

2021 Mid-year legislative review

The American Medical Association's (AMA) Advocacy Resource Center (ARC) collaborates with state medical associations and national medical specialty societies on a collective state legislative and regulatory advocacy agenda. Additionally, the ARC works to influence the priorities of national policy making organizations (e.g., National Association of Insurance Commissioners (NAIC) and the National Governors Association (NGA)), as well as other stakeholders, in their efforts to improve access to care.

As described below, the scope of the ARC's work spans issues including but not limited to public health, scope of practice, antitrust, Medicaid, telehealth, the drug overdose epidemic, managed care, liability reform, physician contracting, and access and coverage in health care. Despite the COVID-19 epidemic there was no shortage of issues to tackle in the states this year.

Finally, the ARC staff looks forward to additional opportunities to collaborate with and support medical societies and our other partners in their state advocacy during the remainder of 2021 and into 2022. For more information on the ARC, please contact Wendy Holmes at wendy.holmes@ama-assn.org and visit the [ARC Staff Directory](#).

Antitrust

UnitedHealth Group's proposed acquisition of Change Healthcare

Overview

On January 6 of this year, UnitedHealth Group (UHG) announced its proposed acquisition of Change Healthcare (CHNG) for \$7.8 billion. The companies said that they expected to close the deal in the second half of this year.

The proposed merger immediately drew the attention of the AMA. In recent years AMA has assumed a leading, successful role working with state and federal antitrust enforcers to prevent mergers with an appreciable risk of harmful effects in health care and related markets, including physician markets.

Consistent with this history, AMA has urged the Antitrust Division of the U.S. Department of Justice (DOJ) to conduct a thorough examination of the horizontal and vertical market ramifications of the UHG/CHNG merger.

Significant activity

On April 6, 2021, AMA furnished DOJ with a letter outlining its concerns. We pointed out that there is significant overlap in the health IT/analytics services that the merging firms supply to health insurers, physicians, and hospitals. Given this overlap and the companies' large sizes, it is likely that the merging firms have been, or absent the merger would become, substantial head-to-head competitors. The loss of such competition, or potential competition, suggests that the merger could have substantial anticompetitive effects.

We have also urged DOJ to investigate the acquisition as a vertical merger because the two firms operate

at different levels of the supply chain i.e., UHG's health insurer subsidiary, United Healthcare (UHC), is a buyer of inputs (health IT / analytics services) that CHNG sells. Thus, UHG's acquisition of CHNG could potentially harm competition in health insurance markets by foreclosing UHC's health insurer competitors from access to CHNG's services - an essential resource needed to compete with UHC—or by making CHNG's services available on comparatively unfavorable terms. This is especially concerning because UHC is already the largest health insurer nationally, and it is one of the four largest insurers in 86% of metropolitan statistical area (MSA)-level commercial markets and 91% of MSA-level Medicare Advantage markets, most of which are highly concentrated.

Also, AMA's letter warns that once CHNG is under the UHG umbrella, UHC will have access to CHNG's large database of competitively sensitive information on physicians. This would include, for example, physician reimbursement data for CHNG's electronic data interchange (EDI) clearinghouse customers, of which non-UHC insurers make up a formidable share. UHC will have an advantage over its competitors in negotiations with physicians once UHC can observe other insurers' negotiated rates; instead of reimbursing competitively, UHC could tie its own reimbursement levels to those of its competitors.

Finally, there is little competition in the clinical guideline market, with only two major players developing standardized products for cross-industry use: MCG and InterQual—the latter of which is owned by CHNG. With the acquisition, InterQual clinical guidelines would fall under the complete control of the parent company of the largest health insurer in the country. UHG may prioritize financial incentives over appropriate quality of care. Since physicians generally must rely on these clinical guidelines to receive payment from insurers, cost-based coverage decisions could disrupt care delivery and harm patient access to necessary care. DOJ staff have also heard AMA's concerns in telephone conferences supplementing its April letter.

Posture of DOJ's investigation

The DOJ appears to be conducting a thorough examination of the merger, consistent with AMA's request. There are press reports that DOJ has issued civil investigative demands seeking documents from a host of third parties. Also, DOJ reportedly is interviewing antitrust trial attorneys who might represent the government in litigating this matter. Based on information contained in a form recently filed by UHG and CHNG with the Securities and Exchange Commission, the DOJ investigation is unlikely to conclude before sometime in January 2022, at the earliest.

State antitrust advocacy

The ARC also works closely with the Federation on matters state legislative proposals concerning competition in health care markets. For example, the ARC worked very closely with the Nevada Medical Association on health care competition reforms that were enacted in 2021—analyzing bills and suggesting amendments to help minimize any negative impact on independent practices and to promote the interests of physician practices in Nevada.

For more information on antitrust issues, please contact Henry Allen, MPA, JD, Senior Attorney, at henry.allen@ama-assn.org.

