditure analysis; Health care spending estimate: Green Mountain Care Board:
The Board shall develop annually an expenditure analysis and an estimate of future health care spending covering a period of at least two years. These analyses shall contain data and information as set forth in this section that the Board shall consider and incorporate into its work in furtherance of its statutory duties, including using them as tools in the Board's review of health insurance rates and the budgets of hospitals and accountable care organizations.
18 VSA § 9376 — Payment amounts; methods: Green Mountain Care Board:
It is the intent of the General Assembly to ensure payments to health care professionals that are consistent with efficiency, economy, and quality of care and will permit them to provide, on a solvent basis, effective and efficient health services that are in the public interest. It is also the intent of the General Assembly to eliminate the shift of costs between the payers of health services to ensure that the amount paid to health care professionals is sufficient to enlist enough providers to ensure that health services are available to all Vermonters and are distributed equitably.

Expansion of DOI Authority

8 VSA § 4062 — Filing and approval of policy forms and premiums: Health Insurance – Generally:
Vests prior approval authority with the insurance commissioner. No policy of health insurance or certificate under a policy filed by an insurer offering health insurance as defined in subdivision 3301(a)(2) of this title, a nonprofit hospital or medical service corporation, a health maintenance

organization, or a managed care organization and not exempted by subdivision 3368(a)(4) of this title shall be delivered or issued for delivery in this State, nor shall any endorsement, rider, or application which becomes a part of any such policy be used, until a copy of the form and of the rules for the classification of risks has been filed with the Department of Financial Regulation and a copy of the premium rates has been filed with the Green Mountain Care Board; and the Green Mountain Care Board has issued a decision approving, modifying, or disapproving the proposed rate.

Creating or Reducing Barriers to New Entrants

18 VSA § 9434 — *Certificate of Need*; General rules: Health Facility Planning:
General provision and guidelines for Certificate of Need.
18 VSA § 9361 — Health care providers delivering Health care services through telemedicine or by store and forward means: Health Information Technology and Telemedicine:
Subject to the limitations of the license under Subject to the limitations of the license under which the individual is practicing, a health care provider licensed in this State may prescribe, dispense, or administer drugs or medical supplies, or otherwise provide treatment recommendations to a patient after having performed an appropriate examination of the patient in person, through telemedicine, or by the use of instrumentation and diagnostic equipment through which images and medical records may be transmitted electronically. Treatment recommendations made via electronic means, including issuing a prescription via electronic means, shall be held to the same standards of appropriate practice as those in traditional provider-patient settings.
8 VSA § 4100k — Coverage of Health care services delivered through telemedicine: Health Insurance — Telemedicine:
All health insurance plans in this State shall provide coverage for health care services delivered through telemedicine by a health care provider at a distant site to a patient at an originating site to the same extent that the plan would cover the services if they were provided through in-person consultation.
26 VSA § 1735a — Supervision and scope of practice: Physicians Assistants:
"(a) It is the obligation of each team of physician and physician assistant to ensure that the physician assistant's scope of practice is identified; that delegation of medical care is appropriate to the physician assistant's level of competence; that the supervision, monitoring, documentation, and access to the supervising physician is defined; and that a process for evaluation of the physician assistant's performance is established.
(b) The information required in subsection (a) of this section shall be included in a delegation agreement as required by the Commissioner by rule. The delegation agreement shall be signed by both the physician assistant and the supervising physician or physicians, and a copy shall be kept on file at each of the physician assistant's practice sites and the original filed with the Board.
€ The physician assistant's scope of practice shall be limited to medical care that is delegated to the physician assistant by the supervising physician and performed with the supervision of the supervising physician. The medical care shall be within the supervising physician's scope of practice and shall be care that the supervising physician has determined that the physician assistant is qualified by education, training, and experience to provide.
(d) A physician assistant may prescribe, dispense, and administer drugs and medical devices to the extent delegated by a supervising physician. A physician assistant who is authorized by a supervising physician to prescribe controlled substances must register with the federal Drug Enforcement Administration.
€ A supervising physician and physician assistant shall report to the Board immediately upon an alteration or the termination of the delegation agreement."

