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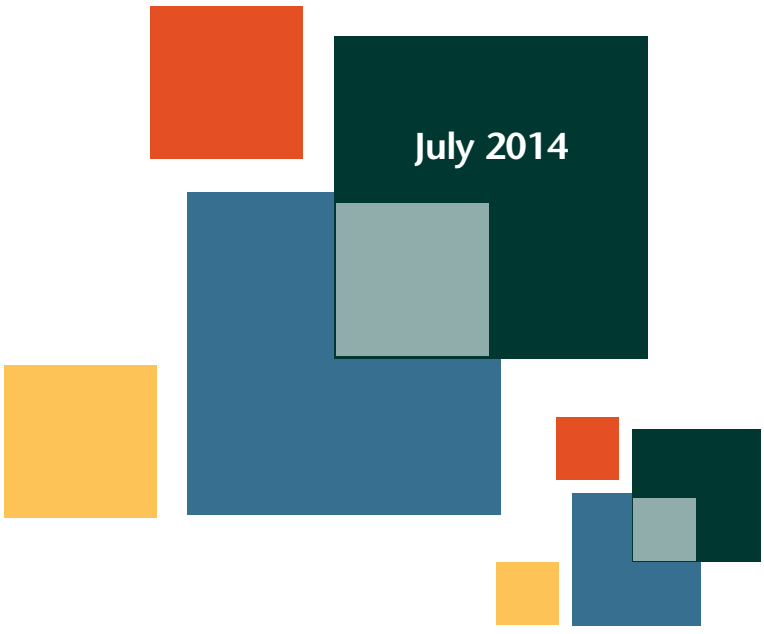
CATALYST FOR PAYMENT REFORM

State Policies on Provider Market Power

Suzanne Delbanco and
Shaudi Bazzaz



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Catalyst for Payment Reform (CPR) is an independent, non-profit organization working on behalf of large employers and other health care purchasers to catalyze improvements in the way healthcare services are paid for and to promote better and higher value care in the United States.

CPR has a shared purchaser agenda for payment reform along with tools that catalyze change in the marketplace and align public and private-sector strategies. CPRs shared purchaser agenda pushes for value-oriented payment as well as progress in specific areas, such as price transparency, reference pricing, maternity care payment reform, and enhancing provider competition.

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Study Panel on Addressing Pricing Power in Health Care Markets

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The views expressed in this report are those of the study panel members and do not necessarily reflect those of the organizations with which they are affiliated.

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Introduction

Today, health care expenditures account for nearly all projected structural deficits at the federal level[1] and for a major – if not the major – component of state budget outlays each year.[2] As costs continue to rise while health care quality continues to vary, all purchasers of health care – including large employers, the federal government and state governments – face the challenge of ensuring they are purchasing high quality care at affordable prices.

Health care economists broadly agree that the market power of certain health care providers is a major driver of price increases, and is associated with significant payment variation across and within markets for both hospital and physician services, each of which are significant contributors to health care spending.[3] Moreover, this increase in prices has historically had no demonstrated correlation to improved care quality.[4]

Because of their reputation or dominant presence in a given geography, many providers have negotiating leverage when contracting with health plans. They may be the premier provider of a particular medical service in the area – or at least perceived to be. Another factor is the recent wave of provider mergers and acquisitions. While the potential benefit of integrated care can result from mergers and acquisitions, there is also fear – based on well-documented historical trends – that unless we manage it carefully, growing provider market power can lead to even higher prices.

There are a number of interventions, market-based and/or regulatory, that could improve competition among health care providers. The National Academy of Social Insurance (NASI) commissioned Catalyst for Payment Reform (CPR) to research regulatory approaches, specifically recent state efforts to enhance the competitiveness of health care markets and reduce the ability of providers to use market power in such a way that creates negative consequences for those who use and pay for care. Specifically, this paper catalogues existing state statutes and regulations that address the contracting practices of health plans and providers likely to reduce competition and lead to higher prices. In doing so, this paper provides insight into the current scope of state authority to regulate and monitor health care prices. In addition, because states may pursue policies that would not be captured in a review of laws and regulations, this paper also explores efforts beyond the legislative realm by states taking an active role to address these issues.

Methodology

CPR used both database analysis and interviews to capture state policy efforts to enhance competition in the health care market.

First, CPR catalogued statutes and enacted laws using the WestLawNext database, LexisNexis, and websites from various state legislatures. The scope of the paper is limited to state activity only, and does not include a review of federal laws and regulations. These searches were systematically structured around the categories below, which together capture the likely range of possible state activity.

Antitrust related laws

All states have antitrust statutes in place that give them the authority to analyze and either condition or potentially put a stop to mergers that reduce competition in the marketplace. While the laws themselves

are not specific to health care, it is critical to examine how the state courts have interpreted them and the degree of resources made available for enforcement to determine how the state has impacted the shape of the health care marketplace.

Laws and regulations encouraging transparency on quality and price

Some states have passed laws and implemented regulations to promote the transparency of price and quality information. Such transparency can help to expose variation in the prices for care and the quality of care. For this review, we contained our search to statutes and regulations directly limiting the suppression of pricing information (e.g. gag clauses) and/or creating an environment in which payers can reasonably incentivize consumers to make health care decisions based on price (specifically contracted rates) and quality information.

Laws and regulations encouraging competitive behavior in health plan contracting

Regulating health plan contracting practices can mitigate the impact on prices resulting from provider leverage. 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 and regulations implementing the monitoring or regulating of prices

Laws intended to monitor or regulate prices can modulate the impact of provider market power. Approaches range from establishing an independent body to monitor provider prices, to setting caps on price increases, to complete market rate regulation. Such stipulations on how providers can negotiate their prices limit their ability to exert market power.

Laws and regulations around development of ACOs

To form Accountable Care Organizations (ACOs), health care providers may establish new relationships with each other that enhance their power in the marketplace, whether they intend that outcome or not. Laws and regulations could set standards to maintain competition among providers within the ACO or between the ACO and other ACOs or other provider systems.

Laws and regulations expanding the authority of Departments of Insurance

Expansion of the Department of Insurance's (DOI) jurisdiction over regulating the health care market can limit the impact of providers with disproportionately high market power. Particularly since the Affordable Care Act pushes for setting standards for the review of proposed rate increases, 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 contracts actively, the DOI could limit provider rate increases.

Laws and regulations facilitating or reducing barriers for new entrants to the market

Existing Certificate of Need Laws (CON), for example, may limit the ability of new providers to enter a market. New entrants into a market can create competition for the incumbent and/or dominant providers. Fostering an environment that supports new entrants can have a disruptive impact on markets with historically dominant providers.

General web searches through Google provided context and supplemental findings. A summary of the search categories with examples as well as defined search terms is in **Appendix A**.

Second, CPR conducted targeted interviews with state attorney generals, the Federal Trade Commission, academics, and various experts, to identify state activity beyond that already captured in statues and regulations. The list of interviewees and the interview guide are in **Appendices B and C**, respectively.

Catalogue of Laws Used to Enhance Market Competition by State

A catalogue of state laws reveals a range of legislative angles to approach the issue of provider market power. There is some state activity in each of the categories defined in the research methodology above. It is important to note that the success of these activities is likely to be contingent on the regulations that follow and the enforcement of those regulations.

Our research revealed the following trends:

Antitrust related laws

All states have access to antitrust remedies (both federally and through state legislation) allowing them to respond to anticompetitive provider consolidation. The extent to which the law can be applied is most evident through the precedents set in prior cases. A summary of the past five years of anti-competitive merger litigation is in **Appendix D**.

Five states currently have Certificate of Public Advantage statutes that permit exemption to antitrust provisions for providers merging or consolidating for the purposes of cooperation and health care delivery improvements. These transactions are only to be granted if health care prices will be lowered due to the merger and if the benefits of consolidating outweigh the negative impact on market competition.

Laws and regulations encouraging transparency on quality and price

Forty-two states have formalized the release of hospital price or charges (and sometimes quality) data in some capacity. However, it is important to note that statutes intended to release data do not always translate to data that is conveyed in the most transparent and meaningful manner for consumers (see CPR's 2014 Report Care on State Price Transparency Laws).

Laws and regulations encouraging competitive behavior in health plan contracting

Eighteen states have attempted to limit providers' influence through banning "most favored nation" contracting clauses. In practice, a "most favored nation" clause would prevent a provider from charging a health insurer 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.

Nine states have some type of "any willing provider" regulation for health care providers (not including those with pharmacy-only regulations). In general, these regulations require health plans to accept any qualified provider who is willing to agree to the terms and conditions of a plan. Any willing provider laws are not uniform state-to-state. In the scenario where these regulations limit a carrier's ability to develop selective, high-value provider networks, a plan's ability to manage costs in a consolidated market may be limited.

Laws and regulations implementing the monitoring or regulating of prices

A growing number of states are forming regulatory bodies to monitor health care prices. Delaware, Maryland, Massachusetts, New York, Pennsylvania, and West Virginia all have statutes establishing health care commissions to monitor and review health care prices.

Laws and regulations around development of ACOs

While there are an increasing number of ACOs nationwide, there is limited state law governing ACOs. Texas is the only state that has enacted legislation that requires review of the impact on market competition during the development and implementation of ACOs. Some states that have enacted legislation supporting the development of ACOs (e.g. Alabama) have included provisions intended to grant provider groups exemptions from state antitrust laws and immunity from federal antitrust laws through the state action doctrine.

Laws and regulations expanding the authority of Departments of Insurance (DOI)

Though most states have a formal rate review program, only Rhode Island has expanded the authority of the DOI to include conditions of approval to limit annual maximum price increases for inpatient and outpatient services to the Centers for Medicare & Medicaid Services (CMS) hospital price index.

Laws and regulations facilitating or reducing barriers for new entrants to the market

Thirty-one states have a Certificate of Need requirement. The extent to which these laws limit the ability of new, lower cost providers to enter the market varies by state. A detailed summary of state Certificate of Need requirements is available **here**.

A growing number of states are addressing the topic of telehealth and beginning to expand telehealth policies in an attempt to address barriers to its use.[5] Setting up a regulatory environment promoting telehealth as a viable option in a market can mitigate some of the effect of provider market power by supporting a lower-cost option for care and helping to control utilization of overpriced services, both of which could help to spur competition in the market.

A complete catalogue of the laws and regulations used by states to enhance market competition or limit provider market power that we identified in our research is in **Appendix E**. An interactive map and continuously updated information on laws and regulations like those listed in Appendix E can be found on the newly released resource, *The Source for Competitive Healthcare* by UC Hastings College of the Law.

State Activity Beyond Statutes and Regulations

Through our review of state laws and regulations and interviews with national experts in health law and health economics, CPR found a short list of states – California, Massachusetts, New Hampshire, New York, Pennsylvania, and Rhode Island – thought to be particularly active in their policy efforts regarding health care provider consolidation and market power. In each of these states, CPR interviewed policy leaders to deepen our understanding of their strategies, particularly strategies that we could not have captured in our review of the laws and regulations. A summary of what we found by state is below.

Across the five states, the general trends we identified include:

- The most common strategy employed by states to maintain a competitive health care market is to block potential mergers under their 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 within it an antitrust bureau.

- A few states are attempting to regulate competition by allowing mergers to occur through conditional settlements. These conduct remedies are designed to enhance competition and limit the ability of the newly consolidated to leverage higher rates due to their increase in market share. Both New York and Pennsylvania have implemented conditional provisions as part of a merger settlement. For example, in Pennsylvania, a conduct remedy resulted in the acquiring health care system not being able to raise prices to commercial payers for at least five years. The success of these conditions has yet to be proven and will ultimately be determined by how well the conditions are implemented and enforced.