Medicaid

Expansion

To date, 38 states and Washington, DC, have expanded Medicaid under the ACA; twelve states have not. A few of the remaining hold-out states made moves to expand Medicaid this year, including Kansas, North Carolina, and Wisconsin, but none have succeeded to date. Last year, Missouri voters approved a ballot initiative to expand Medicaid, but the legislature refused to fund the program. After a legal challenge, the Missouri Supreme Court ruled that the expansion must stand as the voters approved it, regardless of legislative appropriation. It is unclear when enrollment might begin.

Work requirements

Under the previous Administration, several states successfully sought waivers from the federal government to impose work requirements on Medicaid beneficiaries as a condition of enrolling in coverage. Several states faced legal challenges (Arkansas, Kentucky, Michigan, and New Hampshire) and federal courts struck down work requirements in each. At the start of the Biden Administration, the Center for Medicare & Medicaid Services (CMS) withdrew work requirement waiver authorities in Arizona, Arkansas, Indiana, Michigan, New Hampshire, and Wisconsin. The remaining states that had previously received federal approval for work requirements have not implemented the programs.

Postpartum coverage

In 2021, CMS approved three state waiver requests (Georgia, Illinois, and Missouri) to extend Medicaid coverage for pregnant women beyond the current 60-day postpartum requirement. Illinois' program extends coverage for 12 months and Georgia's extends coverage for six months. Missouri's waiver extends coverage for 12 months but is limited to beneficiaries in need of substance use disorder treatment. Following enactment of the federal American Rescue Plan Act, which gave states a new option to extend Medicaid postpartum coverage to 12 months, 15 states (California, Colorado, Connecticut, Florida, Maryland, Maine, Minnesota, New Jersey, Ohio, South Carolina, Tennessee, Texas, Washington, Wisconsin, and West Virginia) enacted legislation directing state agencies to seek federal approval to extend coverage. Two states (Massachusetts and Virginia) have submitted a 1115 waiver and are awaiting federal approval.

For more information on Medicaid issues, please contact Annalia Michelman, JD, Senior Attorney, at annalia.michelman@ama-assn.org.

Medical liability reform

The most significant physician medical liability issue for states this year concerned liability protections for physicians who provided services during the COVID-19 pandemic, as well as protections related to services that physicians *were not* allowed to furnish due to bans on elective procedures. The ARC provided support and advocacy resources to the Federation to help enact such protections. As one example, the ARC proactively and repeatedly reached out to state medical associations working on COVID-19 medical liability protection bills, offering extensive resources and helping state medical associations draft legislation. More than half of the states enacted COVID-19 medical liability immunity laws. Aside from its work on pandemic liability protections, the ARC also supported the Federation on other, more traditional medical liability issues. For example, the ARC successfully advocated that the Illinois Governor veto legislation, which would have imposed prejudgment interest in medical liability cases starting on the day the alleged liability occurred. The ARC also supported the New Mexico Medical

Society in reaching a successful result concerning amendments to its MLR law—the first major change to that MLR law since it was enacted in the late 1970s. Finally, the ARC also published its [2021 edition of MLR NOW!](#)

For more information on medical liability reform issues, please contact Wes Cleveland, JD, Senior Attorney, at wes.cleveland@ama-assn.org.

Nation's drug overdose epidemic

The nation's drug-related overdose and death epidemic grew worse during the COVID-19 pandemic. AMA's state and national focus helped lead to more than 20 state legislative or regulatory victories, as well as several dozen communications and coalition-building efforts and hundreds of media mentions for AMA advocacy materials in the first six months of 2021. These include multiple new laws, regulations, and advocacy efforts (Colorado, Nevada, Texas, Washington, and National Association of Insurance Commissioners) to advance oversight and enforcement of mental health and substance use disorder parity. Notably, Colorado issued the nation's first substantial network adequacy regulation to measure access to evidence-based care for substance use disorders. The AMA also continues to be instrumental in helping the NAIC advance health equity issues in its working group to address mental health and substance use disorder parity.

AMA advocacy also played a key role in developing a national coalition-based effort with the Johns Hopkins School of Public Health and at least five new state laws (Kentucky, Nevada, New York, Texas, and Virginia) requiring states to use any funds received from opioid-related litigation against manufacturers, distributors, and pharmacies are directed to public health uses, contain transparency requirements, and may not revert to the state general fund. AMA advocacy efforts also secured multiple high-profile speaking engagements for the AMA President (e.g., American Bar Association and National Rx Drug Abuse and Heroin Summit).