26 VSA § 1616 — Nurse practitioner and nurse midwife signature authority: Advanced Practice Registered Nurses:
Whenever any provision of Vermont statute or rule or any form provided to any person in this state requires a signature, certification, stamp, verification, affidavit, or other endorsement by a physician, such statute, rule, or form shall be deemed to include a signature, certification, stamp, verification, affidavit, or other endorsement by an advanced practice registered nurse (APRN) licensed pursuant to this chapter and certified as a nurse practitioner or a nurse midwife; provided, however, that nothing in this section shall be construed to expand the scope of practice of APRNs.
26 VSA § 1571 — Purpose and effect: Nursing — General Provisions:
In order to safeguard the life and health of the people of this State, a person shall not practice or offer to practice registered or practical nursing or as a nursing assistant unless licensed under this chapter.

Appendix

VIRGINIA

Antitrust

VA Code § 15.2-5384.1 — Review of cooperative agreements: Southwest Virginia Health Authority:
Allows a hospital to negotiate and enter into proposed cooperative agreements with other hospitals in the Commonwealth if the likely benefits resulting from the proposed cooperative agreements outweigh any disadvantages attributable to a reduction in competition that may result from the proposed cooperative agreements. Benefits to such a cooperative agreement may include, but are not limited to, improving access to care, advancing health status, targeting regional health issues, promoting technological advancement, ensuring accountability of the cost of care, enhancing academic engagement in regional health, strengthening the workforce for health-related careers, and improving health entity collaboration and regional integration where appropriate.
VA Code § 15.2-5374 — Powers of Authority: Southwest Virginia Health Authority:
States that the Southwest Virginia Health Authority may Make and enforce rules and regulations for the management and conduct of its business and affairs and for the use, maintenance and operation of its facilities and properties and receive and review applications for approval of proposed cooperative agreements submitted by two or more hospitals pursuant to § 15.2-5384.1, and provide recommendations to the Commissioner regarding the approval of such applications, among other activities.
VA Code §§ 59.1-9.1 through 9.17 — Virginia Antitrust Act:
States that the purpose of this chapter is to promote the free market system in the economy of this Commonwealth by prohibiting restraints of trade and monopolistic practices that act or tend to act to decrease competition. This chapter shall be construed in accordance with the legislative purpose to implement fully the Commonwealth's police power to regulate commerce.

Encouraging Price Transparency

VA Code § 32.1- 276.2 through 32.1- 276.11 — Health Care Data Reporting:
All medical facilities and health maintenance organizations are required to submit utilization data to the Commissioner to populate the database. HMOs are required to submit quality reports

based on the Health Employer Data and Information Set (HEDIS) and Consumer Assessment of Health Plans (CAHPS) series of metrics, which forms the basis of an online cost and quality comparison tool for consumers. The law also creates the Virginia Patient Level Data System, a database of all licensed Virginia hospital discharges that has operated every calendar quarter since 1993. The System is intended to enhance the ability of health care purchasers and planners to make effective health care decisions. The Commissioner is further directed to contract with a nonprofit for an annual survey confidential survey of carriers offering private group health insurance to determine the reimbursement paid for a minimum of 25 of the most frequently reported health care services, including the average reimbursement rate paid for the same services under Medicare and Medicaid.

Competitive Behavior in Health Plan Contracting

VA Code § 38.2- 4209 — Preferred provider subscription contracts: In General:
Authorizes preferred provider subscription contracts, subject to certain conditions.
VA Code § 18.2-502 — Medical referral for profit: Miscellaneous Offenses in General:
No person, firm, partnership, association or corporation, or agent or employee thereof, shall for profit engage in any business which in whole or in part includes the referral or recommendation of persons to a physician, hospital, health related facility, or dispensary for any form of medical care or treatment of any ailment or physical condition unless the person is advised of the criteria of selection of the physicians, hospitals, health-related facilities or dispensaries considered for the referral or recommendation. The acceptance of a fee or charge for any such referral or recommendation shall create a presumption that the business is engaged in such service for profit. A violation of the provisions of this section shall be punishable as a Class 1 misdemeanor.