- Some of these states are actively working to bring public awareness to the issue of provider market power. Regulatory bodies are being given the authority to collect, monitor, and analyze provider pricing data. None of these actions have been linked with the specific ability to address the consequences of provider market power. The data have, however, proved instrumental to litigation against potentially harmful mergers.

California

In 2012, the California Department of Justice issued civil investigative demands to a number of California hospital networks as part of the state Attorney General's focus on the impact of consolidation of services in the health care sector on medical care costs to consumers. The investigation, still ongoing, is focusing on whether mergers and acquisitions have given health systems enough market power to increase prices in violation of state antitrust laws. The Office of the Attorney General continues to monitor hospital transactions for possible antitrust violations.

The Office of the Attorney General's Antitrust Law Section also works closely with the Charitable Trusts Section to maintain a competitive health care market. California law requires the Attorney General'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 in the State through registration, education, and enforcement. In cases where a potential material change in ownership is occurring with a nonprofit facility, the change must be reviewed by the Attorney General'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 Attorney General's office significant resources because a formal antitrust trial can be avoided.

California has also pursued legislative efforts to limit providers' ability to suppress price information. SB 1196, which was passed into law September 2012, states that "no health insurance contract in existence or issued, amended, or renewed on or after January 1, 2013, 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."[6]

Massachusetts

Massachusetts is taking a number of steps to address the growing burden of health care costs. The Commonwealth's health care cost containment law set the Gross State Product as a statewide benchmark for the growth of total health care expenditures (3.6 percent in 2013). The law, entitled "An Act Improving the Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency and Innovation" establishes the Health Policy Commission (HPC) to monitor healthcare delivery and payment reform. The HPC is also tasked with developing policy to reduce overall cost growth while improving quality. One specific task of the HPC is to review and monitor material changes by provider organizations. The HPC tracks the frequency, type, and nature of changes in the Massachusetts's health care market. Transactions anticipated to have a significant impact on the market are subject to a comprehensive review by the HPC. The HPC conducts a "cost and market impact review" (CMIR), which is released as a public report detailing its findings. Transactions cannot be finalized until the HPC issues 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 against the transaction is needed. The HPC also has the authority to levy fines up to $50,000 to ensure compliance with the performance improvement process.

In 2014, the HPC issued a report to Massachusetts' Attorney General Martha Coakley cautioning that the proposed Partners' takeover of South Shore Hospital and affiliated Harbor Medical Associates would result in higher costs and reduced competition.[7] In May 2014, Attorney General Martha Coakley reached an agreement with Partners HealthCare that will allow them to acquire South Shore Hospital and Hallmark Health Systems. The agreement allows payers to split Partners into separate contracting entities for up to 10 years; prevents Partners from contracting with affiliate physician groups that are not part of its owned hospital for 10 years; caps health costs at the rate of inflation across the entire Partners network through 2020; caps Partners physician growth for five years; and blocks further hospital expansion in eastern Massachusetts, including Worcester County, for the next seven years.[8]

New Hampshire

New Hampshire's Insurance Department (NHID) is responsible for bringing more transparent price information to consumers. The NHID includes rate transparency to the public as part of its mandate to review rates. NHID is currently working to reach more consumers with rate information through a "Consumer Guide to Rate Review" and an All Payer Claims Database. The NHID is also exploring the nature of cost shifting in the market and investigating potential relationships between public payer hospital reimbursement and prices paid by commercial insurance companies.

New York

New York is addressing the issue of maintaining a competitive health care market through active scrutiny of proposed hospital mergers. In December 2013, the New York Office of the Attorney General entered into a settlement with St. Elizabeth Medical Center (SEMC) and Faxton-St. Luke's Healthcare (FSL), allowing them to affiliate under a single parent entity under specific terms design to address anti-competitive concerns. Specifically, the settlement requires a minimum five-year period during which the providers can negotiate contracts jointly, but in cases where an agreement cannot be reached, the providers can enter into separate agreements. The settlement also establishes a rate protection period specifying that negotiated rates cannot exceed the December 2013 contracted prices negotiated prior to the merger. The

hospitals must develop a "Statement of Proposed Activities" including proposed clinical integration, improvements in efficiency, and quality benchmarks. The plan is then subject to review and monitoring by the Attorney General. If the hospitals succeed in following the approved plan, the Attorney General will grant certification that they have achieved the agreed upon efficiencies and integration. If they have not achieved the goals outlined, the rate protection period described above will extend beyond the five-year mark until efficiencies are achieved. The settlement also prohibits exclusionary contracting practices and preserves access to reproductive services.[9]

Pennsylvania

Since 1986, Pennsylvania has had an independent state agency to contain costs and to stimulate competition in the health care market. The Pennsylvania Health Care Cost Containment Council is tasked with delivering comparative information about the most efficient and effective health providers to consumers and purchasers of health services as well as delivering information to health care providers to help them identify opportunities to contain costs and improve quality. In addition to collecting and analyzing price information, the Council is tasked with making recommendations about proposed or existing mandates.

Pennsylvania pursues a competitive health care market by actively limiting hospital consolidation. In 2013 when Geisinger Health System was expanding, the Office of the Attorney General worked with Geisinger to safeguard patient access to care and maintain affordable care. Specifically, Geisinger and the Office of the Attorney General reached an eight-year agreement that limits "arbitrary price increases for hospital and physician services," ensures the ability to build tiered products based on cost and quality, and requires maintenance of existing contracts with the acquired hospital (Lewiston Hospital) with a provision specifying that future contracts be negotiated in good faith within a similar price range.[10] The Attorney General's office will continue to use settlements with requirements designed to monitor the impact of mergers on the health care market, particularly the impact on prices, to help preserve market competition following consolidation. The Pennsylvania Attorney General's office anticipates using conduct remedies, similar to the one issued with Geisinger, as a way to address hospital transactions that threaten to reduce competition.

Rhode Island

Rhode Island's Department of Insurance is leading the way in maximizing the impact of a DOI's authority to review rates. The state's Office of the Health Insurance Commissioner (OHIC) was established by legislation in 2004 to broaden the accountability of health insurers. The OHIC is tasked 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 state identified health plan rate review as an effort that could help to address the underlying cost trend. The rate review process includes a limit on annual maximum price increases for inpatient and outpatient services to the CMS hospital price index as a condition of approval. Contracts between health plans and providers are required to include performance incentives based on no fewer than three nationally accepted clinical quality, service quality or efficiency-based measures and mutual obligations for greater administrative efficiencies.[11]

Looking Ahead: Potential State Activity

Antitrust

States traditionally rely on antitrust litigation to manage provider market power and some recent successes may encourage more action in this space. However, these cases are expensive and time consuming, and states must be very selective in the cases they choose to pursue.

In cases where a state does not want to go to trial, conduct remedies seem to be gaining traction, though the long-term impact of these remedies is unknown. Many of these remedies last only five years, which may not be adequate to preserve a competitive market long-term. Additionally, these remedies often include resource-intensive monitoring that states may not be able to maintain.

ACOs and safe harbors

Collaboration among health care providers to coordinate care is not inherently an antitrust violation and more states may allow providers to integrate as ACOs without being subject to state antitrust regulation. Under ACOs, providers have the ability to join for contracting purposes, allowing them to expand their negotiating power, without actually consolidating, making the development and regulation of ACOs an important issue when assessing provider market power. In developing regulations for commercial ACOs, states will want to consider how they may impact competition among health care providers and whether they have the resources and expertise to regulate and monitor ACOs.

Transparency on quality, price and consolidation

When looking across the more active states, efforts to enhance quality and price transparency, including through the development of all payer claims data bases and public websites, may put pressure on provider prices. State interest in All Payer Claims Databases is growing and 21 states have received federal funding to support the development of these databases.[12] A recent study in New Hampshire showed greater awareness of price variation, the introduction of new benefit designs, and agreements by some providers to lower rates, following the launch of the state's price transparency website. State efforts to review and monitor the impact of consolidation on health care prices, such as the work of Massachusetts' Health Policy Commission, may also spread.

Collaboration across and within state agencies

California's unique use of its regulations for charitable organizations strengthens the ability of the Attorney General to review and reject provider consolidation that is not in the public interest. Other states may look to expand the scope of laws and regulations they turn to for governing new potential provider relationships.

Departments of Insurance

More states may look to rate review and regulation of health insurance payments to providers as a means to counter the ill effects of growing provider market power. Additionally, setting limits on the amount health care premium rates can increase limits the health plan's ability to pass increases in price due to provider market power on to the consumer. The Affordable Care Act requires that proposed increases of ten percent or more will be evaluated by independent experts to assess whether the proposed increases are based on reasonable cost assumptions and solid evidence. Early findings from this policy change are promising.[13] When exploring these options, states should consider how standards for rate increases may encourage providers to push automatically to maximize the rate increase to the set limit.

Conclusion

Within health care markets, policy makers face the difficult challenge of balancing the need for delivery system integration with the potentially anticompetitive effects of increased provider market power. The potential benefits of consolidation must be carefully weighed against the possible harm of higher prices in individual markets. The policy interventions we outline are one set of interventions designed to create this balance. Clearly, there are other interventions, including market-based strategies that employers and other large health care purchasers and health plans can implement. Greater analysis and further experience is required to determine how to best gain the benefits of provider alignment while avoiding the anticompetitive effects of increased market power.

Appendix A:
Search Categories with Examples and Search Terms

General Category	Examples	Search Terms
Antitrust related laws	• State competition laws • Interpretation of state laws	• Antitrust • Monopoly • Merger • Acquisition • Market share • Exclusionary contract • Anticompetitive • Consolidate • Collaboration
Laws and regulations encouraging transparency on quality and price	• State comparison shopping tool • Limitations on gag clauses • Prohibiting information as "trade secret" • Requiring disclosure on rate approvals	• State comparison shopping tool • All payers claims database • Hospital cost and quality reporting information • Physician cost and quality reporting information • Restricts the ability of the health care service plan • Furnish information to subscribers or enrollees of the plan • Proprietary information • Proprietary business nature • Confidential business nature or confidential treatment
Laws and regulations encouraging competitive behavior in health plan contracting	• Limiting most favored nation agreements • Removing restrictions on plan's ability to offer tiered products (e.g. no "anti-tiering" legislation) • Limiting "all or none" contracting for hospital systems • Limiting rate increases by providers to health plans	• Market intervention tools • Competitive markets • Price transparency • Price regulation • Disclosure of prices • Proprietary information • Ensure cost containment in health care • Oversight committee or board
Laws and regulations implementing the monitoring or regulating of prices	• 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	• Market intervention tools • Competitive markets • Price transparency • Price regulation • Disclosure of prices • Proprietary information • Establishes a board of directors to ensure cost-containment in health care • Create a system-wide budget and pursue payment reform • Oversight committee or board

General Category	Examples	Search Terms
Laws and regulations around development of ACOs	• Limits on exclusivity contracts	• Defines an accountable care organization as • Includes ACOs in definition of managed care • Exemption from corporate practice of medicine • Antitrust safe harbor protections • Prohibits provider contract terms, except those involving ACOs, to be effective until approved by the Attorney General • Access to de-identified claims data of the medical assistance recipients receiving health care services • Waivers of HMO laws (Montana) • Gain-sharing model or game-sharing plan • Improving quality and efficiency of care
Laws and regulations expanding the authority of Departments of Insurance	• Rate review • Disclosure requirements • Increased contract scrutiny	• Disclosure requirements • Rate regulation or rate review • Prior approval • Review contracts between insurers and/or health plans and providers • Review by the State Insurance Commissioner
Laws and regulations facilitating or reducing barriers for new entrants to the market	• Certificate of need	• Exclusive contracts • Certificate of need • Certificate of public advantage