Other notable advocacy wins include support for a new law championed by the state medical society (Rhode Island) to authorize the state to implement a "harm reduction center" pilot program to reduce death from overdose. The AMA highlighted this win in one of its three national webinars with Manatt Health, each of which had more than 250 attendees from across the nation. The AMA's efforts to remove barriers to evidence-based care also helped in victories to remove prior authorization for medications to treat opioid use disorder (Kentucky), a new law (Oklahoma) that provides a good faith, safe harbor for physicians who prescribe opioid analgesics at doses higher than CDC's ill-advised and widely misapplied 2016 prescribing guidelines; a new law (Colorado) that increases access to nonopioid pain care options; and new laws (Arizona and North Dakota) that increase access to syringe exchange services and drug checking supplies, such as fentanyl test strips. AMA advocacy also helped defeat or substantially revise mandatory naloxone prescribing bills in multiple states (Illinois, Minnesota, North Carolina, and South Carolina).

One additional notable win has been an ongoing partnership with the Milken Institute and the U.S. Drug Enforcement Administration (DEA) to highlight steps that employers can take to end the nation's drug-related overdose and death epidemic. The AMA created a new issue brief for employers, and on more than five multi-state regional calls with the Milken Institute and DEA, presented on issues ranging from employer-based naloxone educational opportunities, removing stigma, and increasing workplace flexibilities to account for social determinants of health with respect to accessing evidence-based pain and treatment for a substance use disorder.

Recent resources include:

- Key considerations for employers: <https://end-overdose-epidemic.org/wp-content/uploads/2021/04/AMA-Issue-Brief-Key-Considerations-for-Employers-for-the-Nations-Drug-Overdose-Epidemic-FINAL.pdf>
- Reports of increases in overdose: <https://www.ama-assn.org/system/files/issue-brief-increases-in-opioid-related-overdose.pdf>
- Reports of efforts to help increase access to evidence-based treatment: <https://end-overdose-epidemic.org/wp-content/uploads/2021/03/AMA-Issue-Brief-Reports-of-Efforts-to-Help-End-the-National-Overdose-Epidemic-August-2021.pdf>
- Select research relating to the nation's overdose epidemic: <https://end-overdose-epidemic.org/wp-content/uploads/2020/07/American-Overdose-Epidemic-Select-Research-August-2021.pdf>

For more information on drug overdose epidemic-related issues, please contact Daniel Blaney-Koen, JD, Senior Attorney, at daniel.blaney-koen@ama-assn.org.

Payer issues

Prior authorization

In an effort, to ensure timely access to care during the pandemic, many state regulators, legislatures and even private health plans acted to temporarily remove prior authorization and step therapy barriers. But these temporary solutions seemed to do little good in removing the long-term impact of prior authorization on patient and physicians. [Survey](#) data released earlier this year shows the burden continues to increase.

Perhaps recognizing, as a result, of the pandemic, that there are enough barriers to accessing health care without allowing health insurers to erect unnecessary ones, several state legislatures enacted comprehensive prior authorization reform laws this year with incredible guidance from their state medical associations.

In Illinois, H.B. 711, the Prior Authorization Reform Act, was signed into law in August. Among other provisions, the new law:

- Creates a standard definition of “medically necessary;”
- Requires that prior authorization approvals remain valid for six months, and 12 months for chronic conditions and long-term diseases, regardless of changes in dosage;
- Requires a response to a nonurgent request in 5 calendar days and 48 hours for urgent care;
- Requires payment if service or drug is authorized;
- Provides a 90-day period of authorization when a patients change plans;
- Allows continued approval when plan's requirements change;
- Establishes statistical reporting requirements on plans including a list of health care services/drugs subject to prior authorization, total number of prior authorization requests received, total number of denials and the top five reasons for denials, the number of denials appeals and whether they were upheld or reversed, and the average time between submission and response; and
- Requires that services are automatically deemed authorized if a utilization review organization fails to comply.

In Georgia, S.B. 80, the Ensuring Transparency in Prior Authorization Act, was signed into law in May. Among other provisions, the new law:

- Creates a standard definition of medical necessity;
- Set deadlines for insurers to respond to prior authorization requests;
- Requires plan to post their prior authorization requirements and processes on their website before changes go into effect;
- Establishes statistical reporting requirements on prior authorizations including denials and approvals, reasons for denial, whether a denial was appealed; approved or denied on appeal, and the time between submission and response; and
- Prevents insurers from revoking, denying or changing a prior authorization approval for 45 days.

The Medical Association of Georgia is already advocating for additional prior authorization reforms during the next session, including prior authorization automation and repeated prior authorization for individuals with chronic conditions.

Finally, in Texas, the Texas Medical Association was able to push legislation across the finish line that has the attention of many advocates across the country. The legislation is the first of its kind to establish a gold carding program for physicians in commercial plans. Under the new law, physicians who had prior authorization requests for prescriptions and treatments approved by an affected insurer or HMO at least 90% of the time in the most recent six-month review period would achieve “gold-card” exemption status from that insurer for the same treatment. Additionally, the reviewer on a peer-to-peer review call with the treating physician must be a Texas-licensed physician of the same or similar specialty. The gold-carding provisions of the law apply to state-regulated commercial HMO plans, preferred provider benefit plans, exclusive provider benefit plans, and certain Employees Retirement System of Texas and Teacher Retirement System of Texas plans. The new law is in effect and many physician advocates are watching the implementation closely.