Expansion of DOI Authority

VA Code § 38.2-316 — Premium rates:
Insurance companies must file their proposed rates with the department of insurance, but the rates may go into effect without department approval. The department may have the ability to go back and disapprove a rate increase that was later deemed unreason

Creating or Reducing Barriers to New Entrants

VA Code §§ 32.1-102.1 through 32.1-102.11 — Medical Care Facilities Certificate of Public Need: Requires that medical facilities obtain a certificate of public need before developing or expanding medical services.
VA Code § 38.2-3418.16 — Coverage for telemedicine services: Mandated Benefits:
States that each health maintenance organization providing a health care plan for health care services shall provide coverage for the cost of such health care services provided through telemedicine services.
VA Code § 54.1-2952 — Supervision of assistants by licensed physician, or podiatrist; services that may be performed by assistants; responsibility of licensee; employment of assistants: Licensure and Certification of Other Practitioners of the Healing Arts:
A physician or a podiatrist licensed under this chapter may supervise physician assistants and delegate certain acts which constitute the practice of medicine to the extent and in the manner authorized by the Board.

Appendix

Antitrust

WA Rev Code §§ 19.390.010 through 19.390.090 — Health Care Market Participants:
It is the intent of the legislature to ensure that competition beneficial to consumers in health care markets across Washington remains vigorous and robust. The legislature supports that intent through this chapter, which provides the attorney general with notice of all material health care transactions in this state so that the attorney general has the information necessary to determine whether an investigation under the consumer protection act is warranted for potential anticompetitive conduct and consumer harm.

Encouraging Price Transparency

WA Rev Code §§ 43.371.005 through 43.371.100 — Statewide Health Care Claims Data:
The office shall establish a statewide all-payer health care claims database to support transparent public reporting of health care information. The database must improve transparency to: Assist patients, providers, and hospitals to make informed choices about care; enable providers, hospitals, and communities to improve by benchmarking their performance against that of others by focusing on best practices; enable purchasers to identify value, build expectations into their purchasing strategy, and reward improvements over time; and promote competition based on quality and cost.
WA Rev Code §§ 48.49.003 through 48.49.900 — Balance Billing Protection Act:
An Act relating to protecting consumers from charges for out-of-network health care services. [Effective Jan. 1, 2020]
WA Rev Code § 70.41.250 — Cost disclosure to Health care providers: Hospital Licensing and Regulation:
Requires procedures for disclosing to physicians and other health care providers the charges of all health care services ordered for their patients. Copies of hospital charges shall be made available to any physician and/or other health care provider ordering care in hospital inpatient/outpatient services. The physician and/or other health care provider may inform the patient of these charges and may specifically review them. Hospitals are also directed to study methods for making daily charges available to prescribing physicians using interactive software and/or computerized information thereby allowing physicians and other health care providers to review not only the costs of present and past services but also future contemplated costs for additional diagnostic studies and therapeutic medications.
WA Rev Code § 70.01.030 — Health care fees and charges—Estimate:
Requires providers to make information available to consumers upon request.
WA Rev Code § 70.41.450— Estimated charges of hospital services—Notice
Hospitals licensed under this chapter shall post a sign in patient registration areas containing at least the following language: "Information about the estimated charges of your hospital services is available upon request. Please do not hesitate to ask for information."
WA Rev Code § 74.46.441 — Public disclosure of rate-setting information: Nursing Facility Medicaid Payment System:
The department shall disclose to any member of the public all rate-setting information consistent with requirements of state and federal laws.

Competitive Behavior in Health Plan Contracting

WA Admin Code § 246-25-045 —Policy statement: Substantive Rules:
Bans most favored nation clauses in health care provider contracts, a promise obtained by an insurer that the provider will not give a better price to another insurer.
WA Rev Code § 41.05.026 — Contracts–proprietary data, trade secrets, actuarial formulas, statistics, cost and utilization data—Exemption from public inspection—Executive sessions: State Health Care Authority:
Exempts from disclosure requirements such proprietary data, trade secrets, or other information that relate to the bidder's unique methods of conducting business or of determining prices or premium rates.
WA Rev Code § 43.71.005 through 43.71.901 — Washington Health Benefit Exchange:
Tasks the State Health Care Authority (HCA) to contract with one or more health carriers to offer at least three qualified health plans at each metal tier (bronze, silver, and gold) on the Washington health benefit exchange beginning in plan year 2021.