Appendix B:
List of Active State Interviews

Name	Organization
Cory Capps	Partner, Bates White Consulting
Rachel Davis	Assistant Attorney General, Connecticut Office of the Attorney General
James A. Donahue III	Chief Deputy Attorney General, Pennsylvania Office of the Attorney General
David Dranove	Walter McNerney Professor of Health Industry Management, Northwestern University's Kellogg School of Management
Kathleen Foote	Senior Assistant Attorney General, California Department of Justice
Martin Gaynor	Director, Bureau of Economics, Federal Trade Commission
Dan Gilman	Attorney Advisor, Competition Policy at Federal Trade Commission
Christopher F. Koller	President, Milbank Memorial Fund; Former Rhode Island Health Insurance Commissioner
Robert Mechanic	Senior Fellow, the Heller School of Social Policy and Management at Brandeis University and Executive Director of the Health Industry Forum
Robert Murray	Global Health Payment Consulting, Former Executive Director of the Maryland Health Services Cost Review Commission
Thomas O'Brien	Assistant Attorney General, Chief, Health Care Division, Office of the Attorney General of Massachusetts
John Powell	Assistant Deputy Superintendent for Health, New York State Insurance Department
Eric Stock	Chief, Antitrust Bureau, Office of the Attorney General of the State of New York
Karen Tseng	Director of Policy for Market Performance, Massachusetts Health Policy Commission

Appendix C:
CPR Market Power State Activity Interview Guide

1) Please describe the level of focus of your office on consolidation among health care providers and provider market power.

2) Which potential ill effects most concern your office or agency and what steps is it taking to mitigate them?

3) Is your state Attorney General's office currently pursuing again anti-merger litigation with hospitals or other health care providers?

4) Does your Attorney General pursue limiting provider market power through means other than anti-trust legislation? If so, please explain.

5) Are there any proactive efforts in your state to enhance competition among health care providers?

6) Does your Attorney General's office have a long term strategy to combat consolidation or provider market power in the healthcare market? What strategies do you envision the state trying in the future?

7) How has the legislature or insurance commissioner gotten involved?

8) What are the politics in your state like over these issues?

9) What other states are you aware of that are pursuing these issues proactively? How are they going about it?

Appendix D: Review of Recent Hospital Merger Litigation (2009-2014)

State	Date	Summary	Ruling
Alabama and South Carolina	January 22, 2014	Community Health Systems' (CHS) acquisition of rival health system Health Management Associates.	The FTC required CHS to divest hospitals and related assets, including outpatient facilities, in Alabama and South Carolina as a condition of the $7.6 billion merger.
Georgia	August 22, 2013	The FTC challenged Phoebe Putney Health System, Inc.'s (Phoebe's) proposed acquisition of rival Palmyra Park Hospital, Inc. (Palmyra) from Hospital Corporation of America, in Albany, Georgia. The FTC's administrative complaint alleges that the deal will reduce competition significantly and allow the combined Phoebe/Palmyra to raise prices for general acute-care hospital services charged to commercial health plans, substantially harming patients and local employers and employees. The FTC also alleges that Phoebe has structured the deal in a way that uses the Hospital Authority of Albany-Dougherty County (the Authority) in an attempt to shield the anticompetitive acquisition from federal antitrust scrutiny under the "state action" doctrine. The FTC's staff, together with the Attorney General of the State of Georgia, filed a separate complaint in federal district court in Albany, Georgia, seeking an order to halt any transaction involving Phoebe, the Authority, or Palmyra, under which Phoebe would acquire control of Palmyra's operations, until the conclusion of the FTC's administrative proceeding and any subsequent appeals. On 2/19/2013, the Supreme Court reversed the judgment of the Court of Appeals and remanded further proceedings.	The Hospital Authority of Albany-Dougherty County and Phoebe Putney Health System have agreed to settle FTC charges that the acquisition of rival Palmyra Park Hospital harmed competition in six Georgia counties.

State	Date	Summary	Ruling
Arkansas	June 27, 2013	FTC was investigating Capella Healthcare's proposed merger with rival Mercy Hot Springs health system in Hot Springs, Arkansas. However, Capella then announced that it was abandoning its plans to acquire Mercy Hot Springs.	N/A
Idaho	March 12, 2013	"The FTC, together with the Idaho Attorney General, filed a complaint in federal district court seeking to block St. Luke's Health System, Ltd.'s acquisition of Idaho's largest independent, multi-specialty physician practice group, Saltzer Medical Group P.A. According to the joint complaint, the combination of St. Luke's and Saltzer would give it the market power to demand higher rates for health care services provided by primary care physicians (PCPs) in Nampa, Idaho and surrounding areas, ultimately leading to higher costs for health care consumers. Effective December 31, 2012, St. Luke's acquired all of Saltzer's personal property and equipment. The deal transferred to St. Luke's the power to negotiate health plan contracts on Saltzer's behalf and to establish rates and charges for services provided by Saltzer physicians. Saltzer, on behalf of its physicians, has also entered into a five-year professional services agreement with St. Luke's."[14]	On January 24, 2014, after a bench trial, a federal district court in Idaho held that the acquisition violated Section 7 of the Clayton Act and the Idaho Competition Act, and ordered St. Luke's to fully divest itself of Saltzer's physicians and assets.
Texas	December 23, 2009	FTC investigated the Scott & White Healthcare merger with King's Daughters Hospital in Central Texas. However, the FTC closed its investigation without taking any action.	N/A

Appendix E: Catalogue of Laws Used to Enhance Market Competition by State

Category	Statute # (linked)	Description
Alabama		
Encouraging Transparency	Ala. Code. § 560-X-23-.11-.16	Requires a new facility to submit a budget of cost for Medicaid inpatient services for its initial cost reporting period. The Alabama Medicaid Agency will determine a per diem rate from this budget. After the budget period, an actual cost report will be filed for the budgeted period. The Alabama Medicaid Agency will calculate a per diem rate in order to determine if any under or overpayment has been made to the hospital.
Competitive Behavior in Health Plan Contracting	Ala. Code § 27-1-19	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	Ala. Code § 22-6-150 through 22-6-164 (Enabling Legislation: 2013 Al. SB 340)	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	Ala. Code § 27-13-2, 27-14-8	Requires rate filing and prior approval for HMOs and Blue Cross Blue Shield. Requires filing rate for commercial not carriers (approval required).
Facilitating or reducing barriers to New Entrants	Ala. Code § 22-21-260 through 22-21-277:	Certificate of need guidelines and principles.
Facilitating or reducing barriers to New Entrants	Ala. Admin. Code r. 410-2-4-.01 through 4-.15 (Regulation)	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.
Alaska		
Expansion of DOI Authority	Alaska Stat. § 21.51.405: Regulation: 3 AAC 31.235 Enacted bills: § 27 ch 1 FSSLA 2005; am § 62 ch 23 SLA 2011	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.
Expansion of DOI Authority	Alaska Stat. § 21.87.180: Filing and approval of agreements and contracts	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.
Facilitating or reducing barriers to New Entrants	Alaska Stat. § 18.07.031	Certificate of need guidelines and principles.
Arizona		
Encouraging Transparency	Ariz. Rev. Stat. §§ 36-436 through 436.03	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.

Category	Statute # (linked)	Description
Arizona (continued)		
Encouraging Transparency	Ariz. Rev. Stat. § 36-437 Enacted Bill: 2013 Ariz. HB 2045	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.
Encouraging Transparency	Ariz. Rev. Stat. § 36-125.06.	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.
Encouraging Transparency	Ariz. Admin. Code R9-10-209	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).
Expansion of DOI Authority	Ariz. Admin. Code R20-6-607	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.
Expansion of DOI Authority	Ariz. Admin. Code R20-6-2301 to R20-6-2305	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.
Expansion of DOI Authority	Ariz. Admin. Code R20-6-2301 to R20-6-2305	Provides the Arizona DOI the authority to review any individual major medical PPO or indemnity rate increase where the average increase for all enrollees weighted by premium volume is 10% or more.
Arkansas		
Encouraging Transparency	Ark. Code § 20-7-301 to 306	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.
Encouraging Transparency	Ark. Code § 20-8-401 through 403	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 databases; (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.
Encouraging Transparency	Ark. Code. § 20-7-301 et.seq.	All hospitals and outpatient surgery centers must submit complete billing, medical, and personal information describing a patient, the services received, and charges billed directly to the Arkansas Department of Health, Hospital Data Section.
Competitive Behavior in Health Plan Contracting	"Patient Protection Act of 1995" Ark. Code § 23-99-20 to 23-99-209	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.
Facilitating or reducing barriers to New Entrants	Ark. Code § 18.07.010 through 18.07.111	Requires department to administer certificate of need program.

Category	Statute # (linked)	Description
California		
Antitrust	Cal. Bus. Code § 16600 through 17365	Preservation and Regulation of Competition.
Antitrust	Cal. Bus. Code § 16770	Effect of antitrust prohibitions on health care services.
Antitrust	Cal. Health and Safety Code § 1342.6	Effect of antitrust prohibitions on health care services.
Antitrust	Cal. Bus. Code § 17200	Defines general unfair trade practices for the market generally; limits monopoly power.
Encouraging Transparency	Cal. Health and Safety Code § 1367.50	Requires claims data disclosure.
Encouraging Transparency	Cal. Ins. Code § 10117.52	Requires claims data disclosure.
Encouraging Transparency	Cal. Health and Safety Code § 1339.51, § 1339.55	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).
Encouraging Transparency	Cal. Health and Safety Code § 1339.56	Requires hospitals to annually submit to OSHPD a list of the 25 common outpatient procedures and the average charges for these procedures. OSHPD will publish this information online.
Encouraging Transparency	Cal. Health and Safety Code § 1339.585	Requires hospitals to provide to the uninsured written estimates for the cost of care provided to the person by the hospital based on an average length of stay and services provided for the person's diagnosis.
Encouraging Transparency	Cal. Health and Safety Code § 128735	Requires health care facilities to submit a statement detailing patient revenue by payer and hospital discharge data to OSHPD.
Expansion of DOI Authority	Cal. Admin. Code tit. 10, § 2222.11 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) of Section 10293.
Expansion of DOI Authority	Cal. Ins. Code § 10293	Authority for commissioner to consider reasonableness of premiums (but CA does not have prior approval).
Facilitating or reducing barriers to New Entrants	Cal. Code Regs. tit. 10, § 2240-2240.5	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.
Colorado		
Encouraging Transparency	Col. Rev. Stat. § 10-16-104	Reporting of health care and quality data to enable transparency. Also contains mandatory coverage provisions.
Encouraging Transparency	https://www.cohealthdata.org/#/home	Searchable all-payer claims database showing health care costs and utilization by geography.
Competitive Behavior in Health Plan Contracting	Col. Rev. Stat. § 25-37-101	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	Col. Rev. Stat. § 25-3-105	Authorizes state board of health to establish a fee schedule
Regulation around Development of ACOs	Col. Rev. Stat. § 12-36.5-104	Effective July 1, 2012. Contains a provision which allows an ACO created under the Affordable Care Act to qualify as a professional review committee.