Co-pay accumulators

Copay accumulator programs, or accumulator adjustment programs, are a utilization management tool used by pharmacy benefit managers (PBMs) and health insurers to restrict copay assistance from counting toward a patient’s deductible or out-of-pocket maximum. Patients are often unaware that this assistance is not counting toward their cost-sharing requirements and may, often mid-year, find they are not able to afford their medications or other health care services for them or their family when their out-of-pocket responsibilities are too high. Moreover, failure to count copay assistance toward a patient’s deductible out-of-pocket maximum means the health insurer or PBM is essentially being “overpaid.”

Earlier this year, the AMA joined with dozens of organizations to sign onto model legislation to address insurer co-pay accumulator programs as part of the All Copays Count Coalition (ACCC). More than 30 states have introduced or are laying the groundwork for legislation largely based on the model legislation, and Arkansas, Connecticut, Kentucky, Louisiana, Oklahoma, and Tennessee all enacted new laws this year. The model legislation is also under consideration by the National Conference of Insurance Legislators (NCOIL) and the AMA, along with the ACCC, is pushing for its adoption.

Surprise billing

As implementation of the federal No Surprises Act nears (January 1, 2022) and the federal rulemaking process is in full swing, many state medical associations in states without surprise billing laws are pushing for their legislatures to wait until the NSA is implemented to consider new legislation.

Meanwhile, in those states with existing surprise billing laws, questions from advocates and policymakers include:

- Will our state law preempt the federal law for state-regulated plans?
- What are the gaps in our state law that can be addressed, so as, to prevent the federal law from reaching in?
- Should we work to repeal our state law to avoid confusion for physicians?
- Should we push for an opt-in provision in our state law for self-funded plans?

The AMA is working to help state medical societies navigate some of these questions while working with state and specialty societies to influence the regulations that will hopefully provide additionally clarify on some of these implementation questions. The AMA has submitted a number of [detailed comments](#) to the Centers for Medicare and Medicaid Services (CMS) this year stressing the need for transparency, standardization, leniency, and attention to the consequences of a surprise billing resolution process that ultimately favors health plans.

For more information on payer-related issues, please contact Emily Carroll, JD, Senior Attorney, at emily.carroll@ama-assn.org.

Physician contracting issues

Restrictive covenants

In response to instructions from the AMA House of Delegates at the AMA's 2020 Annual Meeting, the ARC developed a comprehensive restrictive covenant legislative template (60+ pages) to help the Federation legislatively address physician restrictive covenant issues. The template extensively analyzes all state restrictive covenant statutes and describes many court decisions regarding restrictive covenants to show how courts may deal with the issues that physician restrictive covenants raise. There have been numerous requests for the template, and the template has been well-received. ARC staff is also helping the Federation develop state restrictive covenant draft legislation.

AMA "National Managed Care Legal Database"

The ARC launched the [National Managed Care Legal Database \(Database\)](#) in 2021. The Database is a comprehensive resource identifying how state and federal law apply to health insurer-related issues that affect patients and physicians and contains over 1,000 statutes and regulations categorized in over 50 discrete topics, e.g., rental networks, all products clauses, prompt payment, medical necessity, etc., as well as a 50-state map. The Database is designed to help physicians and medical society staff in their commercial payer advocacy. The AMA has promoted the Database through a Federation-wide webinar and is continuing to market the Database among the Federation as well as to other interested parties. ARC staff has also used the Database to provide hands-on assistance to state medical associations develop managed care advocacy strategies.

For more information on physician contracting issues, please contact Wes Cleveland, JD, Senior Attorney, at wes.cleveland@ama-assn.org.

Physicians' health and wellness

AMA advocacy and coalition building also extends to advocacy efforts to help support physicians' health and wellness. This includes supporting new laws (Indiana and South Dakota) to increase confidentiality protections for physicians seeking counseling or other help for health and wellness efforts. AMA advocacy also continuing to make progress with state medical boards (e.g., Alaska) to seek changes to medical licensing applications to remove stigmatizing and discriminatory questions about physicians' mental health.

For more information on the nation's drug-related overdose and death epidemic, efforts to increase access to evidence-based care, and ways to support physicians' health and wellness, please contact Daniel Blaney-Koen, JD, Senior Attorney, at daniel.blaney-koen@ama-assn.org.