Monitoring/Regulating Prices

WA Rev Code § 41.05.021 — State Health care authority—Director—Cost control and delivery strategies—Health information technology—Managed Competition—Rules: State Health Care Authority:
Creates the Washington State Health Care Authority within the state's executive branch.

Regulation Around Development of ACOs

WA Rev Code § 70.54.420 — Accountable care organization pilot projects—Report to the legislature: Miscellaneous Health and Safety Provisions:
Creates at least two accountable care organization pilot projects to study the development and implementation of ACOs and payment systems. Sets out ACO requirements.

Expansion of DOI Authority

WA Rev Code § 48.44 — Contracts for services—Examination of contract forms by commissioner—Grounds for disapproval—Liability of participant:
Vests prior approval authority in the insurance commissioner only for subsets of the insurance market.

Creating or Reducing Barriers to New Entrants

WA Admin Code §§ 246-310-001 through 246-310-990 — Certificate of Need:
Certificate of Need guidelines and principles.
WA Rev Code §§ 70.38.015 through 70.38.920 — Health Planning and Development:
Certificate of Need guidelines and principles.
WA Rev Code § 48.43.735 — Reimbursement of Health care services provided through telemedicine or store and forward technology: Insurance Reform:
States that a health plan must provide coverage through telemedicine if certain conditions are true.
WA Rev Code § 41.05.700 — Reimbursement of Health care services provided through telemedicine or store and forward technology: State Health Care Authority:
States that a health plan must provide coverage through telemedicine if the following are true.

WA Rev Code § 74.09.325 — Reimbursement of a Health care service provided through telemedicine or store and forward technology–Report to the legislature: Medical Care: States that a managed health plan must provide coverage through telemedicine under the following circumstances.
WA Rev Code § 18.79.260 — Registered nurse—Activities allowed—Delegation of tasks: Nursing Care:
A registered nurse under his or her license may perform for compensation nursing care, as that term is usually understood, to individuals with illnesses, injuries, or disabilities.
WA Rev Code § 48.43.083 — Chiropractor services–Participating provider agreement–Health carrier reimbursement: Insurance Reform:
A health carrier must reimburse a chiropractor who has signed a participating provider agreement for services determined by the carrier to be medically necessary if the follow apply.

Appendix

WEST VIRGINIA

Antitrust

WV Code §§ 16-29B-1 through 16-29B-30 — Health Care Authority:
States that the Legislature hereby finds that the health and welfare of the citizens of this state is being threatened by unreasonable increases in the cost of health care services, a fragmented system of health care, lack of integration and coordination of health care services, unequal access to primary and preventative care, lack of a comprehensive and coordinated health information system to gather and disseminate data to promote the availability of cost-effective, high-quality services and to permit effective health planning and analysis of utilization, clinical outcomes and cost and risk factors. In order to alleviate these threats: (1) Information on health care costs must be gathered; and (2) an entity of state government must be given authority to ensure the containment of health care costs, to gather and disseminate health care information; to analyze and report on changes in the health care delivery system as a result of evolving market forces, and to assure that the state health plan, certificate of need program, and information systems serve to promote cost containment, access to care, quality of services and prevention. Therefore, the purpose of this article is to protect the health and well-being of the citizens of this state by guarding against unreasonable loss of economic resources as well as to ensure the continuation of appropriate access to cost-effective, high-quality health care services.
WV Code §§ 47-18-1 through 47-18-23 — Antitrust Act; Restraint of Trade:
States that every contract, combination in the form of trust or otherwise, or conspiracy in restraint of trade or commerce in this state shall be unlawful. The Attorney General shall investigate suspected violations of, and institute such proceedings as are hereinafter provided for violation of the provisions of this article. The Attorney General may direct the county prosecutor of any county in which such proceedings may be brought to aid and assist him in the conduct of such investigation and proceedings.
WV Code §§ 46A-6-101 through 46A-6-110 — General Consumer Protection:
States that the Legislature hereby declares that the purpose of this article is to complement the body of federal Law governing unfair competition and unfair, deceptive and fraudulent acts or practices in order to protect the public and foster fair and honest competition.
WV Code § 16-2L-5 — Anti-trust exemption: Provider Sponsored Networks:

Provides that agreement and coordination among health care providers, who may be competitors, is required to establish and operate provider sponsored networks; thus, they are exempted from state antitrust laws.