Category	Statute # (linked)	Description
Colorado (continued)		
Expansion of DOI Authority	Col. Rev. Stat. § 10-16-133	The Insurance Commissioner is required to maintain a consumer guide on its website to allow consumers to make more informed health care decisions. Information on the website must be derived from information submitted by carriers to the Division of Insurance. The website guide must include information that the Commissioner deems useful to consumers of health insurance.
Connecticut		
Antitrust	Conn. Gen. Stat. §§ 35-24 through 35-46	Connecticut Antitrust Act
Antitrust	Conn. Gen. Stat. § 42-110b	Defines general unfair trade practices for the market generally; limits monopoly power.
Antitrust	Conn. Gen. Stat. § 35-50 through 35-58	Expands the U.S. Trade Secret Act's definition of trade secret.
Encouraging Transparency	Conn. Gen. Stat. § 19a-612, 613	Establishes the Office of Health Care which is tasked to collect patient-level outpatient data from health care facilities or institutions.
Encouraging Transparency	Conn. Gen. Stat. § 19a-654	Establishes an Office of Health Care Access.
Encouraging Transparency	Conn. Gen. Stat. §§ 19a-634	Establishes data submission requirements and guidelines to the Office of Health Care Access.
Encouraging Transparency	Conn. Gen. Stat. § 38a-1091	State-wide health care facility utilization study. State-wide health care facilities and services plan. Inventory of health care facilities, equipment and services.
Monitoring/Regulating Prices	Conn. Gen. Stat. § 38a-513f	Certificate of need guidelines and principles.
Expansion of DOI Authority	Conn. Gen. Stat. § 38a-676a	Establishes an all-payer claims database program and an All-Payer Claims Database Advisory Group. Includes specification for a state-wide multi-payer data initiative.
Expansion of DOI Authority	Conn. Gen. Stat. § 38a-815, 816	Review of professional liability rates for physicians and surgeons, hospitals, advanced practice registered nurses and physician assistants.
Facilitating or reducing barriers to New Entrants	Conn. Gen. Stat. § 19a-638	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.
Facilitating or reducing barriers to New Entrants	Conn. Gen. Stat. § 19a-639	Certificate of need. When required and not required. Request for office determination. Policies, procedures and regulations.
Delaware		
Encouraging Transparency	Del. Code Ann. tit. 16 § 2003	Details provisions for claims information to be provided to certain employers.
Encouraging Transparency	Del. Code Ann. tit 16 §§ 2004	Requires hospitals and nursing homes to submit charge levels and trends in health care charges to the state agency. The state agency shall prepare and distribute or make available reports to health care purchasers, health care insurers, health care providers and the general public.
Monitoring/Regulating Prices	Del. Code Ann. tit 16 § 9304	Delaware's version of certificate of need is called certificate of public review.

Category	Statute # (linked)	Description
Delaware (continued)		
Monitoring/Regulating Prices	Del. Code Ann. tit. 16 § 9902-9903	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	Del. Code Ann. tit. 16 § 2503, § 2504, § 2507	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.
Florida		
Antitrust	Fla. Stat. §§ 408.18 through 408.185	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 Transparency	Fla. Stat. § 408.05	Establishes a Florida Center for Health Information and Policy Analysis.
Encouraging Transparency	Fla. Stat. § 408.061	Requires health care facilities, health care providers, and health insurers to submit data to the Agency for Health Care Administration.
Encouraging Transparency	Fla. Stat. § 408.062	Requires the Agency for Health Care Administration to conduct research, analyses, and studies relating to health care costs and access to and quality of health care services as access and quality are affected by changes in health care costs.
Encouraging Transparency	Fla. Stat. § 408.063	The Agency for Health Care Administration will distribute collected information in a timely and consistent manner in such a way that promotes public education and informed decision-making.
Encouraging Transparency	Fla. Stat. § 408.09	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.
Encouraging Transparency	Fla. Admin. Code R. 59B-9.030	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	Fla. Stat. § 456.053	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	Fla. Stat. §§ 626.951 through 626.99:	Defines unfair insurance trade practices and provides the state the authority to regulate.
Expansion of DOI Authority	Fla. Stat. § 641.3903	Defines unfair methods of competition and unfair or deceptive acts or practices.
Expansion of DOI Authority	Fla. Stat. §§ 641.437	Provides the state the power to examine and investigate the affairs of every person, entity, or prepaid health clinic in order to determine whether the person, entity, or prepaid health clinic is operating in accordance with the provisions of this part or has been or is engaged in any unfair method of competition or any unfair or deceptive act.
Expansion of DOI Authority	Fla. Stat. §§ 641.44 through 641.441	Prohibits and defines unfair methods of competition and unfair or deceptive acts. Provides the state the authority to regulate these unfair or deceptive acts.

Category	Statute # (linked)	Description
Florida (continued)		
Expansion of DOI Authority	Fla. Stat. § 627.410	Requires all insurance policies or annuity contract forms to be reviewed by the state.
Expansion of DOI Authority	Fla. Stat. § 627.640	Insurers must file classification of risks and premium rates with the Commissioner's office before delivering or issuing policies.
Facilitating or reducing barriers to New Entrants	Fla. Stat. § 408.036, 408.041	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.
Georgia		
Antitrust	Ga. Code Ann. § 10-1-393	Applies provisions of the Fair Business Practices Act to contracts for health care services between a physician and an insurer.
Encouraging Transparency	Ga. Code Ann. § 33-60-5	Requires insurer to provide a notice and an acknowledgement at the beginning of the application for alternative health benefit plan containing the following language in boldface type: "You have the option to choose this Small Business Employee Choice of Benefits Health Insurance Plan which does not provide all of the state mandated health benefits normally required in accident and sickness insurance policies in Georgia. This health benefits plan may provide a more affordable health insurance policy for you, although, at the same time, it may provide you with fewer health benefits than those normally included as state mandated health benefits in policies in Georgia. If you choose this option, please consult with your insurance agent to discover which state mandated health benefits are excluded in this policy."
Competitive Behavior in Health Plan Contracting	Ga. Code Ann. § 33-20-29	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.
Competitive Behavior in Health Plan Contracting	Ga. Code Ann. § 33-20A-62	Contains various prohibitions for managed health care plans, e.g. no post payment audit or retroactive denial of payment.
Competitive Behavior in Health Plan Contracting	Ga. Code Ann. § 33-30-25	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.
Expansion of DOI Authority	Ga. Code Ann. § 33-29A-5	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.
Facilitating or reducing barriers to New Entrants	Ga. Code Ann. § 31-6-40 to 31-6-50	Certificate of need guidelines and principles.
Hawaii		
Expansion of DOI Authority	HRS § 431:14G-101 through 431:14G-112	Prior approval for health maintenance organizations and/or Blue Cross Blue Shield plans only.
Expansion of DOI Authority	HRS § 431:13-103	Defined as unfair methods of competition and unfair or deceptive acts or practices.
Facilitating or reducing barriers to New Entrants	HRS § 323D-43	Certificate of need guidelines and principles.

Category	Statute # (linked)	Description
Idaho		
Competitive Behavior in Health Plan Contracting	Idaho Code Ann. § 41-3443.	Prohibits the use of most favored nation clauses.
Regulation around Development of ACOs	Idaho Code Ann. § 56-263	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.
Illinois		
Encouraging Transparency	Ill. Admin. Code tit. 77 pt. 2500 to 2550	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.
Encouraging Transparency	20 ILCS 2215/4-2	Requires hospitals to submit claims and encounter data for inpatient and outpatient claims and encounter data related to surgical and invasive procedures to the department. Requires each ambulatory surgical treatment center to submit outpatient claims and encounter data collected for each patient to the department. The department will collect and compile this data and publicly disclose it in an understandable and accessible format for consumers. Requires ambulatory surgical treatment centers and hospitals to also report average charges for at least 30 inpatient and 30 outpatient conditions and procedures demonstrating the highest degree of variation in patient charges and quality of care. The department will collect and compile this data and make it available on its website as part of a Consumer Guide to Care.
Encouraging Transparency	20 ILCS 2215/4-4	Requires hospitals to provide to prospective patients the normal charge incurred for any procedure or operation the prospective patient is considering. Requires the posting of a letter that describes the established charges for services, including but not limited to the hospital's private room charge, semi-private room charge, charge for a room with 3 or more beds, intensive care room charges, emergency room charge, operating room charge, electrocardiogram charge, anesthesia charge, chest x-ray charge, blood sugar charge, blood chemistry charge, tissue exam charge, blood typing charge and Rh factor charge.
Competitive Behavior in Health Plan Contracting	215 ILCS 5/370h	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.

Category	Statute # (linked)	Description
Illinois (continued)		
Regulation around Development of ACOs	305 ILCS 5/5-30 Public Act 096-1501 (2011)	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.
Expansion of DOI Authority	215 ILCS 5/355 and Ill. Admin. Code tit. 50 pt. 2026	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. Insurers may not use rates until the Illinois DOI has issued a disposition that rates have been filed.
Facilitating or reducing barriers to New Entrants	20 ILCS 3960/5	Illinois Health Facilities Planning Act: IL certificate of need law.
Indiana		
Encouraging Transparency	Ind. Code Ann. § 16-39-5	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.
Encouraging Transparency	Ind. Code Ann. § 16-21-6	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.
Expansion of DOI Authority	Ind. Code Ann. § 27-8-5-1	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.
Iowa		
Competitive Behavior in Health Plan Contracting	Iowa Code § 191-27.3 (514F)	Establishes, *inter alia*, the minimum requirements for a valid preferred provider agreement. Effective 1999.
Monitoring/Regulating Prices	Iowa Code § 135.166	Memorandum of understanding with department of public health concerning transparency and disclosure of information by hospitals.
Monitoring/Regulating Prices	Iowa Code § 513C.5	Restrictions on premium rates for individual health insurance.
Regulation around Development of ACOs	Iowa Code § 249N.6	Regulates incorporation of ACOs into the Iowa Health and Wellness Provider Network. Effective June 20, 2013.
Regulation around Development of ACOs	H.S.B. 232, 2013	Would create the healthy Iowa 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.

Category	Statute # (linked)	Description
Iowa (continued)		
Expansion of DOI Authority	Iowa Code § 515.102	Interprets I.C. section 515.102 (2009) to require the approval of all certificate of insurance forms before such forms may be used in the state. http://www.iid.state.ia.us/sites/default/files/comissioners_bulletins/bull1004.pdf
Expansion of DOI Authority	Iowa Code § 513C.8	Subject to the commissioner's approval, allows for adoption of a basic health benefit plan and standard health benefit plan for the individual market.
Facilitating or reducing barriers to New Entrants	Iowa Code § 135.61-.83	Certificate of need guidelines and principles.
Kansas		
Encouraging Transparency	K.S.A. 65-4955	Statute regarding improving quality through cooperative agreements. Effective 1994.
Encouraging Transparency	K.S.A. 65-6801	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. Effective July 2012.
Encouraging Transparency	KS S.B. 251, 2012	Provides that real-time EOBs have the potential to reduce health care costs by making true costs transparent to patients and their physicians at the time of treatment decisions. Last activity 2/12/2014.
Competitive Behavior in Health Plan Contracting	https://www.ksinsurance.org/gpa/news/2014/KID-HHS_rules_decision_3-6-14.pdf	Transitional policy where companies will be allowed to renew certain "non-grandfathered" plans for policy years beginning on or before October 1, 2016. Non-grandfathered plans are those issued after March 23, 2010, but prior to January 1, 2014. Statement issued March 6, 2014.
Competitive Behavior in Health Plan Contracting	K.S.A. 40-5108	Maintains that insurance scoring models and other insurance scoring processes are "trade secrets" (therefore limiting transparency).
Expansion of DOI Authority	K.S.A. 40-2215	Provides that no health insurance policy can be used in the state until approved by the insurance commissioner.
Kentucky		
Encouraging Transparency	Ken. Stat. Ann. § 216.261	Provides that the University of Kentucky and the University of Louisville shall jointly establish and operate a Kentucky Health Care Infrastructure Authority, the purpose of which is to improve the quality of health care and deduct costs. Effective 2005.
Encouraging Transparency	Ken. Stat. Ann. § 216.2923	Requires secretary to, *inter alia*, make available information that relates to the health care financing and delivery system, information on charges for health care services and the quality and outcomes of health care services.
Encouraging Transparency	Ken. Stat. Ann. § 216B.135	Creates Task Force on Health Care Cost and Quality to study the implementation of specific Kansas statutes. Effective 1998.
Encouraging Transparency	Ken. Stat. Ann. § 216.2929	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. Effective July 2008.
Competitive Behavior in Health Plan Contracting	Ken. Stat. Ann. § 304.17A-560	Bans most favored nation clauses in provider contracts, effective July 15, 2010.