Public health

COVID-19 vaccines and masks (as of 9/9/2021)

COVID-19 vaccines are mandated for some or all health care workers in 22 states (California, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Kentucky, Maine, Maryland, Massachusetts, Minnesota, New Jersey, New Mexico, New York, North Carolina, Oregon, Pennsylvania, Rhode Island, Vermont, Virginia, and Washington). In addition, 19 states mandate that state employees received COVID-19 immunization (California, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Maryland, Massachusetts, Minnesota, Nevada, New Jersey, New Mexico, New York, North Carolina, Oregon, Vermont, Virginia, and Washington). Ten states (Arizona, Arkansas, Georgia, Montana, New Hampshire, North Dakota, Oklahoma, Tennessee, Texas, and Utah) prohibit vaccine mandates in for certain types of employees, but all but one (Montana) exempt health care organizations.

Twenty states have prohibited certain entities from requiring proof of COVID-19 vaccination (sometimes called vaccine passports) as a condition of receiving services, entering premises, or maintaining employment. Sixteen states prohibit state and/or local governments from requiring proof of vaccination to receive government services, enter government buildings, and/or maintain employment with the government (Alaska, Arizona, Arkansas, Georgia, Idaho, Indiana, Iowa, Kansas, Missouri, New Hampshire, Oklahoma, South Carolina, South Dakota, Tennessee, Utah, and Wyoming). Five states prohibit requiring proof of vaccination by private businesses, in addition to state and/or local governments (Alabama, Florida, Montana, North Dakota, and Texas). These bans were largely, but not exclusively, enacted via executive order. Three states have taken steps to facilitate use of digital vaccine credentialing services, though no state mandates their use (California, Hawaii, and New York).

During the height of the pandemic, all but 11 states issued statewide mask mandates. Most were allowed to expire, though three states currently require masks for unvaccinated individuals indoors (California, Connecticut, and New York) and eight states have reinstituted mask mandates for all individuals, vaccinated or not (District of Columbia, Hawaii, Illinois, Louisiana, Nevada, New Mexico, Oregon, and Washington).

As students return to school in the fall of 2021, 16 states require all students wear masks in school regardless of vaccination status (California, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Kentucky, Louisiana, Massachusetts, Nevada, New Jersey, New Mexico, New York, Oregon, Virginia, and Washington.) Eight states ban mask mandates in schools (Arizona, Arkansas, Florida, Iowa, Oklahoma, South Carolina, Texas, and Utah). In Florida, however, a court ruled that the state cannot sanction local school districts that defy the ban on school mask mandates. Finally, while no state mandates COVID-19 vaccinations for as condition of attending school, 15 states prohibit vaccines

mandates for students (Alabama, Arizona, Arkansas, Florida, Georgia, Idaho, Indiana, Montana, New Hampshire, Ohio, Oklahoma, South Dakota, Tennessee, Texas, and Utah).

LGBTQ+ health

2021 saw a continuance of the legislative assault on the health of transgender individuals. Twenty states introduced legislation to ban physicians and other healthcare providers from providing gender-affirming care to minor patients. Some of these proposals included criminal penalties. The AMA worked closely with Federation partners to defeat most of these harmful bills.

Two states, however, succeeded in enacting new laws. Tennessee now prohibits a healthcare prescriber from prescribing a hormone treatment for transgender minors before puberty. Importantly, professional guidelines do not recommend hormone therapy prior to puberty.

Arkansas also enacted a bill that prohibited any physician or healthcare professional from providing gender transition procedures to a minor under 18 years of age. The law also prohibited referring a patient to another provider for gender-affirming care and prohibited Medicaid and health insurance coverage of these services for minors. Violations would be considered unprofessional conduct and subject to disciplinary proceeding by the medical board. Arkansas' law was immediately challenged in court, and, in July, a Federal Court enjoined the law, stating that it was likely to be struck down as unconstitutional. The AMA, along with several other medical associations, filed an amicus brief in the case.

Vaccines

Politics surrounding COVID-19 vaccination helped pave the way for states to enact new laws governing immunizations more broadly. Connecticut eliminated religious exemptions for vaccines required for K-12 schools, preschools, and daycares. In doing so, it became the sixth state to eliminate all non-medical exemptions for required childhood vaccines. On the other end of the spectrum, Kentucky enacted a law recognizing non-medical vaccine exemptions if based on conscientiously held beliefs. Previously, Kentucky recognized religious exemptions, but not person belief exemptions. In addition, a new Montana law prohibits discrimination against an individual on the basis, of vaccination status, effectively banning all vaccine requirements in the state. The law does not apply to vaccines required for school entry, but another new Montana law now makes it easier for children and parents to seek religious exemptions for required vaccines.

Tobacco and e-cigarettes

In 2019, Congress raised the minimum age to purchase tobacco products from 18 to 21. To simplify enforcement, state laws should mirror the federal minimum. In 2021, six states (North Dakota, Florida, Alabama, Nevada, Louisiana, and Rhode Island) enacted laws raising the minimum purchase age to 21, bringing the total number of states to 39.