Encouraging Price Transparency

WV Code §§ 33-16G-1 through 33-16G-9 — All-Payer Claims Database:
Creates an all-payer claims database where all providers are required to submit data to the commissioner or a designated entity to provide such information to state residents.
WV Code §§ 33-50-1 through 33-50-3 — Patient Protection and Transparency Act:
The commissioner shall on his or her website provide information regarding the qualified health plans being offered for sale through the exchange in a format easily found by a consumer on such website. Information may be provided through links to specific information, including through links to the website of each health carrier offering a qualified health plan for sale through the exchange.
WV Code § 16-29D-4. — Prohibition on balance billing; exceptions:
The law doesn't require consumers to pay balance bills but doesn't prohibit balance billing by providers. This means many consumers will pay bills they have no obligation to pay. Protections are limited to emergency department settings.

Expansion of DOI Authority

WV Code § 16-29B-1 — West Virginia Hospital Authority Act:
Vests the insurance commissioner with prior approval authority.

Creating or Reducing Barriers to New Entrants

WV Code §§ 16-2D-1 through 16-2D-20 — Certificate of Need:
Certificate of Need guidelines and principles.

Appendix

WISCONSIN

Antitrust

WI Stat §§ 150.84 through 150.86 — Health Care Cooperative Agreements:
Permit parties to a cooperative agreement to file an application with the department for a certificate of public advantage governing the cooperative agreement. A certificate of public advantage is granted if it is demonstrated that the benefits of the cooperation outweigh the potential harm, such as reduction in competition.
WI Stat § 165.40 — Acquisition of Hospitals: Department of Justice:
States that no person may engage in the acquisition of a hospital or a system of hospitals owned by any of the following unless the person has first received review and approval of an application concerning the acquisition under this section from the attorney general, the office and the department.

Encouraging Price Transparency

WI Stat §§ 153.01 through 153.78 — Health Care Information:
This statute discusses the range of data collection activities the department will take as part of an effort to disseminate it to various stakeholders, including laypersons, and ensure quality assurance. Data will be collected from health care providers other than hospitals and ambulatory surgery centers as well as insurers. The types of information collected include: health care information, health care claims information with respect to the cost, quality, and effectiveness, and other health care information. Requires hospitals to publish any changes in rates or charges in class 1 notice in a newspaper. The department's contractor for data collection under Wisconsin Statutes §153.05(2m) shall prepare a report to the Governor and Legislature that summarizes utilization, charge, and quality data on patients treated by hospitals and ambulatory surgery centers during the most recent calendar year. Requires the department to release public use data files for information that is submitted by health care providers other than hospitals or ambulatory surgery centers. The public use files will include charges assessed with respect to the procedure code.
WI Stat § 146.903 — Disclosures required of Health care providers and hospitals: Miscellaneous Health Provisions:
Requires each hospital to provide charge information: 1) The median billed charge; 2) The average allowable payment under Medicare; and 3) The average allowable payment from private, 3rd- party payers. The charge information is for inpatient care for each of the 75 diagnosis- related groups and for each of the 75 outpatient surgical procedures identified. This information must be made available to consumers at no cost or can be made available online.

Expansion of DOI Authority

WI Stat § 625.13 — Filing of rates and consent to rate: Insurance–Rate Regulation:
Requires the company to send the rate adjustment to the state insurance board for filing, but does not require insurance companies to receive approval for a new insurance rate.
WI Stat § 625.11 — Rate Standards:
Vests prior approval authority in the insurance commissioner only for subsets of the insurance market.

Creating or Reducing Barriers to New Entrants

WI Stat § 150.93 — Moratorium on construction of hospital beds: Moratorium on Construction of Hospital Beds:
Limits the maximum number of beds in approved hospitals to 22,516.
WI Stat § 609.22 — Access Standards: Defined Network Providers:
A defined network plan shall include a sufficient number, and sufficient types, of qualified providers to meet the anticipated needs of its enrollees, with respect to covered benefits, as appropriate to the type of plan and consistent with normal practices and standards in the geographic area.