Category	Statute # (linked)	Description
Kentucky (continued)		
Competitive Behavior in Health Plan Contracting	Ken. Stat. Ann. § 304. 17A-527	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.
Competitive Behavior in Health Plan Contracting	Ken. Stat. Ann. § 304. 17A-577	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. Effective July 2008.
Competitive Behavior in Health Plan Contracting	Ken. Stat. Ann 304.17A-270	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.
Louisiana		
Antitrust	La. Rev. Stat. Ann. § 22:1964	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. Effective 2012.
Encouraging Transparency	La. Rev. Stat. Ann. § 9:2800.20	Limits liability for any health care provider or health plan which voluntarily reports/discloses information to a health care quality improvement corporation unless there is an injury caused by willful or wanton misconduct. Effective 2007.
Competitive Behavior in Health Plan Contracting	La. Rev. Stat. Ann. § 22: 263	Sets out general contracts requirements between health maintenance organizations and health care providers.
Expansion of DOI Authority	La. Rev. Stat. Ann. § 22:971	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 accountable for decisions which harm patients, which could be viewed as a general regulation around ACOs and other managed care orgs. Effective 2003, amended 2010.
Facilitating or reducing barriers to New Entrants	La. Rev. Stat. Ann. § 40:2116	Facility Need Review guidelines and principles.

Category	Statute # (linked)	Description
Maine		
Encouraging Transparency	22 M.R.S. § 8712	Establishes a system of healthcare quality/price data reporting. Effective 2003.
Competitive Behavior in Health Plan Contracting	24-A M.R.S § 4303	Establishes requirements for health plan contracts. Bans the use of most favored nation clauses effective October 2013.
Competitive Behavior in Health Plan Contracting	2011 Maine House Paper No. 979, Maine One Hundred Twenty-Fifth Legislature—First Regular Session	Proposed legislation which provides that the highest premium rate for each rating tier in a health benefit plan may not exceed 2.5 times the premium rate that could be charged to an eligible individual with the lowest premium rate for that rating tier in a given rating period. WestLaw Bill Tracking says the law was enacted and signed May 2011.
Regulation around Development of ACOs	24-A M.R.S. § 4320-H	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).
Facilitating or reducing barriers to New Entrants	22 M.R.S. § 326-350-C	Certificate of need guidelines and principles.
Maryland		
Antitrust	Md. COMMERCIAL LAW Code Ann. § 11: Anti-trust 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.
Antitrust	Md. COMMERCIAL LAW Code Ann.§ 13: Con-sumer Protection Act	Provides minimum standards for the protection of consumers in the State.
Antitrust	Md. HEALTH-GENERAL Code Ann. § 19-129	Discusses the conditions in which a merger or consolidation of hospitals is acceptable.
Encouraging Transparency	Md. HEALTH-GENERAL Code Ann. §§ 19-133	Permits Commission to establish a Maryland medical care data base that compiles statewide data on health services rendered by health care practi-tioners 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.
Encouraging Transparency	Md. HEALTH-GENERAL Code Ann. § 19-202, 207	Creates the "Health Services Cost Review Commission [that] shall periodi-cally participate in or do analyses and studies of"(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.
Competitive Behavior in Health Plan Contracting	Md. INSURANCE Code Ann. § 27-102: Unfair trade practices prohibited	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).
Competitive Behavior in Health Plan Contracting	Md. INSURANCE Code Ann. § 27-103: Cease and desist orders	Commissioner can issue cease and desist order if an entity is engaging in unauthorized practices.

Category	Statute # (linked)	Description
Maryland (continued)		
Competitive Behavior in Health Plan Contracting	Md. INSURANCE Code Ann. § 27-215	If an insurer may invest, acquire all or part of the capital stock of another insurer or have common management with another insurer, unless it substantially lessens competition.
Competitive Behavior in Health Plan Contracting	Md. INSURANCE Code - § 15-112(l)(1)-(3)	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. HEALTH-GENERAL Code Ann. § 19-101 through §§ 19-113:	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.
Monitoring/Regulating Prices	Md. HEALTH-GENERAL Code Ann. § 19-201 through 19-210:	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.
Monitoring/Regulating Prices	COMAR 10.24.02.01 through 10.24.02.05:	Regulations requiring hospitals to submit data to the MD Health Care Commission for the purposes of developing methodologies, planning, analysis and CON reviews as requested on a periodic basis. Information can include aggregate facility data (e.g., number of licensed and operating beds) and patient-specific data (from admissions data to revenue data).
Monitoring/Regulating Prices	COMAR 10.24.04.01 through 10.24.04.02:	Regulations requiring freestanding ambulatory surgical facilities to submit data required by the Commission for the development of methodologies and planning on a periodic basis as requested.
Monitoring/Regulating Prices	COMAR 10.24.06.01 through 10.24.06.04:	Regulations requiring freestanding medical facility to submit data which the Commission considers to be necessary for planning and analysis purposes, as requested by the Commission.
Monitoring/Regulating Prices	Md. HEALTH-GENERAL Code Ann. § 19-222:	If facilities are changing rate structures or charges they must provide justification. Statute also delineates the process for them to do so.
Monitoring/Regulating Prices	HB0298	Establishes hospital rate levels and rate increases consistent with all-payer model contract. Requires facilities to notify the Health Services Cost Review Commission if they engage in a transaction or contract that transfers 50% of voting rights or governing power.
Regulation around Development of ACOs	Md. HEALTH-GENERAL Code Ann. §§15-1901 through 1903:	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. INSURANCE Code Ann. §§ 11-601 through 11-604:	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.

Category	Statute # (linked)	Description
Maryland (continued)		
Expansion of DOI Authority	Md. INSURANCE Code Ann. § 7-303	Must file with the Commissioner prior to acquiring or divesting control of an insurer.
Expansion of DOI Authority	Md. INSURANCE Code Ann. § 7-304: Statement	Describes the content for the above filing.
Expansion of DOI Authority	Md. INSURANCE Code Ann. § 7-306:	Commissioner may disapprove of a transaction that lessens competition.
Expansion of DOI Authority	Md. INSURANCE Code Ann. § 7-402	Defines the factors for whether the acquisition leads to increased market share.
Expansion of DOI Authority	Md. INSURANCE Code Ann. § 7-403	The acquiring person in an acquisition must file a prenotification with the Commissioner, including providing any information related to whether it may lead to less competition.
Expansion of DOI Authority	Md. INSURANCE Code Ann. § 7-405	The Commissioner may issue orders that include cease and desist or denials of certificate of authority for insurers involved in acquisitions that lessen competition. Exemptions exist for situations where there is no other option to achieve efficiency or economies of scale.
Expansion of DOI Authority	Md. INSURANCE Code Ann. § 7-501	Must comply with subtitles 3 and 4 of this title before seeking control of a foreign nonprofit health service plan. This includes entering into an agreement to merge or consolidate with or otherwise to acquire control of the plan.
Expansion of DOI Authority	Md. INSURANCE Code Ann.: § 7-502.	Allows the financing money to serve as security for any outstanding payments owed to hospitals prior to the merger/consolidation/acquisition.
Expansion of DOI Authority	Md. INSURANCE Code Ann. § 15-1902	In consultation with the MD Health Care Commission, the Authority Commissioner may develop regulations for the types of payments and incentives allowed in contracts.
Facilitating or reducing barriers to New Entrants	Md. HEALTH-GENERAL Code Ann. § 19-120	Certificate of need guidelines and principles.
Facilitating or reducing barriers to New Entrants	COMAR 10.24.01.01 through 10.24.01.22	Certificate of need guidelines and principles.
Facilitating or reducing barriers to New Entrants	Md. HEALTH-GENERAL Code Ann. § 19-121	Extension of certificate of need regulation to HMOs.
Facilitating or reducing barriers to New Entrants	Md. HEALTH-GENERAL Code Ann. § 19-319	Must have CON in order to be licensed as a hospital or residential treatment center.
Massachusetts		
Antitrust	Mass. Gen. Laws ch. 93, § 1 -14A: The Massachusetts Antitrust Act	Encourages free and open competition by prohibiting restraints on trade and monopolistic practices.
Antitrust	Mass. Gen. Laws ch. 176D, § 3A	Describes unfair methods of competition or deceptive practices in the business of insurance.
Antitrust	Mass. Gen. Laws ch. 176G, § 9	Extends state laws related to restraint of trade to HMOs.
Antitrust	Mass. Gen. Laws ch. 176G, § 27	The state insurance commissioner should not approve mergers and acquisitions involving an HMO if it reduces competition or leads to a monopoly.

Category	Statute # (linked)	Description
Massachusetts (continued)		
Antitrust	Mass. Gen. Laws ch. 6D, § 13	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 Transparency	114.1 CMR 17.00	Required publicly submitting discharge and charge data.
Encouraging Transparency	Mass. Gen. Laws ch. 12C, § 20	Regulated that the state consumer website will have information comparing the quality, price and cost of health care services.
Encouraging Transparency	Mass. Gen. Laws ch. 12C, § 16	The Health Policy Commission publishes an annual report based on the and information submitted under sections 8, 9 and 10 concerning health care provider, provider organization and private and public health care payer costs and cost trends, section 13 of chapter 6D relative to market power reviews and section 15 relative to quality data.
Encouraging Transparency	Mass. Gen. Laws ch. 176J, § 15	Requires clearly stating the cost-sharing differences between tiers for small group insurance.
Encouraging Transparency	129 CMR 3.00	Describes the Health Policy Council's duty to make health care claims data available for public use and the types of information disclosed.
Competitive Behavior in Health Plan Contracting	Mass. Gen. Laws ch. 176O, § 9A	Bans carriers from entering into contracts that limit tiered networks or guarantees a provider's participation.
Monitoring/Regulating Prices	Mass Gen. Laws. ch. 6D	The collective statutes describing the MA Health Policy Commission.
Monitoring/Regulating Prices	Mass. Gen. Laws ch. 6D, § 8	Commission activities to hold public hearing related to its activities on cost analysis and containment.
Monitoring/Regulating Prices	Mass. Gen. Laws ch. 6A, § 16M	Reviews and evaluates rates and payment systems by the office of Medicaid and recommend Title XIX rates and rate methodologies.
Monitoring/Regulating Prices	Mass. Gen. Laws ch. 6A, § 16T	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	Mass. Gen. Laws ch. 6D, § 1: Definitions	Defines an ACO.
Regulation around Development of ACOs	Mass. Gen. Laws ch. 6D, ß 15: Accountable Care Organizations — Certification Standards.	Directs the development of certification standards for ACOs.
Expansion of DOI Authority	Mass. Gen. Laws ch. 176J, § 12	Rates offered by carriers in group purchasing are the same as those for individual and small group plans.
Expansion of DOI Authority	Mass. Gen. Laws ch. 175J, § 3	Describes the conditions in which the Insurance Commissioner can supervise insurers.
Expansion of DOI Authority	211 CMR 66.09: Submission and Review of Rate Filings	Requires rate filing of premiums and rating factors for the small group market prior to implementation. Subject to disapproval.
Facilitating or reducing barriers to New Entrants	Mass. Gen. Laws ch. 111, § 25C	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.