For more information on public health issues, please contact Annalia Michelman, JD, Senior Attorney, at annalia.michelman@ama-assn.org.

Public option

State legislatures are renewing their interest in public options, with several states introducing bills this year that would essentially set-up a public-private health insurance product. Laws were enacted in both Nevada and Colorado despite strong opposition from physicians, hospitals, and payers. With that said, the medical societies in both states were able to significantly improve their respective bills before they were passed. Additionally, many details will need to be worked out with regulators prior to both laws being implemented.

The sticking points in many of the public option proposals are related to mandatory physician participation requirements and rate-setting, especially using Medicare as a benchmark. The AMA submitted letters with the medical societies in [Nevada](#) and Colorado outlining possibilities for alternatives to incent participation and the problems associated with using Medicare, or even negotiated rates, as benchmarks for physician payment.

For more information on public option-related issues, please contact Emily Carroll, JD, Senior Attorney, at emily.carroll@ama-assn.org.

Scope of practice

State medical associations, state osteopathic associations, national and state-level specialty societies, the American Osteopathic Association, and AMA have all been extremely busy on scope this year—sometimes working out front and often behind the scenes. The AMA worked with 35 state medical associations to help defeat scope legislation this year, including legislation related to advanced practice registered nurses (APRNs) (nurse practitioners, nurse anesthetists, nurse midwives, and clinical nurse specialists), naturopaths, optometrists, pharmacists, physician assistants, psychologists, and podiatrists. Due to the tremendous efforts of organized medicine at all levels and physician leaders across the country there have been many wins, but some tough losses as well. The following is a summary of some key bills:

Advanced practice registered nurses (APRNs)

APRNs continue to seek opportunities to expand their scope of practice at the state level including through legislation that would allow APRNs to sign death certificates, certify home health orders, order durable medical equipment, certify disability, prescribe controlled substances, and receive payment at the same rate as physicians, as well as legislation modifying or eliminating collaborative practice agreements or supervision requirements. **Key bills that would have significantly expanded APRN scope of practice were defeated in eight states this year, including Florida, Kansas, Kentucky, Louisiana, Maine, Mississippi, Tennessee, and Texas.** In Florida, the legislation would have allowed all nurse practitioners (NPs) to practice independently, expanding the law enacted last year which only allows NPs practicing in primary care to practice independently. Kansas S.B. 174 would have allowed all APRNs the ability to provide medical care without any physician involvement and allow them to prescribe controlled substances. Kentucky S.B. 78 would have eliminated physician oversight for prescribing. Louisiana H.B. 495 would have allowed all APRNs to provide medical care without any physician involvement, including diagnosing and treating patients, and prescribing medications. Maine L.D. 295 would have removed the current transition to practice requirement thereby allowing all APRNs to practice without any physician involvement, including newly graduated APRNs. Mississippi H.B. 1303 would have allowed all APRNs the ability to provide medical care without any physician involvement and would have also allowed NPs, one type of APRN, to provide oversight of other APRNs, including certified registered nurse anesthetists, nurse midwives, and clinical nurse specialists, without any education or training in these specialized areas of care. In Tennessee, legislation that would have removed physician oversight was defeated. Texas, H.B. 2029/S.B. 915 was also defeated. This bill would have drastically

expanded the scope of practice of APRNs, including allowing them to prescribe without any physician involvement. Legislation enacted in Virginia, which would have allowed NPs to practice independently, was amended to retain the current transition to practice requirement but reduced the number of years required from five-years to two-years. This provision is only applicable until July 1, 2022, at which time the law reverts back to 5 years. The bill also retained the current oversight of NPs from the medical board and nursing board.

As mentioned, however, there have been some losses as well. For example, Massachusetts enacted legislation in early 2021 that creates a transition to independent practice process in which NPs, psychiatric nurse mental health clinical specialists, and certified registered nurse anesthetists (CRNAs) can practice independently after two years of practice under a physician or nurse practitioner with independent practice authority and who meets other requirements (to be determined by regulatory process). Utah enacted legislation removing the physician collaboration requirement for prescribing. Delaware enacted legislation that removes physician collaboration and the existing requirement that APRNs seeking independent practice must practice pursuant to a collaboration agreement for two years and a minimum of 4,000 full-time hours.

Unfortunately, several states also enacted legislation specifically related to nurse anesthetists, one type of APRN, including Arkansas, and Michigan. Arkansas enacted legislation replacing physician supervision of nurse anesthetists with “consultation.” In Michigan, the medical society and partner organizations were able to secure favorable amendments to a bill that would have allowed nurse anesthetists to practice independently (H.B. 4359). Based on amendments adopted in the Senate and included in the final version of the bill, nurse anesthetists must meet the following requirements to practice anesthesia care without supervision:

- Have a minimum of three-years or more of experience practicing in the specialty field of nurse anesthesia along with a minimum of 4,000 hours practicing in a health care facility, or hold a doctor of nurse anesthesia practice degree or Doctor of Nursing practice degree, and
- Collaboratively practice in a patient-centered care team which must include a licensed physician that is immediately available in-person or through telemedicine to address any urgent or emergent clinical concerns.
- The amendments also prohibit nurse anesthetists from practicing pain management in a freestanding pain clinic without the supervision of a physician.