Appendix

WYOMING

Antitrust

WY Stat §§ 40-4-101 through 40-4-105 — Discrimination:
States that If complaint shall be made to the attorney general of the state of Wyoming, or the county attorney of any county thereof, that any corporation, chartered in this state or any foreign corporation, doing business in this state by virtue of compliance with the laws thereof, or any person or firm of persons doing business in this state, is guilty of unfair discrimination, within the terms of this act [§§ 40-4-101 through 40-4-105], it shall be the duty of the attorney general, and the county attorneys of this state to institute an inquiry as to such discrimination, giving to the party complained against notice and reasonable opportunity to be heard, and if in the judgment of such prosecuting officers, or either of them, any corporation, foreign or domestic, or any person or firm of persons shall have been guilty of unfair discrimination, within the terms of this act, it shall be their duty to institute quo warranto proceeding, to forfeit the charter of said domestic corporation, or if a foreign corporation to procure an order of court to cause the permit of said corporation to do business in this state, immediately forfeited.
WY Stat §§ 35-24-101 through 35-24-116 — Health Care Cooperative Arrangements for Anti-trust Exemptions:
States that the legislature finds that the policies specified under subsection (a) of this section will be significantly enhanced by cooperative arrangements including joint ventures and similar enterprises, and contracts among health care providers and purchasers, and certain collaborative agreements between third party payors and health care providers, that might otherwise be prohibited by federal and state antitrust laws if undertaken without governmental involvement. The legislature declares that the formation and operation of cooperative arrangements be the subject of government regulation by the state and that state regulation be substituted for the marketplace and market competition. The legislature intends by provisions of this chapter, that approval of cooperative arrangements among health care providers, purchasers and third party payors be accompanied by appropriate conditions and ongoing supervision and regulation of the operations of the cooperative arrangements, in order to protect against any abuses and to effectively except the actions of approved and regulated cooperative arrangements from state and federal antitrust liability.
WY Stat § 17-19-1102 — Limitations on mergers by public benefit or religious corporations: Wyoming Nonprofit Corporation Act:
Without the prior approval of a district court in a proceeding which the secretary of state has been given written notice, a public benefit or religious corporation may merge only with certain organizations.
WY Stat § 17-19-1111 — Limitations on consolidations by public benefit or religious corporations: Wyoming Nonprofit Corporation Act:
(a) Without the prior approval of the district court in a proceeding which the secretary of state has been given written notice, a public benefit or religious corporation may consolidate only with: (i) A public benefit or religious corporation; (ii) A foreign corporation that would qualify under this act as a public benefit or religious corporation; (iii) A wholly-owned foreign or domestic business or mutual benefit corporation, provided the new corporation is and will continue to be a public benefit or religious corporation; (iv) A governmental subdivision; or (v) A business or mutual benefit corporation, provided that: (A) On or prior to the effective date of the consolidation, assets with a value equal to the greater of the fair market value of the net tangible and intangible assets, including goodwill, of the public benefit corporation or the fair market value of the public benefit corporation if it were to be operated as a business concern are transferred or conveyed to one (1) or more persons who would have received its assets under W.S. 17-19-1406(a)(v) and (vi) had it dissolved; (B) It shall return, transfer or convey any assets held by it upon condition requiring return, transfer or conveyance, which condition occurs by reason of the consolidation, in accordance with the condition; and (C) The consolidation is approved by a majority of directors of

each public benefit or religious corporation who are not and will not become members or shareholders in or officers, employees, agents or consultants of the new corporation.

Competitive Behavior in Health Plan Contracting

WY Stat § 26-22-503 — Policies with incentives or limits on reimbursement authorized; conditions: Hospital or Medical Service Insurance and Prepaid Health Service Plans:
Any provider willing to meet the established requirements has the right to enter into contracts relating to health care services.
WY Stat § 26-34-134 — Written agreement with providers; discrimination prohibited: Health Maintenance Organizations:
Providers willing to meet an HMO's established terms shall not be denied the right to contract. An HMO may not discriminate against a provider on the basis of the provider's academic degree.

Expansion of DOI Authority

WY Stat § 26-18-135 — Filing of rates; adherence to rates filed: General Provisions:
Required prior approval for HMO rate increase only.

Appendix B