Category	Statute # (linked)	Description
Michigan		
Encouraging Transparency	MCL 333.17757.	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.
Encouraging Transparency	MCL 400.105f.	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	MCL 550.1400.	Statute barring health care corporations and insurers and HMOs from using most favored nation clauses in provider contracts.
Competitive Behavior in Health Plan Contracting	MCL 500.3405a.	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.
Competitive Behavior in Health Plan Contracting	Order no. 12-035-M, Dept. Lic. & Reg. Affs (July 18, 2012)	Order issued 1/18/12 by the Michigan Deptartment of Licensing and Regulatory Affairs banning the use of most favored nation clauses in insurer-provider contracts as of 2/1/2013 unless submitted and approved by that department's commissioner.
Monitoring/Regulating Prices	MCL 550.1504.	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.
Facilitating or reducing barriers to New Entrants	SSections 2226, 2233, and 22255 of 1978 PA 368, MCL 333.226, 333.233, and 333.22255, and Executive Reorganization Order No. 1996-1, MCL 330.101	Certificate of need guidelines and principles.
Minnesota		
Encouraging Transparency	Minn. Stat. § 62J.63	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.
Encouraging Transparency	Minn. Stat. § 62J.72	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.
Encouraging Transparency	Minn. Stat. § 62J.71	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.
Encouraging Transparency	Minn. Stat. § 62J.81	Disclosure of Payments for Health Care Services: Requires healthcare providers to give consumers a good faith estimate of the allowable payment the provider

Category	Statute # (linked)	Description
Minnesota (continued)		
		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.
Encouraging Transparency	Minn. Stat. § 62J.82	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.
Encouraging Transparency	Minn. Stat. § 62J.823	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.
Encouraging Transparency	Minn. Stat. § 62U.04	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.
Competitive Behavior in Health Plan Contracting	Minn. Stat. § 62J.73	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	Minn. Stat. § 62U.05	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	Minn. Stat. § 256B.0755	Requires the Commissioner to develop and authorize a demonstration project to test alternative and innovative health care delivery systems in public programs.
Expansion of DOI Authority	Minn. Stat. § 62J.74	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.
Expansion of DOI Authority	Minn. Stat. § 62Q.645	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.
Expansion of DOI Authority	Minn. Stat. § 62Q.746	Provides commissioner access to health plan information on providers, network design, performance, size, and other operations.
Expansion of DOI Authority	Minn. Stat. §§ 72A.17 through 72A.32	Outlines regulation of trade practices in the business of insurance.
Facilitating or reducing barriers to New Entrants	Minn. Stat. § 144.551	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.
Facilitating or reducing barriers to New Entrants	Minn. Stat. § 144.552	Defines the public interest review as the process for hospitals seeking exemptions to the moratorium.

Category	Statute # (linked)	Description
Mississippi		
Encouraging Transparency	Miss. Code Ann. § 41- 95-7 ENACTED BILL(S): S.B. 2503 (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.
Expansion of DOI Authority	Mississippi Department of Insurance LA &H 73-4 Regulation	The Mississippi Insurance Department (MID) does not approve rate increases on any type of accident and health policies other than Medicare Supplement policies and Long Term Care policies. MID only acknowledges and files rate increases on all other types of policies.
Facilitating or reducing barriers to New Entrants	Miss. Code Ann. §§ 41-7-171 through 41-7-209	Health Care Certificate of Need Law of 1979.
Missouri		
Encouraging Transparency	Mo, Rev. Stat. § 192.665, § 192.667	Requires all health care providers [includes hospitals and ambulatory surgical centers] to provide charge data to the Department.
Encouraging Transparency	19 Mo. Code of State Regulations 10-33.010	Requires all hospitals and all ambulatory surgical centers to report average and total charges for all inpatient and outpatient services to the department. The department will develop and publish reports that include information on charges and quality of care indicators pertaining to individual hospitals and ambulatory surgical centers. The department may also release patient abstract data to a public health authority to assist the agency in fulfilling its public health mission.
Encouraging Transparency	19 Mo. Code of State Regulations 10-33.030	Requires hospitals to report financial data for all inpatient and outpatient revenue to the department. The department will develop and publish public reports pertaining to individual hospitals.
Competitive Behavior in Health Plan Contracting	2014 Missouri Senate Bill No. 847 (Proposed)	Proposed bill would ban most favored nation clauses in health plan contracts.
Competitive Behavior in Health Plan Contracting	Mo. Rev. Stat. § 354.535	Every health maintenance organization has to apply the same coinsurance, co-payment and deductible factors to all prescriptions filled by a pharmacy provider who participates in the network if the provider meets the contract's product cost determination. Also HMOs may not set a limit on the quantity of drugs which an enrollee may obtain at any one time with a prescription unless such limit is applied uniformly to all pharmacy providers in the network.
Montana		
Antitrust	Mont Code Ann § 50-4-601 through 4-603	Grants certificates of public advantage for cooperative agreements, and mergers and consolidations of health care facilities and physicians if they further the goal of controlling costs as well as improving access and quality. The certificate of public advantage would provide the grantee state action immunity from state or federal antitrust laws.
Encouraging Transparency	2011 Montana House Bill No. 573	Requires the Insurance Commissioner to convene an advisory council to review the costs, benefits, and procedural and technical requirements necessary to design, implement, and maintain a statewide all-payer, all-claims database for health care. The all-payer, all-claims database should include data related to health care safety and quality, utilization, health outcomes, and cost. With available funding the Insurance Commissioner will investigate, matters related to health care, including usable and comparable information that allows public and private health care purchasers, consumers, and data analysts to identify

Category	Statute # (linked)	Description
Montana (continued)		
		and compare health plans, health insurers, health care facilities, and health care providers regarding the provision of safe, cost-effective, high-quality health care services.
Competitive Behavior in Health Plan Contracting	Mont Code Ann § 33-22-1704	A preferred provider agreement must provide all providers with the opportunity to participate on the basis of a competitive bid.
Expansion of DOI Authority	Mont Code Ann § 33-22-107	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.
Nebraska		
Encouraging Transparency	Neb. Rev. Stat. § 71-2075	Requires hospitals and ambulatory surgical centers to provide a written estimate of the average charges for health services.
Encouraging Transparency	Neb. Rev. Stat. § 439B.400	Requires hospitals to maintain and use a uniform list of billed charges for units of service or goods provided to all inpatients. A hospital may not use a billed charge for an inpatient that is different from the billed charge used for another inpatient for the same service or goods provided.
Encouraging Transparency	Neb. Rev. Stat. § 44-1317	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. Effective September 2013.
Monitoring/Regulating Prices	Neb. Rev. Stat. § 44-5258	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%. Effective 1994.
Monitoring/Regulating Prices	Neb. Rev. Stat. § 44-7506	All insurance rating systems and prospective loss costs must be filed with the director of insurance in accordance with further provisions of the statute. Effective 2000.
Regulation around Development of ACOs	2013 NE L.B. 887	This legislation is currently being debated in the state legislature as of March 19, 2014. Comprehensive health care reform statute. Provides, *inter alia*, that a participating accountable care organization must enter into a contract with the department of health and human services directly or with a plan provider through a managed care organization under K with the department, to ensure the coordination and management of the health of its members, to produce quality health care outcomes, and to control overall costs. Statute also provides that the department, in conjunction with the Wellness in Nebraska Oversight Committee, shall recommend payment models for ACOs that include, but are not limited to, risk sharing and bonus payments for improved quality.
Facilitating or reducing barriers to New Entrants	Neb. Rev. Statt. § 71-5801	Certificate of need guidelines and principles.
Nevada		
Encouraging Transparency	N.R.S. 439B.400	Hospital must maintain and use uniform list of billed charges: requires a uniform list of billed charges. Effective 1987.

Category	Statute # (linked)	Description
Nevada (continued)		
Encouraging Transparency	N.R.S. 695G.190	Requires managed care organizations to create a quality improvement committee directed by a physician who is licensed to practice medicine in Nevada. Statute contains other provisions governing managed care organization and quality improvement. Effective 1997.
Competitive Behavior in Health Plan Contracting	N.R.S. 689C.435	Contracts between carrier and providers of health care: prohibiting carrier from charging provider of health care fee for inclusion on list of providers given to insured's; form to obtain information on provider of health care; modification; schedule of fees. Requires, *inter alia*, that a contract between a carrier and health care providers cannot contain a provision which charges a fee for inclusion on a list of preferred providers. Effective 1999.
Competitive Behavior in Health Plan Contracting	N.R.S. 689A.695	An individual carrier must disclose relevant information and documents described by the statute to the Commissioner upon request. The information, other than premium rates charged by the individual carrier, is proprietary—i.e. a trade secret. Effective 1997.
Competitive Behavior in Health Plan Contracting	N.R.S. 695G.430	Contracts between managed care organization and provider of health care: Form for obtaining information on provider of health care; modification; schedule of fees.
Monitoring/Regulating Prices	N.R.S. 439.915	Requires disclosure of prices for prescription drugs. Also mandates the Department to create an internet site containing information on pharmacies and prices.
Facilitating or reducing barriers to New Entrants	N.R.S 439A.100	Certificate of need guidelines and principles.
New Hampshire		
Encouraging Transparency	NH Rev Stat § 420-G:11	Requires disclosure of prices for prescription drugs. Also mandates the Department to create an internet site containing information on pharmacies and prices. Requires health carriers to make reasonable disclosure in solicitation and sales materials, including the methodology by which premium rates are established and provisions concerning the health carrier's right to change premium rates and the factors which affect changes in premiums. Also Created the New Hampshire Comprehensive Health Information System (CHIS) with data used to provide information for consumers and employers on an interactive website called New Hampshire HealthCost. The site provides comparative information about the estimated amount that a hospital, surgery center, physician, or other health care professional receives for its services. For an insured individual, HealthCost provides information that is specific to that person's health benefits coverage. It also shows health costs for uninsured patients. Employers can use the Benefit Index Tool on the website to compare different carriers' health plan premiums versus benefit richness.
Competitive Behavior in Health Plan Contracting	NH Rev Stat § 417:4	Defines most favored nation clauses as an unfair trade method.
Monitoring/Regulating Prices	NH Rev Stat § 161-L:2	Requires the department to establish the NH Rx Advantage Program, which allows the department to enter into rebate agreements with drug manufacturers, subject to certain conditions, including price restrictions.
Expansion of DOI Authority	NH Rev Stat § 415:24	Requires that any rate modifications on individual accident and health policy forms shall be filed with the insurance commissioner prior to implementation.