Physician assistants

Physician assistants introduced the American Academy of Physician Assistants (AAPA) Optimal Team Practice Act, their model independent practice legislation, in multiple states this year. Such bills were defeated in Colorado, Indiana, Louisiana, South Dakota, and Texas. Other states also had physician assistant legislation, but state medical associations were able to secure favorable amendments. For example, Florida’s bill was amended to retain physician supervision but increased the number of physician assistants a physician can supervise. The bill in Tennessee was amended to create a semi-autonomous board requiring all rules related to prescribing and collaboration to be jointly adopted by the Board of Physician Assistants and the Board of Medical Examiners. Nevada S.B. 184 was amended to retain physician supervision of physician assistants. Several states replaced physician supervision of physician assistants with collaboration, including Delaware, Idaho, Oregon and Wyoming. In Oregon, collaboration can occur with a physician, podiatric physician, or employer. In Wyoming, collaboration can occur with any member of the healthcare team. In Delaware and Idaho, collaboration must be with a physician.

Unfortunately, Utah enacted S.B. 27, which replaces physician supervision of physician assistants with

collaboration and requires such collaboration only for the first 4,000 hours of practice. Between 4,000-10,000 hours of practice, a physician assistant can collaborate with a physician or physician assistant who has met the 10,000-hour requirement in the same specialty as the physician assistant. If the physician assistant changes specialties, the physician assistant must engage in collaboration for a minimum of 4,000 hours with a physician who is trained and experienced in the specialty to which the physician assistant is changing. While there are some guardrails, this type of transition to practice legislation is concerning and Utah now marks the 4th state to allow this type of path to independence for physician assistants. Over 30 states continue to require physician supervision of physician assistants.

In addition to this legislative activity, AAPA adopted new policy at their Annual House of Delegates to change the title of physician assistants to “physician associate.” The AMA stands in strong opposition to this title change, please read Dr. Bailey’s statement [here](#). The American Osteopathic Association (AOA) and several national specialty organizations have also issued strong statements opposing the title change. As stated in Dr. Bailey’s statement, this title change is incompatible with laws and regulations at the state and federal levels, and we are ready to work with interested partners to address this issue.

Optometrists

Legislation that would have allowed optometrists to perform eye surgery was defeated in Alabama and Florida, while favorable amendments were secured in Texas. S.B. 174 and H.B. 402 in Alabama would have allowed optometrists to perform laser surgery and in Florida S.B. 876 and H.B. 631 would have significantly expanded the list of medications an optometrist can prescribe and would have allowed optometrists to perform laser and non-laser procedures as determined by the Board of optometry. Texas H.B. 2340/S.B. 993 passed with significant and important amendments including removal of language allowing optometrists to perform any type of surgery (laser, scalpel, or injection).

Unfortunately, legislation expanding optometrist scope of practice passed in Mississippi and Wyoming. Mississippi’s H.B. 1302 allows optometrists to remove superficial foreign bodies from the eye, administer and prescribe pharmaceutical agents rational to the diagnosis and treatment of the eye, and perform YAG laser procedures. Optometrists, however, are not permitted to perform cataract surgery or other procedures not specifically allowed. Wyoming’s legislation is much broader allowing optometrists to perform eye surgery.

For more information on scope of practice issues, please contact Kim Horvath, JD, Senior Attorney, at kimberly.horvath@ama-assn.org.

Telehealth

As expected, telehealth was a top legislative priority in many states in 2021 with states seeking opportunities to solidify temporary measures adopted in 2020. As a result of this significant activity, several states enacted comprehensive telehealth legislation this year, including Arizona, Illinois, Maryland (Medicaid), Massachusetts, Nevada, and Oklahoma. In addition, a number of states enacted legislation addressing everything from the definition of telehealth to coverage, payment, and other payer policies and in many states setting up task forces or other committees to conduct further study for report back to the legislature. The following is a summary of various provisions related to telehealth adopted in states across the country this year.

Coverage

Prior to the COVID-19 pandemic about 30 states required state-regulated health plans to cover services provided via telehealth when the same service would be covered for an in-person visit. This year at least

five states enacted legislation to expand coverage of telehealth by removing any remaining barriers and/or requiring coverage on the same basis as in-person services, including Connecticut, Illinois, Kentucky, Massachusetts, and Oregon.