Category	Statute # (linked)	Description
New Hampshire (continued)		
Facilitating or reducing barriers to New Entrants	NH RSA 151-C	Certificate of need guidelines and principles.
New Jersey		
Encouraging Transparency	N.J.S.A. 45:14-82	Prescription drug retail price list required to be maintained by each pharmacy. Effective 2007.
Competitive Behavior in Health Plan Contracting	N.J.A.C. 11:24C-4.3	Bans most favored nation clauses in health insurance contracts.
Monitoring/Regulating Prices	N.J.S.A. 26:2H-18.70	Major health care reform statute from the early 90s--effective 1992. Statute 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. See http://www.njspotlight.com/stories/14/03/24/explainer-nj-healthcare-deregulation-s-impact-felt-more-than-20-years-later/
Regulation around Development of ACOs	N.J.S.A. 30:4D-8.1	Declares that ACOs are permissible mechanisms to improve quality and outcomes. Statute relates to creation of an ACO for state Medicaid system. Effective 2011.
Facilitating or reducing barriers to New Entrants	N.J.A.C. 8:33	Certificate of need guidelines and principles.
New Mexico		
Encouraging Transparency	NM Stat § 59A-18-13.2	Requires filing of all health insurance or health care plan rates.
Competitive Behavior in Health Plan Contracting	NM Stat § 59A-22A-5	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."
Competitive Behavior in Health Plan Contracting	NM Stat § 59A-46-51	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	Requires filing of health insurance/plan rates with superintendent.
Monitoring/Regulating Prices	NM Stat § 59A-46-35	Statute prohibits preferred provider arrangements with HMOs.
Regulation around Development of ACOs	2012 NM S.J.M. 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.
New York		
Encouraging Transparency	NY Pub Health L § 213	Creates a commission within the department of insurance to study the impact on health insurance costs and quality of proposed legislation which would mandate that health benefits be offered or made available in individual and group health insurance policies, contracts and comprehen-

Category	Statute # (linked)	Description
New York (continued)		
		sive health service plans, including legislation that affects the delivery of health benefits or services or the reimbursement of health care providers.
Competitive Behavior in Health Plan Contracting	NY Pub Health L § 4406-C	Health plan contract prohibitions: sets out various prohibitions for health plan contracts.
Competitive Behavior in Health Plan Contracting	NY Pub Health L § 3221	Mandatory provisions for group or blanket health insurance policies. See § 3216 for individual policies.
Monitoring/Regulating Prices	2013 NY S.B. 2319	No policy of group accident, group health or group accident and health shall impose copayments in excess of 20% of total reimbursement to the provider of care.
Regulation around Development of ACOs	NY Pub Health L § 2999-N	Declaration of findings regarding ACO—namely, that they promote effective allocation of health care resources and better the quality and accessibility of health care.
Facilitating or reducing barriers to New Entrants	NY Pub Health L § 2801	Certificate of need guidelines and principles.
Facilitating or reducing barriers to New Entrants	2013 N.Y. SB 4215	Authorizes the commissioner of health to establish a program to provide loans, through the dormitory authority, to hospitals to finance health care reform projects.
North Carolina		
Encouraging Transparency	NC Gen Stat § 131E-214.2	Requires statewide data processor to compile a report comparing the prices of the 35 most common surgical procedures using data from hospitals/surgical facilities.
Encouraging Transparency	NC Gen Stat § 131E-214.12	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.
Competitive Behavior in Health Plan Contracting	NC Gen Stat § 58-50-295	Prohibits most favored nation clauses in contracts with health care providers.
Competitive Behavior in Health Plan Contracting	NC Gen Stat § 131E-97.3	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. Sect. 4, 131E-97.3; Sect. 5—131E-99.
Competitive Behavior in Health Plan Contracting	2013 N.C. HB 70	Would create a standard health plan for state residents as an alternative to the Health Benefits Exchange. Last activity was 2/6/13 when referred to Appropriations.
Monitoring/Regulating Prices	2013 N.C. HB 862	Would make various changes to insurance laws regulating benefit plans. For non-grandfathered health benefit plans in the individual market issued or renewed on or after 1/1/14, premiums will be deemed unreasonable in relation to benefits if the anticipated medical loss ratio over the period for which rates are effective is less than 80%. Last activity 4/15/13.
North Dakota		
Encouraging Transparency	NDCC, 23-01-24	Health care cost and quality review program—penalty: Requires the department of health to conduct a continuous program to review and improve the quality of health care in the state.

Category	Statute # (linked)	Description
North Dakota (continued)		
Competitive Behavior in Health Plan Contracting	NDCC, 26.1-47-02	Explicitly allows for insurers to enter into preferred provider agreements, subject to certain conditions.
Competitive Behavior in Health Plan Contracting	NDCC, 26.1-04-03	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.
Ohio		
Encouraging Transparency	Ohio Rev Code § 4729 .361	Retail sellers of "dangerous drugs" must disclose price information in certain ways.
Competitive Behavior in Health Plan Contracting	Ohio Rev Code § 3963.03	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.
Competitive Behavior in Health Plan Contracting	Ohio Rev Code § 3963.11	Most favored nation clauses prohibited.
Monitoring/Regulating Prices	Ohio Rev Code § 3924.04	Regulation around the premium rates in health benefit plans. See section 3924.27 for rates for individuals in group plans.
Regulation around Development of ACOs	2014 OH LEGIS 60	Specifically allows the development of ACOs; contains provision regarding confidentiality of peer review information.
Facilitating or reducing barriers to New Entrants	Ohio Rev Code § 3702.54	Certificate of need guidelines and principles.
Oklahoma		
Competitive Behavior in Health Plan Contracting	2013 OK H.B. 1342	An Act relating to insurance; this is a huge statute that could apply to various categories in this survey. Some significant provisions include: premium rates restrictions, mandatory coverage provisions, mandatory health benefit contract provisions, and quality of care reporting requirements. Last activity was 2/19/2014; referred to the rules committee.
Competitive Behavior in Health Plan Contracting	Okl. Admin. Code § 63-1-120	Provides that information collected/disclosed for/to the Division of Health Care Information or to a data processor pursuant to the Oklahoma Health Care Information System Act shall be confidential.
Facilitating or reducing barriers to New Entrants	Okl. St. Ann § 63-1-880	Certificate of need guidelines and principles.
Oregon		
Antitrust	OR Rev Stat § 646.735	Holds coordinated health care delivery to be in the best interest of the public, and thus exempt from state antitrust laws.
Encouraging Transparency	OR Rev Stat § 442.420	Provides that the Office for Oregon Health Policy and Research shall analyze studies relating to costs of health care, quality control, and other information.
Encouraging Transparency	2014 OR H.B. 4109	Requires Oregon Health Authority to commission an independent study of costs and impacts of operating basic health program in Oregon.
Encouraging Transparency	OR Rev Stat § 442.466	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.

Category	Statute # (linked)	Description
Oregon (continued)		
Monitoring/Regulating Prices	OR Rev Stat § 743.018	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.
Facilitating or reducing barriers to New Entrants	OR Rev Stat 442.315	Certificate of need guidelines and principles.
Pennsylvania		
Antitrust	35 P.S. § 449.15	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
Encouraging Transparency	35 P.S. § 449.17b	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 P.S. § 776.3	Empowers the Insurance Commissioner to issue regulations around standard policy provisions for health and accident insurance.
Competitive Behavior in Health Plan Contracting	35 P.S. § 449.5	Broadly empowers the council to promote competition in the health care and health insurance markets.
Competitive Behavior in Health Plan Contracting	2011 PA H.B. 1763	Proposed bill prohibits health insurer from including most favored nation clauses in contracts with physicians. Last activity was 11/29/2011.
Monitoring/Regulating Prices	35 P.S. § 448.202	Authorizes the department of health to plan and review activities in order to to foster competition and promote cost efficient, quality, and access to care.
Expansion of DOI Authority	2013 PA H.B. 225	Would create the Pennsylvania Health Insurance Exchange; assigns new duties/powers to the Insurance Department regarding the same. Last activity was 1/22/2013; referred to insurance.
Rhode Island		
Encouraging Transparency	RI § 23-17.14-32,	AG has power to decide whether information required to be disclosed by the Hospital Conversions Act is confidential and/or proprietary.
Encouraging Transparency	RI Chapter 23-17.13, Chapter 27-41,	Rule and regulation of Rhode Island's all-payer claims database.
Encouraging Transparency	RI Gen L § 23-17.17-9b	Establishes a database to promote price transparency and quality controls.
Competitive Behavior in Health Plan Contracting	RI Gen L § 27-50-17	Statute concerning a reinsurance program for small businesses who pay a minimum of 50% of single coverage premiums for their eligible employees, and who purchase the wellness health benefit plan.
Competitive Behavior in Health Plan Contracting	RI Gen L § 27-18-33, 27-19-26, 27-20-23, 27-41-38	Insurers may not require covered persons to obtain prescriptions from a mail-order pharmacy as a condition of obtaining benefits.
Expansion of DOI Authority	RI Gen L § 42-14.5-3	Granted broad authority to the health insurance commissioner for health insurance oversight.
Expansion of DOI Authority	RI Gen L S550	Requires rate filing and prior approval. If the insurers file rates and forms and, if not disapproved within 60 days, then the rates are deemed approved. The rate review process includes a limit on annual maximum price increases for inpatient and outpatient services to the CMS hospital price index as a condition of approval.
Facilitating or reducing barriers to New Entrants	RI Gen L § 23-15	Certificate of need guidelines and principles.

Category	Statute # (linked)	Description
South Carolina		
Encouraging Transparency	SC Code § 44-6-170	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.
Encouraging Transparency	S.C. Code of Regulations R. 19-801, 19-1010 (Regulation)	Requires hospitals to report financial data elements pertaining to patient charges for all patients, inpatients and outpatient, the Office of Research and Statistics.
Expansion of DOI Authority	SC Code § 38-71-310	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.
South Dakota		
Encouraging Transparency	SD Codified L § 1-43-24	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.
Encouraging Transparency	SD Codified L § 1-43-32	Requires that implementation of a comprehensive health data system is contingent on availability of state and federal funds.
Encouraging Transparency	ARSD 44:66:02:01 through 44:66:02:03 (Regulation)	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. Any hospital that does not have charge information that can be grouped to APR DRGs is exempt from the reporting requirement. Hospitals are required to provide specified information, including total charges. SDAHCO is required to collect, analyze, validate, and disseminate the data and information.
Encouraging Transparency	ARSD 44:66:03:01 (Regulation)	The South Dakota Association of Health Organizations will annually publish hospital charge data.
Encouraging Transparency	SD Codified L § 34-12E	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.
Monitoring/Regulating Prices	SD Codified L § 1-43-19	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

Category	Statute # (linked)	Description
South Dakota (continued)		
		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.
Monitoring/Regulating Prices	SD Codified L § 1-43-32	Requires that implementation of comprehensive health data system is contingent on availability of state and federal funds.
Expansion of DOI Authority	SD Codified L 58-17-4.1	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.
Tennessee		
Antitrust	T. C. A. § 68-11-1303	States explicitly that hospitals may negotiate and enter into coop 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.
Antitrust	T. C. A. § 940-3-10-01	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 Transparency	T.C.A. § 56-7-122	A provider shall not be prohibited by a health plan, by contract or otherwise, 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.
Competitive Behavior in Health Plan Contracting	T.C.A. § 56-7-2209	Provides mandatory health benefit plan provisions, restrictions on premiums, disclosures, and rating methods.
Competitive Behavior in Health Plan Contracting	T. C. A. § 56-7-1013	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.
Facilitating or reducing barriers to New Entrants	T.C.A. § 68-11-1607	Certificate of need guidelines and principles.
Texas		
Antitrust	Tex. Health & Safety Code §§ 4F 314	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 Transparency	Tex. Government Code § 531.0082	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,

Category	Statute # (linked)	Description
Texas (continued)		
		payment methodologies, and compliance with requirements in Medicaid and child health plan program managed care and fee-for-service contracts. 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.
Encouraging Transparency	Tex. Insurance Code §§ 38.351 through 38.358	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: https://wwwapps.tdi.state.tx.us/inter/asproot/life/reimbursement/index.asp?q=1
Encouraging Transparency	Tex. Health & Safety Code §§ 1002.001 through 1002.202	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.
Encouraging Transparency	25 TX ADC § 421.62 (Regulation)	Each facility will report to the Department of State Health Services on all patient events in which the patient received one or more of the surgical procedures or radiological services. The facility will report an event claim corresponding to each bill.
Encouraging Transparency	25 TX ADC § 421.68 (Regulation)	Requires the Department of State Health Services to create public use files for outpatient surgical and radiological procedures at hospitals and ambulatory surgical centers. The data reported will include: total charge and total non-covered charges.
Encouraging Transparency	25 TX ADC § 421.67 (Regulation)	For all patients that are uninsured or considered self-pay or covered by third party payers, facilities will report event files for outpatient bills, including institutional claims, professional claims, and total claim charges.
Encouraging Transparency	25 TX ADC § 421.8 (Regulation)	Requires the Department of State Health Services to create public use files for inpatient discharges. The data reported will include: total charges - acommodations, total charges - ancillary, and service line charge amount.
Encouraging Transparency	Tex. Health & Safety Code § 108.006, 9, 11, 12	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.
Encouraging Transparency	Tex. Health & Safety Code § 324.051	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.

Category	Statute # (linked)	Description
Texas (continued)		
Encouraging Transparency	Tex. Health & Safety Code § 324.001	Requires facilities and physicians to provide an estimate of the facility's [or physician's] charges for any elective inpatient admission or nonemergency outpatient surgical procedure or other service on request and before the scheduling of the admission or procedure or service.
Regulation around Development of ACOs	Tex. Ins. Code § 848	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	Tex. Ins. Code § 1201.109	Requires individual health insurers to notify consumers 60 days before a premium rate increase takes effect.
Utah		
Encouraging Transparency	Utah Code Ann. § 26-3-2	Permits the Department of Health Organization to collect and maintain health data on, including but not limited to, health care costs and financing.
Encouraging Transparency	Utah Code Ann. § 26-21-20	Requires hospitals to provide a statement of itemized charges to any patient receiving medical care or other services from that hospital.
Encouraging Transparency	Utah Code Ann. § 26-21-27	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.
Encouraging Transparency	Utah Code Ann. § 26-33a-104	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 expected 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.

Category	Statute # (linked)	Description
Utah (continued)		
Encouraging Transparency	Utah Code Ann. § 26-33a-106.1	The Committee shall establish an advisory panel to advise the Committee on the development of a plan for the collection and use of health care data pursuant to Subsection 26-33a-104(6) and this section. This will entail: (i) establishing a plan for collecting data from data suppliers, as defined in Section 26-33a-102, to determine measurements of cost and reimbursements for risk adjusted episodes of health care; (ii) sharing data regarding insurance claims and an individual's and small employer group's health risk factor with insurers participating in the defined contribution market created in Title 31A, Chapter 30, Part 2, Defined Contribution Arrangements, only to the extent necessary for: (A) establishing rates and prospective risk adjusting in the defined contribution arrangement market; and (B) risk adjusting in the defined contribution arrangement market; and (iii) assisting the Legislature and the public with awareness of, and the promotion of, transparency in the health care market by reporting on: (A) geographic variances in medical care and costs as demonstrated by data available to the committee; and (B) rate and price increases by health care providers: (I) that exceed the Consumer Price Index — Medical as provided by the United States Bureau of Labor statistics; (II) as calculated yearly from June to June; and (III) as demonstrated by data available to the committee.
Encouraging Transparency	Utah Code Ann. § 26-33a-106.5	Permits the Committee to publish compilations or reports that compare and identify health care providers or data suppliers from the data it collects. The reports should be published at least annually; and (ii) contain comparisons based on at least the following factors: (A) nationally or other generally recognized quality standards; (B) charges; and (C) nationally recognized patient safety standards.
Encouraging Transparency	UT ADC R428-10 (Regulation)	Establishes the reporting standards for inpatient discharge data by licensed hospitals, which includes submitting total charges by revenue code as well as prior payments and estimated amount due to the Office of Health Care Statistics within the Utah Department of Health, which serves as staff to the Utah Health Data Committee.
Encouraging Transparency	UT ADC R428-11 (Regulation)	Establishes the reporting standards for ambulatory surgery data by licensed hospitals and ambulatory surgical facilities, which includes reporting total facility charges to the Office of Health Care Statistics within the Utah Department of Health, which serves as staff to the Utah Health Data Committee.
Regulation around Development of ACOs	Utah Code Ann. § 26-18-405	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;

Category	Statute # (linked)	Description
Utah (continued)		
		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.
Expansion of DOI Authority	Utah Code Ann. § 31A-22-602	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.
Vermont		
Encouraging Transparency	18 VSA § 9405b	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.
Encouraging Transparency	18 VSA § 9410	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.
Encouraging Transparency	Chapter 020. (Regulation No. H-2007-05)	Requires each health insurer to submit a Consumer Information Plan for approval by the Commissioner. There will be a phased-in approach for releasing various types of information to consumers.
Competitive Behavior in Health Plan Contracting	18 VSA § 9418e	Forbids contracting entities to offer, enter into, or amend a contract that includes a most favored nation clause.
Expansion of DOI Authority	8 VSA § 4062	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.
Facilitating or reducing barriers to New Entrants	18 VSA § 9434	General provision and guidelines for Certificate of Need.

Category	Statute # (linked)	Description
Virginia		
Encouraging Transparency	VA Code Ann. § 32.1-276.5	Requires, *inter alia*, all health care providers in the data to submit data as required pursuant to regulations of the Board.
Encouraging Transparency	VA Code Ann. § 32.1-276.5:1	Requires Commissioner to negotiate and contract with a nonprofit organization for an annual survey of carriers offering health insurance, and to determine the reimbursement that is paid for a minimum of the 25 most frequently reported health care services. Also requires disclosure of contractual arrangements.
Competitive Behavior in Health Plan Contracting	VA Code Ann. § 38.2-4209	Authorizes preferred provider subscription contracts, subject to certain conditions.
Competitive Behavior in Health Plan Contracting	VA Code Ann. § 38.2-3406.1	Authorizes Commissioner to promulgate rules to advance the provisions of the statute.
Competitive Behavior in Health Plan Contracting	VA Code Ann. § 38.2-5805	Governs provider-insurance contracts; contains provision regarding hold harmless clauses. Grants Insurance commissioner certain regulatory powers.
Competitive Behavior in Health Plan Contracting	VA Code Ann. § 38.2-5806	General prohibitions for managed care health insurance plans.
Facilitating or reducing barriers to New Entrants	VR355-30-000	Certificate of need guidelines and principles.
Washington		
Encouraging Transparency	RCW 70.41.250	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.
Competitive Behavior in Health Plan Contracting	WAC 246-25-045	Bans Most Favored Nation clauses in health care provider contracts.
Competitive Behavior in Health Plan Contracting	RCW 41.05.026	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.
Monitoring/Regulating Prices	RCW 41.05.021	Creates the Washington State Health Care Authority within the state's executive branch.
Regulation around Development of ACOs	RCW 70.54.420	Creates at least two accountable care organization pilot projects to study the development and implementation of ACOs and payment systems. Sets out ACO requirements.
Facilitating or reducing barriers to New Entrants	246-310 WAC	Certificate of need guidelines and principles.

Category	Statute # (linked)	Description
West Virginia		
Antitrust	W. Va. Code, § 16-2L-5	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.
Competitive Behavior in Health Plan Contracting	2014 WV H.B. 3073	Allows selected out-of-state insurers to do business in the state. Could be relevant to competitive contracting in West Virginia. Last activity 1/09/2014.
Regulation around Development of ACOs	W. Va. Code, § 5-16-3	Empowers Public Employees Insurance Agency to coordinate with providers, private insurance carriers and, to the extent possible, Medicare to encourage the establishment of cost-effective accountable care organizations.
Expansion of DOI Authority	2014 WV H.B. 4564	Requires navigators and nonnavigator assisters to receive certification by the Insurance Commissioner.
Facilitating or reducing barriers to New Entrants	W.Va. Code § 16-2D	Certificate of need guidelines and principles.
Wisconsin		
Antitrust	Wis. Stat. ß 150.85	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.
Encouraging Transparency	Wis. Adm. Code § DHS 120.12 (Regulation)	Requires hospitals to file with the department inpatient and outpatient data with respect to uncompensated care charge data and total charges and components of those charges.
Encouraging Transparency	Wis. Adm. Code § DHS 120.13 (Regulation)	Requires freestanding ambulatory surgery centers to report to the department adjusted total charges and components of those charges.
Encouraging Transparency	Wis. Adm. Code § DHS 120.14 (Regulation)	Requires physicians to submit to the department outside lab charges, physician charges and total charges.
Encouraging Transparency	Wis. Adm. Code § DHS 120.15 (Regulation)	Requires dentists, chiropractors, and podiatrists to provide the department a schedule of the proposed charges for enrollee coverage for health care services for office visits, routine tests and preventive measures and frequently occurring procedures.
Encouraging Transparency	Wis. Adm. Code § DHS 120.22 (Regulation)	Requires health care providers to provide charge and quality data for hospital inpatients and selected surgical procedures at hospitals, free-standing ambulatory surgery centers and physician's offices and emergency departments. The department shall make available from the department's website an electronic version of the report.
Encouraging Transparency	Wis. Adm. Code § DHS 120.23 (Regulation)	Requires health care providers to provide health plan costs, such as premium per member and usual and customary charges for office visits, routine tests and diagnostic work-ups, preventive measures and frequently occurring procedures. Also requires department to produce a consumer guide that contains information on how to find and choose a doctor, hospital, health care plan, nursing home or other health care provider.
Encouraging Transparency	Wis. Stat. § 153.05	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

Category	Statute # (linked)	Description
Wisconsin (continued)		
		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.
Encouraging Transparency	Wis. Stat. § 153.08	Requires hospitals to publish any changes in rates or charges in class 1 notice in a newspaper.
Encouraging Transparency	Wis. Stat. § 153.22	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.
Encouraging Transparency	Wis. Stat. § 153.45	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.
Encouraging Transparency	Wis. Stat. § 146.903	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	Wis. Stat. § 625.13	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.
Facilitating or reducing barriers to New Entrants	Wis. Stat. ß 150.93	Limits the maximum number of beds in approved hospitals to 22,516.
Wyoming		
Encouraging Transparency	Senate Enrolled Act No. 82 (2013)	Permits the Wyoming Department of Health to proceed with a reform and redesign of the Wyoming Medicaid program to include the use of incentives to encourage health care providers to meet identified, measurable performance outcomes in the provision of health care.
Competitive Behavior in Health Plan Contracting	WY Stat § 26-22-503	Any provider willing to meet the established requirements has the right to enter into contracts relating to health care services.
Competitive Behavior in Health Plan Contracting	WY Stat § 26-34-134	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	Wyo. Stat. § 26-18-135	Required prior approval for HMO rate increase only.

Endnotes

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