Many states also took steps to expand coverage of telehealth provided via audio-only. While many states, such as Arkansas, Colorado, Connecticut, Georgia, Illinois, Kentucky, Massachusetts, Montana, Nevada, Oregon, Rhode Island, Vermont, and West Virginia, simply added audio-only to the definition of telehealth or extended coverage to telehealth services appropriately provided via audio-only, other states allowed audio-only under certain circumstances. For example, per Arizona H.B. 2454, coverage of audio only telehealth is now permitted for behavioral health and substance use disorder. Furthermore, for all other services, audio-only is permitted with an established patient and when audio-visual is not reasonably available due to the patient's functional status or lack of technology or where there is a lack of telehealth infrastructure and the patient initiates or agrees to audio-only prior to the service. Arkansas allows audio-only when it, "substantially meets the requirements for a health care service that would otherwise be covered by the plan." Similarly, Maryland H.B. 123 expanded the definition of telehealth to include, "an audio only conversation...that results in the delivery of a billable, covered health care service." This bill also specifies that behavioral health care services, including counseling and treatment for substance use disorders and mental health conditions, can be appropriately provided via telehealth. North Dakota passed legislation allowing audio-only for e-visits and virtual check-ins. Nebraska now allows audio-only for behavioral health services to established patients. Similarly, Washington H.B. 1196 allows audio-only telehealth for established patients.

Payment

About a dozen states enacted legislation requiring private payers to reimburse services provided via telehealth at the same rate for the same or equivalent service provided in-person, including Arizona, Connecticut, Illinois, Iowa, Massachusetts, Maryland, Missouri, Nebraska, Nevada, New Jersey, Oklahoma, Oregon, Rhode Island, and Tennessee. Many of these laws, however, are limited in duration and/or only require parity for certain services. Depending on how one defines payment parity, about 20-25 states now have laws in place requiring state regulated plans to reimburse providers for services provided via telehealth at the same or similar rate for the same or comparable service in-person. Some laws set different payment structures or standards for audio-only telehealth and some limited to specific services. For example, Nebraska only requires payment parity for mental health care provided via telehealth, but not other services. Nevada does not require payment parity for audio-only telehealth and limits parity to one-year after the end of the public health emergency (PHE) or June 30, 2023, whichever is earlier, except for mental health services which expire on June 30, 2023. Arizona now requires payment for services via telehealth at the same level as an equivalent service identified by the "healthcare common procedure coding system," whether provided through telehealth using audio-visual or in-person care, with behavioral health and substances abuse services paid at the same level for audio-only services. Some states like Connecticut, Maryland, and Tennessee only require payment parity for a limited period of time. For example, Maryland H.B. 123 requires payment at the same rate as an in-person service from July 1, 2021–July 1, 2023—the reimbursement also does not include any facility fees. Payment parity in Iowa is limited to mental health services provided between January 1, 2021–July 30, 2023. Finally, other states like Massachusetts took an even more nuanced approach with permanent payment parity for behavioral health (mental health, developmental, or substance use disorders), parity for two-years for primary care and chronic disease services, and parity for all other services for 90-days beyond the end of the COVID-19 PHE.

Other payer policies

Prior to the pandemic, many payers limited care via telehealth to large telehealth companies with whom the payer owns or contracts. As more physicians have integrated telehealth in their practices, this parallel track no longer makes sense and is often confusing to patients who seek telehealth from the same physician whom they see for in-person care. AMA's model state telehealth bill includes language prohibiting this practice, which was enacted by California and Kentucky prior to the pandemic. Many states also took steps to prohibit this practice through temporary measures during the pandemic and now many states have solidified these provisions through legislation. To date at least six states, including Arkansas, Illinois, Georgia, Maryland, Massachusetts, and Oklahoma, have enacted legislation this year to prohibit plans from limiting telehealth to select corporate telehealth providers.

In addition to limiting patient telehealth access to only select corporate telehealth providers, payers also incentivize or steer patients toward select telehealth providers through no or lower cost sharing. This practice, in effect, steers patients away from their regular in-network physician whom the patient receives care from in-person, thereby weakening the patient-physician relationship, care coordination, and continuity of care. Arkansas limits this practice in H.B. 1063 by prohibiting plans from imposing a, “copayment, coinsurance, or deductible that is not equally imposed upon commercial telemedicine providers as those imposed on network providers.”

Finally, at least seven states, including Georgia, Kentucky, Massachusetts, Nevada, Oklahoma, Oregon, and Rhode Island, enacted legislation prohibiting health plans from implementing more stringent prior authorization or utilization review procedures than exists for in-person services.

Network adequacy

At least four states enacted legislation prohibiting plans from using telehealth only networks to meet network adequacy requirements, including Arizona, Massachusetts, Maine, and Oregon.

For more information on telehealth issues, please contact Kim Horvath, JD, Senior Attorney, at kimberly.horvath@ama-assn.org.